

**EFFECTIVENESS OF MCH CARE PACKAGE ON  
KNOWLEDGE AND ATTITUDE REGARDING  
MALE INVOLVEMENT IN MCH SERVICES  
AMONG MALES AT SELECTED SETTING,  
CHENNAI - 2011.**

DISSERTATION SUBMITTED TO  
**THE TAMIL NADU DR.M.G.R.MEDICAL UNIVERSITY**  
**CHENNAI.**  
IN PARTIAL FULFILMENT OF REQUIREMENT FOR THE DEGREE OF  
**MASTER OF SCIENCE IN NURSING**  
**APRIL 2012**

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**His love endures forever. Psalms 106:1**

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# CHAPTER – I

## INTRODUCTION

### BACKGROUND OF THE STUDY

Pregnancy is a period of transition from women to motherhood. Attainment of motherhood is considered as fulfillment in a women's life. Their complete passage is considered to be crucial to women. It is a period of physical and psychological preparation for mother hood. It is a special journey for women and to ensure safe journey, social support play a vital role. Pregnant women's family, husband's family, friends and health care professionals provide most of the social support for the pregnant women.

**MATERNAL AND CHILD HEALTH SERVICES<sup>77</sup>** is defined as various facilities and programs organized for the purpose of providing medical and social services for mothers and children. Medical services include prenatal and postnatal services, family planning care, and pediatric care in infancy.

### Maternal Health Situation

**Globally** about 210 million women become pregnant each year where 30 million (15%) are developing maternal complications and resulting into over half million maternal deaths. In that developing countries accounts for more than 99% of all maternal deaths, about a half occurring in sub Saharan Africa, and south Asia.

### **WHO SURVEY REPORT (2010)<sup>101</sup>**

There are approximately 6 million pregnancies every year throughout the United States among that 4,058,000 were live births and 1,995,840 were pregnancy losses .**AMERICAN PREGNANCY ASSOCIATION (2011)<sup>104</sup>**.

Among 11 **South East Asian (SEA)** countries, 37 million childbirths occur annually where 1, 70, 000 maternal and 1.3 million neonatal deaths and 1 million

stillbirths occur per year. Social and cultural factors affect access and utilization of Maternal and Neonatal Health services and the main causes of maternal and neonatal deaths can be prevented and managed by cost-effective interventions **(WHO, 2009)**<sup>105</sup>

Thousands of women die during childbirth [from complications] every minute around world, and in **sub-Saharan Africa** where there is a 1 in 16th chance of a woman dying during childbirth (**www.unicef.org**)<sup>83</sup>. Yet many of the factors (i.e. unsafe child birthing conditions) that lead to maternal mortality are for the most part preventable. A mother who has access to safe and effective medical services also has a better chance of raising a child

In a study by **Gyimah, Takyi, & Addai (2006)**, researchers found that socio-economic factors, such as extreme poverty, was not one of the major predictors of maternal health and infant mortality, however religious and other very strong ideological beliefs were seen as more of a predictor of current disparities in the rates at which women seek reliable medical services.

In **India**, about 28 million pregnancies occur every year of which there are 24 million deliveries where 40.7% are Institutional Delivery (NFHS III-2005-06) and 15% of these are likely to develop complications. Over 67,000 avoidable maternal deaths occur per year. **(MOHFW, 2009)**<sup>102</sup>

Every 7 minutes a woman die during pregnancy or childbirth. Every day, over 160 women die in India from pregnancy and complications of child birth by **(SAVE THE MOTHER 2011)**<sup>78</sup>

Maternal health is intimately connected with the health of a child therefore while defining the barriers to maternal health; it helps to predict barriers to child mortality. In the most general sense, maternal health and child mortality is described as a mother's ability to eat healthy, to have access to safe reproductive

strategies, to seek and have access to the appropriate medical services, and to get educated on how to ensure that their life and the life of their baby remains healthy. Under the Millennium Development Goals, nations around the world have the opportunity to sign on to reduce the maternal mortality ratio by at least three quarters as soon as 2015 ([www.unicef.org](http://www.unicef.org))<sup>79</sup>.

Becoming a father and a parent can be a transformational process for a man. When a man becomes a father, through loving his child, partner and family, he comes in contact with a deep paternal masculinity. When a child enters a man's life, a new depth of feeling and emotion are awakened within him. A whole world of feelings is awakened in a man through the process of pregnancy and birth. It has been the researcher's experience that although women often appreciate this new awakening of feeling in their spouse or partner, they don't really understand what it means to the new or expectant father.

Many research findings showed that the male involvement in the maternal and child health end up in the positive outcome of pregnancy and child birth. Apart from this there were many other benefits related to male involvement.

- Fathers offer quality support through pregnancy – and this is clearly beneficial.(Kiernan, 2006)
- Laboring women benefit when they feel ‘in control’ of the birth process – and that a key component in this is experiencing support from their partner during the birth. Gibbins & Thomson (2001)
- Shorter duration of delivery, less pain experienced and less likely to have epidural (Tarkka, 2000).
- Positive attitude by the mother towards motherhood (Mercer et al, 1984).
- Studies repeatedly show high levels of satisfaction postpartum for both mothers and fathers in sharing the experience of labor and birth (Chan & Paterson-Brown, 2002).
- Laboring women generally disappointed by the level of midwife involvement while their partner's involvement much more nearly met their

expectations – a personal experience also reported by Llewellyn Smith (2006).

- Father's presence at the birth pay off in greater involvement later in child rearing.
- The quality of the couple's relationship improved.
- The best predictor of each parent's adjustment to parenthood is the quality of the relationship between them (Fathers Direct, 2000).
- The quality of mothering provided to an infant has been linked with supports the mother receives from her partner; and the quality of the relationship between the parents has been shown to predict how both mother and father nurture and respond to their children's needs (for review, see Guterman & Lee, 2005).
- Frequent care-taking of a firstborn by the father is associated with a large increase in the firstborn's positive behaviors toward the mother, after the birth of a second sibling (Kojima et al, 2005).

Male involvement is highly seen during the pregnancy and child birth. During pregnancy males try to involve themselves by attending prenatal visits, prenatal classes, and searching information through internets and also from their peer groups. Many men begin during the pregnancy to develop a bond with their child. Helping choose the birth attendants, midwife or doctor and being involved in the choice of where the baby will be born is another way men begin becoming involved.

In terms of child birth, males show their involvement by participating in the birth process, being with the partner, offering love and support. They want to be there with and for their partners. They want to be involved in offering support and love. Men always considered these as one of the most important moments in their relationship and in their lives. Even if the birth is difficult or a cesarean delivery, men still feel strongly about being together at this special time. Fathers' importance



in participating at the birth is finally getting acknowledged highly now a days in western countries.

Men's involvement in pregnancy and birth and their participation in the early years of their child/children's lives have changed dramatically over the past 25 years. In 1965, about 5% of fathers attended the birth of their child. In 1989, almost 95% of fathers were present at childbirth. Men are clearly asking for more participation in the childbirth process. It is also interesting to note how, in a recent survey on men and work, 75% of the men would accept slower career advancement if they could have a job that would let them arrange their work schedule to have more time with their families.

In United Kingdom, Fifty years ago, very few fathers attended their children's births. Today 93% of fathers who live with their partners do so, as do 45% of those who live separately (**Kiernan & Smith, 2003**). NHS data shows even higher figures: 98% of fathers attending the birth, 48% attending antenatal/parenting classes, 85% at least one prenatal appointment with a midwife, and 86% at least one ultrasound scan (**National Health Service, 2005**)<sup>85</sup>.

During the eighties and early nineties, almost all the reproductive and child health programs in India focused exclusively on women. Men were left out of the programs. It was during the mid nineties that researchers and policy makers started realizing the important role that men can play as supportive partners in achieving good health for women and children. Further, the International Conference on Population and Development (ICPD) held in Cairo in 1994 reminded people that good reproductive health is the right of all people, men and women alike, and that together they share responsibility of making decisions about reproductive matters.

As part of this broader view, reproductive health programs started to focus their attention on the role of men as it relates to women's access to and utilization of reproductive health services. Men are key players in influencing, both positively

and negatively, directly and indirectly, the productive health outcomes of their wives and children (Dudgeon and Inhorn 2004). Therefore, ensuring men's involvement in reproductive and maternal health matters can, in theory, promote a better partnership between men and women in both the household and community at large. The other perspective that emphasizes this relationship is that male involvement can yield positive health benefits for women through added social support (Carter 2002). The involvement of men in the programmes can also enhance outreach as well as utilization of the various reproductive health services.

Report by **2005-06 National Family Health Survey (NFHS-3)<sup>103</sup> on Men's Involvement in Maternal Health Care**

- Two-thirds of men with a child under age 3 reported that the mother **received antenatal care**
- Half of men with a child under 3 **were present** for at least one of the mother's antenatal care visits
- Slightly more than one-third of men were informed what do to in case of **pregnancy complications**
- Half of men were informed about proper **nutrition**, and about 2 in 5 men were informed about the **importance of delivery in a health facility and family planning**
- Men in the South and in Gujarat, Punjab, Delhi, Sikkim, and Mizoram are more likely to be informed about the importance of delivery at a health facility.

The report concluded that

- Men's participation in maternal health care needs to be strengthened
- The information provided to men who participate in ANC visits is inadequate and needs to be more comprehensive.

## **NEED FOR THE STUDY**

Women, it seems, are still the only people worth talking to in the multi-million pound maternity and baby industry – and the same goes for our health

professionals, who tend to see their client as the mother, rather than taking on the bigger challenge of communicating more holistically with the support network that surrounds the baby – which in most cases includes its father.

Just about all the information expectant and new families receive is still aimed at mothers – either directly or in such a way that while the word ‘parent’ might be used, it’s obvious to anyone reading it that really it’s just the mums that count.

At the prospect of becoming a father, men are filled with excitement, fear, wonder, worry, love, and confusion. (Just to name a few feelings!) Throughout the pregnancy and birth, the man, who is now becoming a father, is trying to find ways to express and integrate these and many more feelings. In many cases the father (hereafter referred to as the father) is not an integral part of the pregnancy process, and in this both the pregnant woman and the father may be losing the chance to grow together. With a loss of contact between the partners, the possibility of them both becoming more “connected” to their child lessens.

As the nuclear system is emerging in our Indian country for the past two decades, the health related aspects are fully confined between the couples especially when the woman is pregnant. Hence there is in need for the male involvement in order to take care of their partner’s health as because it’s the precious time where they are creating their own generations.

**Bond MJ, et al., (2010)<sup>76</sup>** conducted an observational and intervention study on father involvement in African American fathers. The findings revealed that increasing work force led to father absence and very less were aware of availability of programs to encourage greater father involvement.

**Persson EK, et al., (2010)<sup>62</sup>** conducted an exploratory study on fathers' sense of security during the first postnatal week among 13 fathers residing in

Sweden. Various themes were identified and the study concluded that fathers' sense of early postnatal security may be enhanced by giving them a genuine opportunity to participate in the post natal care and Midwives should strengthen the fathering role by acknowledging and listening to the father as an individual person.

**Reeves J, et al.,(2009)<sup>66</sup>** stated in the article focusing on young men: developing integrated services for young fathers that while some girls cope well as teenage mothers and often have a range of support services; young fathers do not often access services in their own right.

**Mullany, et al ., (2007)<sup>74</sup>** conducted a study and provided evidence that educating pregnant women and their male partners yields a greater net impact on maternal health behaviors compared with education of women alone.

**Sahip Y et al ., (2007)<sup>75</sup>** conducted an intervention study was developed to test the feasibility and effects of expanding a special program for expectant fathers to large workplaces in Istanbul. The findings indicate that it is possible to train workplace physicians in Istanbul to conduct regular educational programs for expectant fathers on reproductive health, and that such programs may have beneficial effects, especially in the areas of pregnancy nutrition, exclusive breast-feeding, and support behaviors. Considering the difficulty of getting men to attend hospital or clinic-based educational programs in large urban areas, bringing such training programs to men at their places of work has the potential to be an important strategy.

**Britta.C.et al (2005)<sup>83</sup>** conducted a study on the impact of including husbands in the antenatal health education services on the maternal health practices in Urban Nepal, In 442 women seeking antenatal services during II trimester of pregnancy were randomized into 3 groups, women who received education with their husband, women who received alone, women who received no education. In

this women who received the education with their husbands were more likely to attended postpartum visit than the other two groups.

**Britta C. Mullany et al (2005)**<sup>87</sup> had conducted a study regarding whether women's autonomy impede male involvement in pregnancy health among 592 pregnant women using a structured questionnaire in Katmandu, Nepal. The study revealed that joint decision-making between the husband and wife was associated with significantly higher levels of male involvement in pregnancy health.

**AlkaBarua et al., (2004)**<sup>98</sup> had conducted a survey on caring men? Husband's involvement in maternal care of young wives in Maharashtra. Findings revealed that men were often excluded from participating in routine care because the medical system does not accommodate them and the community considers maternal care as exclusively women's domain. Thus, it may be crucial to get husbands involved, since they are often the decision-makers, the ones who have to accompany the young woman to a clinic and the ones who pay for care.

In Indian society, men play an important role in decision making in almost all spheres of life including reproductive life. In such society, where men stands as a “**gate keepers**” for women in choosing their reproductive health care services. But still due to traditional patriarchal dominance, poor autonomy for women, cultural factors and economic dependency of women on men partner's support is not encouraged much. Hence male involvement is essential for the improvement of women's health and the overall status of women. The investigator felt that the above situation was still existing and therefore the investigator chose this study to assess the knowledge and attitude of males regarding their involvement in MCH services and to create awareness among males in order to improve the health of the mother and the child.

## **STATEMENT OF THE PROBLEM**

A pre-experimental study to assess the effectiveness of MCH Care Package on knowledge and attitude regarding male involvement in the MCH services among males at selected setting, Chennai.

## **OBJECTIVES**

1. To assess the pre and post level of knowledge and attitude regarding male involvement in the MCH services among males
2. To assess the effectiveness of MCH Care package on knowledge and attitude regarding male involvement in the MCH services among males
3. To correlate mean differed knowledge score with attitude score.
4. To associate the mean differed level of knowledge and attitude score with selected demographic variables.

## **OPERATIONAL DEFINITIONS**

### **Effectiveness**

It refers to the outcome of MCH Care package on knowledge and attitude among males regarding MCH services assessed using knowledge questionnaire and attitude scale.

### **Maternal and Child Health Package**

In this study it refers to the educational package prepared by the investigator which includes the following components

### **Antenatal Period**

The knowledge on antenatal care services included early registration, immunization, antenatal visit, diet, sexual relationship, early and warning signs of pregnancy was imparted with the help of computer assisted learning for 15 mins.

**Intra natal Period**

Video film depicting the support of the male partner during the time of delivery for 7 mins was shown.

**Postnatal Period and Child Care**

One to one teaching on postnatal visit, diet, family planning methods and sexual relationship along with teaching on child care services which included breast feeding, immunization and prevention of hypothermia for 20 mins was organized.

**Knowledge on Male Involvement**

In this study it refers to the information possessed by the males regarding their involvement in the MCH services which was elicited by using structured interview schedule.

**Attitude on Male Involvement**

In this study it refers to the expressed beliefs of the males regarding their involvement in the MCH services which was measured by a structured 5 point likert scale.

**Males**

In this study it refers to the married males and whose wives are primi mothers.

**ASSUMPTIONS**

1. Males have a role to play in the maternal and child health services
2. Males may have some knowledge regarding their involvement in the maternal and child health services.
3. The maternal and child health care package may enhance the knowledge and attitude regarding male involvement in the maternal and child health services.
4. Knowledge on male involvement in MCH care may enhance the attitude on male involvement during MCH care practices.

## **NULL HYPOTHESES**

- NH<sub>1</sub>** - There is no significant difference between pre & posttest level of knowledge and attitude regarding male involvement in the MCH services
- NH<sub>2</sub>** - There is no significant relationship between mean differed knowledge and attitude score.
- NH<sub>3</sub>** - There is no significant association of the mean improvement level of knowledge and attitude score with the selected demographic variables.

## **DELIMITATION**

The study was delimited to a period of 4 weeks of data collection.

## **CONCEPTUAL FRAMEWORK**

Conceptual framework or model refers to concepts that structure or offers a framework of proposition for conducting research. The conceptual framework comprises of interrelated concepts linked together, which explains the phenomenon of interest of the investigator, this explains the nature of relationship between the concepts and guides the investigator to propose the study and work on it systematically.

The Investigator adopted integrated modified **IMOGENE KING'S GOAL ATTAINMENT AND J.W.KENNEY'S MODEL**, as a basis for conceptual framework, which was aimed to assess the effectiveness of MCH Care Package on knowledge and attitude regarding male involvement in the MCH services among males.

According to this theory, two people come together to help or to be helped to maintain a state of health where they communicate information, establish goals, and take action to attain goals.



## **1. Perception**

Refers to personal representation of reality. It gives meaning to one's experience and represents one's image of reality and influences one's behavior. Here the investigator perceives that males lack knowledge and attitude regarding their involvement in MCH services. The males in turn perceive the need to gain more knowledge and attitude regarding their involvement in MCH services.

## **2. Judgment**

Individuals come together for a purpose; each person makes a judgment, takes mental or physical action, and reacts to the other individual and the situation. The investigator judges that MCH care package can enhance more knowledge and attitude regarding their involvement in MCH services. Males too judge, that utilization of MCH care package will enhance their knowledge and attitude regarding their involvement in MCH service

## **3. Action**

Individual transfers the perceived energy as demonstrated by observable behavior by performing mental and physical action. Investigator develops MCH care package in order to enhance knowledge and attitude regarding their involvement in MCH services. The males were willing and ready to gain knowledge and attitude regarding their involvement in MCH service

## **4. Mutual Goal Setting**

The investigator and males set mutual goals. The mutual goal setting was done with a belief that MCH care package will enhance the knowledge and attitude regarding their involvement in MCH services.

## **Input**

It consists of the assessment of demographic variables using personal data sheet, existing level of knowledge and attitude using structured interview schedule and a 5 point likert scale.

**Throughput**

It includes administration of MCH care package on male involvement in MCH services.

**Output**

It consists of posttest assessment of knowledge and attitude among males using self-structured interview schedule and 5 point likert scale. If the results show an adequate knowledge and favorable attitude the same may be enhanced by MCH care package and if they have inadequate knowledge and un favorable attitude they need to be reassessed and reinforced.



## **OUTLINE OF THE REPORT**

**Chapter I** : This chapter dealt with the background of the study, need for the study, statement of the problem, objectives, operational definitions, assumptions, null hypothesis, delimitation of the study and conceptual framework.

**Chapter II** : This chapter deals with the review of literature.

**Chapter III** : This chapter deals with the research methodology.

**Chapter IV** : This chapter deals with the data analysis and interpretation.

**Chapter V** : This chapter contains the discussion of the findings.

**Chapter VI** : This chapter consists of the summary, conclusion, implications, recommendations and limitations of the study.

The report ends with the **Bibliography** and **Appendices**.

## **CHAPTER – II**

### **REVIEW OF LITERATURE**

Review of literature is a systemic search of a published work to gain information about a research topic (**Polit & Hunger**). Conducting a review of literature is challenging and an enlightening experience.

The literature review was based on extensive survey of books, journals and international nursing indicates. A review of literature relevant to the study was undertaken which helped the investigator to develop deep insight into the problem and gain information on what has been done in the past.

An extensive review of literature was done by the investigator to lay down a broad foundation for the study and a conceptual framework to proceed with the study under the following headings.

- Section –A : Reviews related to male involvement during antenatal period
- Section-B : Reviews related to male involvement during intranatal period.
- Section-C : Reviews related to male involvement during postnatal period

#### **SECTION A: REVIEWS RELATED TO MALE INVOLVEMENT DURING ANTENATAL PERIOD**

**Lima- Pereira P et al., (2011)**<sup>56</sup> conducted a cross sectional descriptive study on use of internet as a source of health information amongst participants of antenatal classes using a self administered questionnaire. The findings reported that 93.5% of both men and women were using the internet on a regular basis as a

source of information after the physician. The study concluded that midwives should keep up to date and give links to high quality sites.

**Ahman A et al., (2011)<sup>46</sup>** conducted a qualitative study on facts first, then reaction-expectant father's experiences of an ultrasound screening identifying softmakers at Uppsala hospital among 17 expectant fathers using a semi structured in depth interviews. Findings revealed in major five themes and concern about the partner was also included. The study concluded that relevant knowledge about ultra sound should be provided to the fathers to reduce their anxiety.

**Alio AP et al., (2010)<sup>47</sup>** reviewed the literature on paternal involvement during the perinatal period and its influence on feto-infant health and survival. Although results are limited, results suggested that paternal involvement has a positive influence on prenatal care usage, abstinence from alcohol and smoking, and a reduction in low birth weight and small for gestational age infants.

**Iiyasu Z et al., (2010)<sup>92</sup>** understudied about birth preparedness, complication readiness and male participation in maternity care in Ungogo, a northern Nigerian community using in depth interviews and questionnaire. The results revealed that only 32.1% of men ever accompanied their spouses for maternity care.

**Murphy Tighe S, (2010)<sup>60</sup>** conducted a qualitative study to explore the attitudes of first-time mothers towards antenatal education from the perspective of attenders and non-attenders using focus group interviews in Ireland the findings suggested many barriers to attendance at antenatal education and one among that was partner's absence. The mothers alluded to the importance of father's attendance and inclusion at classes.

**Simbar M et al., (2010)<sup>70</sup>** conducted a qualitative study on Fathers' educational needs for perinatal care in urban Iran among 8 groups of men and women using focus group discussions. Findings revealed that emotional support of women as the most appropriate form of men participation in perinatal care. Study concluded that majority were preferring men's education about perinatal care.

**Li HT et al., (2009)<sup>99</sup>** conducted randomized control trial on a birth education program for expectant fathers; effects on their anxiety. 87 expectant fathers were allocated by block randomization to an experimental (n = 45) and a control (n = 42) group. Their results showed no statistically significant differences between the experimental and control groups of fathers in trait anxiety and their prenatal childbirth expectations and the childbirth program was significant for the postnatal level of anxiety

**Williamson M et al., (2009)<sup>90</sup>** had conducted a study to describe and explore the sexual relationship of fathers related to pregnancy and child birth among 204 men experiencing fatherhood for the first time Comments by the study participants revealed that sexual relationships during pregnancy and the postnatal period undergo a variety of changes that may affect the couple's relationship and concluded that, there is a need for the midwife to have an individual discussion for the couples regarding sexual activity during pregnancy and childbirth.

**Deave T et al., (2008)<sup>95</sup>** conducted a qualitative study at health care organizations in England. Purposive sampling was used to recruit 24 nulliparous women in the last trimester to 3-4 months of post partum period, where as 20 of whom had their partners. The results were knowledge about the transition to parenthood was poor and the men felt very involved with their partners' pregnancy but excluded from antenatal appointments, antenatal classes. This study concluded

on the need for including fathers in antenatal education and the couple's preparation for parenthood.

**Fletcher R, et al., (2008)**<sup>53</sup> conducted a descriptive study on psychosocial assessment of expectant fathers among 307 males in public and private hospitals in new south Wales. The results revealed that the fathers were in need of ability to cope up with their stresses of new parenthood and the skills and knowledge to care for their new baby. The study concluded that psychological assessment should be advised to detect fathers who may require assistance and parenting education in infant care.

**Martin LT, et al., (2007)**<sup>58</sup> conducted a longitudinal study on the effects of father involvement during pregnancy on receipt of prenatal care among 5,404 women and their partners. The findings revealed that women whose partners were involved in their pregnancy were 1.5 times more likely to receive prenatal care in the first trimester. The study concluded that improving father involvement may have important consequences for the health of the partner.

**Saha KB, et al., (2007)**<sup>67</sup> conducted a door to door survey on male involvement in reproductive health among scheduled tribe by canvassing a pre-designed interview schedule among 15-40 year old, currently married males in Madhya Pradesh, India. The results finding were very few among them (29%) had knowledge of antenatal care and approximately 59% of the males were aware of family planning. The study revealed the male Scheduled tribe population's lack of knowledge and of male-oriented reproductive health services.

**Kao BC, et al., (2004)**<sup>55</sup> conducted a comparative study of expectant parents' childbirth expectations among 200 couples from hospitals in central Taiwan. The



study revealed that expectant fathers with a higher socio economic status and who had received prenatal education had higher child birth expectations.

## **SECTION-B: REVIEWS RELATED TO MALE INVOLVEMENT DURING INTRANATAL PERIOD.**

**Long worth HL,et al.,(2011)<sup>57</sup>** conducted a phenomenological study on Fathers in the birth room: what are they expecting and experiencing? utilizing in-depth interviews among 11 first time expectant fathers in a large tertiary maternity unit in England. Four main themes were evident: fathers' disconnection with pregnancy and labour; fathers on the periphery of events during labour; control; and fatherhood beginning at birth and reconnection. The study concluded that they struggled to find a role there due to lack of knowledge and perceived control.

**Sapountzi-Krepia et al., (2010)<sup>96</sup>** conducted a study to determine the fathers' feelings and experience related to their wife/partner's delivery among 417 fathers in Greece . Data were collected using the Kuopio Instrument for Fathers (KIF). Results revealed that (82.1%) of the participants were proud to become fathers and agree that they felt love and were grateful to their wife/partner. Half of the fathers felt anxious and nervous.

**Sabitri Sapkota RN et al., (2010)<sup>89</sup>** conducted a qualitative study to explore husbands' experiences of supporting their wives during childbirth using semi structured interviews among 12 nepalese fathers who had supported their wives during childbirth in maternity and Neonatal Service Centre. The study revealed that husbands reflected positive experience, despite of profound hesitation and overwhelming emotions.

**Sengane ML et al., (2009)<sup>69</sup>** examined the experience of black fathers concerning support for their wives during labour using a phenomenological

approach where by unstructured interviews were conducted with 10 black fathers. 2 groups of fathers were purposively selected were as one group were provided support and the other group were not provided any support to their wives during labour. The results identified were some of group 1 fathers experienced negative feelings due to lack of information. Both the groups expressed a feeling of wanting to be there.

**Pestvenidze E, et al., (2007)<sup>63</sup>** stated that father's presence in the delivery rooms can effectively provide skin to skin contact to the infants to prevent hypothermia. Increased father's participation showed improved delivery outcomes, ultimately leading to better maternal and child health.

**Swiatkowska-Freund M et al., (2007)<sup>84</sup>** studied about the advantages of father's assistance at the delivery among 37 couples using a questionnaire about reasons for being together at the delivery ward and impressions after the delivery. The results identified were father's presence at the delivery ward was a desire to experience the delivery together with the mother and men were also satisfied being with the mother and taken part in giving birth to their baby.

**Tomeleri KR, et al., (2007)<sup>86</sup>** conducted a descriptive exploratory study on experience of fathers in delivery room among 40 young fathers who were experiencing the birth of the child. From the study it was verified that the fathers were unaware of their right to present during these events and the experience was considered as positive because of the support given to the mothers. Finally, daddies in the delivery room: parents' education in Georgia.

**Clifford odimegwn et al., (2005)<sup>92</sup>** conducted a survey to examine the role of men in emergency obstetric care in 900 houses of South-West Nigeria. Simple random sampling was used and separate interviewers interviewed the man and his

wife in each of the households. The results showed that there was high level of awareness of emergency obstetric conditions and men play useful roles during their partner's obstetric conditions (89.2%). Education is found to be the major determinant of this change in male knowledge and behaviour.

**Modarres Nejad V (2005)**<sup>97</sup> determined the attitudes of men and women in the Islamic Republic of Iran to the husband's presence in the delivery room. 150 couples awaiting delivery were selected randomly. Results revealed that most women (88.4%), men (82.1%) and couples (76.9%) had positive attitudes to the husband's presence in the delivery room. Providing facilities to accommodate husbands and training for their presence in the delivery room is recommended.

**Olayemi O et al., (2005)**<sup>100</sup> carried out a cross-sectional study to assess the level of participation of men in pregnancy and birth among 462 pregnant women attending antenatal care in Ibadan, Nigeria. The findings were nearly all husbands (97.4%) encouraged their wives to attend antenatal clinic - paying antenatal service bills (96.5%), paying for transport to the clinic (94.6%) and reminding them of their clinic visits (83.3%). (72.5%) accompanied their wives to the hospital for their last delivery, while 63.9% were present at last delivery.

### **SECTION-C: REVIEWS RELATED TO MALE INVOLVEMENT DURING POSTNATAL PERIOD**

**Avery AB, et al., (2011)**<sup>48</sup> conducted a focus group study in three US cities on Expectant fathers' and mothers' perceptions of breastfeeding and formula feeding among 121 focus group participants. The study revealed that men expressed empathy for their partner's pregnancies and deferred to their partners feeding decisions. Both the father and mother emphasized father's support of the infant.

**Massoudi P, et al., (2011)**<sup>59</sup> conducted a study on Fathers' involvement in Swedish child health care - the role of nurses' practices and attitudes among 499 nurses through a postal questionnaire. The findings identified that fathers' participation in child health care was much lower than that of mothers'. It concluded that various methods need to be developed to involve both parents in child health care.

**Wang DH, et al., (2011)**<sup>72</sup> conducted a cross sectional survey on family adaptation during postpartum period and its influencing factors among 232 mothers and fathers in china. The results revealed that there were no significant differences between mothers' adaptation and fathers' adaptation during the postpartum period, as well as their perceived stress, family function and family resources ( $p>0.05$ )

**Laanterä S, et al., (2010)**<sup>88</sup> conducted a study on Breastfeeding attitudes of Finnish parents during pregnancy among 172 people (123 mothers, 49 fathers) using electronic breast feeding on knowledge and attitude and confidence scale. The results revealed that first time fathers had moderate breast feeding knowledge and negative feelings and were worried about breast feeding than the fathers who had at least one child. The study concluded that father's eagerness to participate should be included in prenatal breast feeding counselling.

**Magoma M,et al., (2010)**<sup>94</sup> conducted a grounded theory approach on high ANC coverage and low skilled attendance in a rural Tanzanian district among 12 key informants. The study revealed that husbands typically serve as gatekeepers of women's reproductive health in the two groups including decisions about where they will deliver yet they are rarely encouraged to attend antenatal sessions.

**Engebretsen IM, et al., (2010)<sup>91</sup>** conducted a qualitative study on gendered perceptions on infant feeding in Eastern Uganda: continued need for exclusive breastfeeding support among 81 informants. The results revealed that among men; not giving supplements to breast milk was associated with poverty and men's failure as providers. Most men felt left out from health education. The study concluded that male involvement was imperative.

**Sasaki Y, et al., (2010)<sup>68</sup>** conducted a survey on predictors of exclusive breast-feeding in early infancy among 312 mothers in the national maternal and child health centre, Cambodia. The survey identified that there was lack of paternal attendance at breast feeding classes and it revealed that paternal involvement could have positive influence in promotion of EBF.

**Hildingsson I, et al., (2009)<sup>80</sup>** conducted a cohort study to identify fathers' satisfaction with postnatal care among 284 fathers in a Swedish hospital. It was found that no support from the staff and not being treated nicely dissatisfied the fathers. The study concluded that the staff working in postnatal wards should involve the fathers in postnatal care.

**Nte AR, et al., (2009)<sup>61</sup>** conducted a cross-sectional descriptive study on male involvement in family planning: women's perception among 558 mothers who came to immunize their children at 5 public immunization centers in Port Harcourt. The findings revealed that about 15.8% would depend on their spouses for choice of contraceptive methods and 52.7% would discontinue family planning if their spouses objected. The conclusion was in order to improve the acceptance of family planning males should also be targeted by family planning programmes.

**Pontes CM et al., (2009)<sup>64</sup>** had conducted a qualitative study to analyze the opinions of men and women on the father's participation in breast feeding in

Brazil. The fathers who participated in the study suggested ways of including them in the process of breast feeding. According to the participants, they could (1) provide a favorable environment for the mother and baby; (2) participate more during pregnancy and birth; (3) help with domestic chores; (4) develop parenthood; and (5) be present during breast feeding.

**Fägerskiöld A, (2008)<sup>52</sup>** conducted a qualitative study on “A change in life as experienced by first-time fathers”. Grounded theory and constant comparative method were used and 20 fathers aged 20-48 participated. The fathers stated that becoming a father was much more fantastic than they could have imagined and they suggested that they performed childcare to the same extent as the mother when both parents were at home and developing relationship with their child implied increasing possibilities to learn to know the infant's signals.

**Premberg A, et al., (2008)<sup>65</sup>** conducted a phenomenological approach on Experiences of the first year as father in Sweden. 10 men, recruited by a purposive sample, were interviewed after 12-14 months after the delivery of the first child. The fathers stated that the contact between the father and child was facilitated by engagement and time spent alone with the child. The study concluded that it is important to develop an independent relationship with the child and health personnel of today must be aware of father's own needs.

**Chang JJ, et al., (2007)<sup>50</sup>** done a secondary data analysis on maternal depressive symptoms, father's involvement, and the trajectories of child problem behaviors in a US national sample. The study sample included 6552 mother and father who were having children from 0 to 10 years. The findings revealed that the effects of maternal depressive symptoms on child problem behaviors varied by the level of the father's positive involvement.

**Wang SY,et al., (2006)**<sup>71</sup> conducted a study on psychosocial health of postnatal husbands and wives using a structured questionnaire among 83 couples in Taiwan. The results revealed that fathers perceived lower social support than mothers, but the couples experienced similar depression level. The study concluded that antenatal guidance and development of support groups for the couples make smoother transition.

**DeRose LF et al., (2004)**<sup>81</sup> took the Demographic and Health Survey (Kenya) data which assessed the relationship between spousal discussions and correct reporting of partner's attitude toward family planning from 21 Sub-Saharan African countries. The results revealed that the discussion was positively associated with correct reporting of husband's approval.

## CHAPTER – III

### RESEARCH METHODOLOGY

The chapter describes the methodology followed to assess the effectiveness of MCH Care Package on knowledge and attitude regarding male involvement in the MCH services among males in selected setting, Chennai.

#### RESEARCH APPROACH

The research approach used in the study was Quantitative Research Approach in accordance to the nature of the problem and to accomplish the objectives of the study.

#### RESEARCH DESIGN

The Research Design adopted for this study was Pre-experimental One group – Pretest and Posttest design. The rationale for adopting this design was control and homogeneity cannot be maintained among the selected samples.

According to **Polit and Beck (2011)**<sup>33</sup> the Schematic representation of Pre-Experimental Study is shown below.

<b>Pretest</b> <b>O<sub>1</sub></b>	<b>Intervention</b> <b>X</b>	<b>Post test</b> <b>O<sub>2</sub></b>
Pretest level of knowledge and attitude regarding male involvement in MCH services among males	Maternal and child health care package which includes antenatal, intranatal, postnatal and child care.	Posttest level of knowledge and attitude regarding male involvement in MCH services among males



## **VARIABLES**

### **Independent Variables**

The independent variable in this study was the Maternal and child health care Package

### **Dependent Variables**

The dependent variables in this study were the knowledge and attitude regarding male involvement in MCH care services.

### **Extraneous Variables**

Demographic variables of the males which included were age, religion, educational status, type of family, years of married life, type of occupation, work schedule, hours of working, income, previous information about MCH Services were collected using a personal data sheet.

### **Spouse details**

Demographic variables such as age, religion, educational status, type of occupation, income, obstetrical history, details about maternal health care services and present maternal illness regarding the spouse were collected from the males using a personal data sheet.

## **SETTING OF THE STUDY**

The study was conducted at the antenatal OPD of Sir Ivan Stedeford Hospital, Ambattur, Chennai. It is a 250 bedded hospital, which consists of 40 beds exclusively for maternity and has labor room, antenatal, postnatal ward and outpatient department. The antenatal OPD functions on all days, except Sundays and public holidays. Approximately 150-200 mothers attend OPD between 9am- 1pm in the mornings and between 2pm- 4pm in the evenings. The setting was chosen on the feasibility in terms of availability of adequate samples and familiarity of the investigator with the setting.

## **POPULATION**

The target population for the study includes married males and whose wives are primi mothers and the accessible populations were 120 males who attended the antenatal OPD at Sir Ivan Stedeford hospital, Ambattur.

## **SAMPLE**

Males who fulfill the inclusive criteria.

## **SAMPLE SIZE**

The sample size for the study was 60 males. However the researcher conducted pretest for 72 males but as they did not turn up for the post test the samples were dropped at an attrition rate of 16.66%

## **SAMPLING TECHNIQUE**

Non-Probability Purposive sampling technique was used to select the participants for the study.

## **CRITERIA FOR SAMPLE SELECTION**

### **Inclusive Criteria**

1. Males who were married and their wives are primi mothers.
2. Males who can understand Tamil or English Language.
3. Males who have not attended any education program regarding MCH care services.

### **Exclusive Criteria**

1. Males who are not willing to participate.
2. Males who will not be able to participate due to any illness.

## DEVELOPMENT AND DESCRIPTION OF THE TOOL

After an extensive Review of Literature and discussion with experts in the field of Community Health Nursing, a self-structured interview schedule and attitude scale were constructed as a tool for the data collection.

Part A - Data collection tool

Part B – Intervention tool

### Part A – Data collection tool

The data collection tools used for the study included 2 sections.

#### Section – A

This section dealt with demographic variables of males such as age, religion, educational status, type of family, years of married life, type of occupation, work schedule, hours of working, income and previous information about MCH Services were collected using a personal data sheet.

#### Spouse details

The demographic variables such as age, religion, educational status, type of occupation, income, obstetrical history, details about maternal health services and present maternal illness regarding the spouse were collected from males using a personal data sheet.

#### Section – B:

##### Part I

This section consisted of structured knowledge questionnaire to assess the knowledge regarding male involvement in the MCH services .

Antenatal period	11 questions
Intranatal period	3 questions
Postnatal period	6 questions
Child care	5 questions
<b>Total</b>	<b>25 questions</b>

<b>SCORING IN PERCENTAGE (%)</b>	<b>LEVEL OF KNOWLEDGE</b>
< 50%	Inadequate
50-75%	Moderately adequate
>75%	Adequate

**PART II:** This section consisted of 5 point Likert scale to assess the level of attitude which totally 10 questions, whereas 5 questions with positive response and 5 with negative response.

<b>SCORING IN PERCENTAGE (%)</b>	<b>LEVEL OF ATTITUDE</b>
< 50%	Inadequate
50-75%	Moderately adequate
>75%	Adequate

.A 5 point Likert scale used to assess the attitude of regarding male involvement in the MCH services

Each statement had 5 responses to select.

Strongly agree	- 5
Agree	- 4
Uncertain	- 3
Disagree	- 2
Strongly disagree	-1

## **PART – B INTERVENTION TOOL**

### **MATERNAL AND CHILD HEALTH CARE PACKAGE**

In this study it refers to the educational package prepared by the investigator which includes the following components

**(i) Antenatal period:** The knowledge on antenatal care services included early registration, immunization, antenatal visit, diet, sexual relationship, early and

warning signs of pregnancy was imparted with the help of computer assisted learning for 15 mins.

**(ii) Intra natal period:** Video film depicting the support of the male partner during the time of delivery for 7 mins was shown.

**(iii) Postnatal period and child care:** One to one teaching on postnatal visit, diet, family planning methods and sexual relationship along with teaching on child care services which included breast feeding, immunization and prevention of hypothermia for 20 mins was organized.

## **CONTENT VALIDITY**

The validity of the tool was obtained from 1 Community Medicine Expert and 3 Nursing Experts in the field of Community Health Nursing. Corrections given were to avoid the use of medical jargons, to modify the questionnaire and intervention tool as more specific and simple. Modification was done in the tool as suggested by the experts and it was incorporated in the main study and tool was finalized.

## **ETHICAL CONSIDERATION**

Ethics is a system of moral values that is concerned with the degree to which the research procedures adhere to the professional, legal and social obligations to the study participants. **Polit and Hungler (2011)**.

### **1. BENEFICIENCE**

The investigator followed the fundamental ethical principle of beneficence (Doing good) by adhering to

**a) The right to freedom from harm and discomfort**

The study will be beneficial for the participants as it enhances their knowledge and attitude of the youth club members regarding ill-effects of substance use.

**b) The right to protection from exploitation**

The investigator explained the procedure and nature of the study to the participants and ensured that none of the participants will be exploited or denied fair treatment.

**2. RESPECT FOR HUMAN DIGNITY.**

The investigator followed the second ethical principle with respect for human dignity. It includes the right to self determination and the right to self disclosure.

**a) The Right to Self-determination**

The investigator gave full freedom to the participants to decide voluntarily whether to participate in the study, to withdraw from the study and the right to ask questions.

**b) The Right to Full Disclosure.**

The researcher has fully described the nature of the study, the person's right to refuse participation and the researcher's responsibilities based on which the informed consent both oral and written consent was obtained from the participants.

**3. JUSTICE**

The researcher adhered to the third ethical principle of justice, it includes participant's right to fair treatment and right to privacy.

**a) Right to Fair Treatment**

The researcher selected the study participants based on the research requirements, no vulnerable or compromised candidates were selected as study participants.

**b) Right to Privacy.**

The researcher maintained the participant's privacy throughout the study.

#### **4. CONFIDENTIALITY**

The researcher maintained confidentiality of the data provided by the study participants.

#### **PILOT STUDY**

Pilot study is a trial run for the main study to test the reliability, practicability and feasibility of the study and the tool. The pilot study was conducted in the month of June at Sir Ivan Stedeford Hospital, Ambattur, Chennai after receiving a formal permission letter from the Principal, Omayal Achi College of Nursing; the Director, HOD of the obstetrical and gynecology department and the nursing superintendent of Sir Ivan Stedeford Hospital, Ambattur, Chennai .The investigator selected 6 samples using Non probability purposive sampling technique, who fulfilled the inclusive criteria as samples.

The investigator made the participants to sit comfortably in a separate room which was given for the research purpose. The room was well ventilated and free from noise. A brief explanation was given on the purpose of the study and consent was taken from them. Confidentiality of the information was reassured.

Pre-test was done individually by using structured interview schedule for 6 samples to assess their knowledge and attitude. Initially Demographic variables were collected by using a personal data sheet followed that knowledge questionnaire was given. It consisted of 25 questions based on the 4 components (antenatal, intranatal, postnatal and childcare) and participants were asked one by one providing their responses and the participants were given time to choose the best among them. After that attitude of the samples were assessed by explaining 10 statements in the 5 point Likert scale. It took about 40-45 minutes for the investigator to complete the pretest for an individual.

After the pretest the investigator administered the MCH Care package focusing on the male involvement. The investigator explained each individual

about the partner's role in antenatal, intranatal and post natal period and also about the child care using laptop. It took about 45 minutes for completing the intervention. Post test was conducted after 4 days.

Pilot study revealed that the study was feasible and practicable to conduct the main study. The pilot study was presented to the committee members and suggestions given by them were incorporated in the main study. The data collection for the main study was planned to be done by excluding the samples included in the pilot study.

### **RELIABILITY OF THE TOOL**

The reliability of the tool was established by interrater method to assess the reliability of the structured knowledge Questionnaire and the split half method to assess the attitude. The reliability score was  $r = 0.8$ . The  $r$  value indicated the highly positive correlation. Hence the tool was considered highly reliable for proceeding with the main study.

### **PROCEDURE FOR DATA COLLECTION**

The main study was conducted at antenatal OPD of Sir Ivan Stedeford Hospital, Ambattur, Chennai after receiving a formal permission letter from the Principal, OmayalAchi College of Nursing, the Director, HOD of the obstetrical and gynecology department and the nursing superintendent of Sir Ivan Stedeford Hospital, Ambattur, Chennai. The investigator selected 60 samples using Non probability purposive sampling method, who fulfilled inclusive criteria as samples.

The investigator made the participants to sit comfortably in a separate room which was given for the research purpose. The room was a well-ventilated and free from noise. A brief explanation was given on the purpose of the study and consent was taken from them. Confidentiality of the information is reassured.



Pre-test was done individually using structured interview for 60 samples to assess their knowledge. Initially Demographic variables were collected by using a personal data sheet followed by a knowledge questionnaire consisting of 25 questions based on the 4 components (antenatal, intranatal, postnatal and childcare) participants were asked one by one providing their responses and the participants were given time to choose the best among them. After that attitude of the samples were assessed by explaining 10 questions in the 5 point Likert scale. It took about 40-45 minutes for the investigator to complete the pretest for an individual.

After the pretest the investigator administered the MCH Care package focusing on the male involvement. The investigator explained about the partner's role in antenatal, intranatal and post natal period and also about the child care using laptop. It took about 45 minutes for completing the intervention. Post test was conducted after 7 days.

## **PLAN FOR DATA ANALYSIS**

The data was analyzed by descriptive and inferential statistics

### **Descriptive Statistics**

1. Frequency and percentage distribution will be used to analyse the demographic variables
2. Mean & standard deviation will be used to analyze the pre and posttest level of knowledge.

### **Inferential Statistics**

1. Paired 't' test will be used to compare the pre and posttest level of knowledge
2. Correlation coefficient to find out the relationship between knowledge and attitudes.
3. One way ANOVA will be used to associate the mean difference knowledge and attitude with selected demographic variables.

## CHAPTER – IV

### DATA ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of the data collected from 60 samples regarding male involvement in MCH services among males. The data collected was organized, tabulated and analyzed according to the objectives. The findings based on the descriptive and inferential statistical analysis, presented under the following sections.

#### ORGANISATION OF THE DATA

**Section A:** Description of the demographic variables of the males.

**Section B:** Description of the demographic variables of the spouse.

**Section C:** Assessment of pretest and posttest level of knowledge and attitude regarding male involvement in MCH services among males.

**Section D:** Comparison of pre and posttest level of knowledge and attitude regarding male involvement in MCH services among males.

**Section E:** Correlation between mean differed knowledge score and attitude score regarding male involvement in MCH services among males.

**Section F:** Association of mean differed knowledge score with selected demographic variables.

**Section G:** Association of mean differed attitude score with selected demographic variables.

**SECTION A: DESCRIPTION OF THE DEMOGRAPHIC VARIABLES OF THE MALES.**

**Table 1(a) : Frequency and percentage distribution of demographic variables with respect to age, religion, type of family, and years of married life of the males.**

N= 60

S.NO	Demographic Variables	No.	%
<b>1.</b>	<b>Age in years</b>		
	20 – 25	12	20.00
	26 – 30	33	55.00
	31 – 35	14	23.33
	Above 35	1	1.67
<b>2.</b>	<b>Type of family</b>		
	Nuclear family	25	41.67
	Joint family	35	58.33
	Extended family	0	0.00
	Others	0	0.00
<b>3.</b>	<b>Religion</b>		
	Hindu	52	86.67
	Muslim	0	0.00
	Christian	8	13.33
	Others	0	0.00
<b>4.</b>	<b>Years of married life</b>		
	Within 3 years	56	93.33
	4 - 6 years	1	1.67
	7 - 10 years	3	5.00

Table 1(a) shows the frequency and percentage distribution of demographic variables with respect to age, religion, type of family and years of married life.

With regard to age, majority 33(55%) were in the age group of 26-30 yrs, 52(86.67%) of them were Hindus, 35(58.33%) of them belong to nuclear family, and 56(93.33%) couples were married within 3 years.

**Table 1(b): Frequency and percentage distribution of demographic variables with respect to type of marriage, educational status and occupation of the males.**

N=60

S.NO.	Demographic variables	No.	%
<b>1.</b>	<b>Type of marriage</b>		
	Consanguineous	23	38.33
	Non consanguineous	37	61.67
<b>2.</b>	<b>Educational Status</b>		
	No formal education	0	0.00
	Primary	0	0.00
	Elementary	6	10.00
	High school	14	23.33
	Higher secondary	6	10.00
	Diploma	18	30.00
	Graduate and above	16	26.67
<b>3.</b>	<b>Occupational status</b>		
	Professional	5	8.33
	Skilled	32	53.33
	Unskilled	23	38.33

Table 1(b) shows the frequency and percentage distribution of demographic variables with respect to type of marriage, educational status and occupation of the males.

With regard to type of marriage majority 37(61.67%) were of non-consanguineous type, 16(26.67%) were graduates, 32(53.33%) were skilled workers.

**Table 1(c): Frequency and percentage distribution of demographic variables with respect to hours of working per day, shift system, individual monthly income and conception of their spouse.**

N=60

S.NO.	Demographic variables	No.	%
<b>1.</b>	<b>Hours of working per day</b>		
	8 hours	31	51.67
	More than 8 hours	29	48.33
<b>2.</b>	<b>Shift system</b>		
	Yes	24	40.00
	No	36	60.00
<b>3.</b>	<b>Individual monthly income</b>		
	Rs.<5,000	6	10.00
	Rs.5,001 - Rs.10,000	40	66.67
	>Rs.10,001	14	23.33
<b>4.</b>	<b>Conception</b>		
	Normal	57	95.00
	After medical intervention	3	5.00

Table 1(c) shows the frequency and percentage distribution of demographic variables with respect to hours of working per day, shift system, individual monthly income and conception of their spouse.

With regard to hours of working per day, majority 31(57.67%) were working only 8 hours, 36(60%) of them had shift system and 40(66.67%) had family income between Rs.5,001 to 10,000.

With regard to conception of their spouse 57(95%) had undergone normal conception.

**Table 1(d): Frequency and percentage distribution of demographic variables with respect to area of residence, involvement in household activities and previous experience in taking care of pregnant women in their family.**

N=60

<b>S.NO.</b>	<b>Demographic variables</b>	<b>No.</b>	<b>%</b>
<b>1.</b>	<b>Area of residence</b>		
	Urban	21	35.00
	Semi urban	35	58.33
	Rural	4	6.67
<b>2.</b>	<b>Involvement in household activities</b>		
	Within home	1	1.67
	Outside home	6	10.00
	Both	53	88.33
<b>3.</b>	<b>Previous experience in care of pregnant women</b>		
	Yes	32	53.33
	No	28	46.67

Table 1(d) shows the frequency and percentage distribution of demographic variables with respect to area of residence, involvement in household activities and previous experience in taking care of pregnant women in their family

With regard to area of residence majority 35(58.33%) were residing in semi urban areas, 53(88.33%) were involved in both i.e., within and outside house hold activities, 32(53.33%) were had previous experience in taking care of pregnant mothers.

**SECTION B: DESCRIPTION OF THE DEMOGRAPHIC VARIABLES OF THE SPOUSE.**

**Table 2(a): Frequency and percentage distribution of demographic variables with respect to age, educational status, occupational status and individual income of the spouse.**

N = 60

S.NO.	Spouse Details	No.	%
<b>1.</b>	<b>Age of the mother in years</b>		
	20 – 25	39	65.00
	26 – 30	21	35.00
	31 – 35	0	0.00
<b>2.</b>	<b>Educational Status</b>		
	No formal education	2	3.33
	Primary	2	3.33
	Elementary	7	11.67
	High school	8	13.33
	Higher secondary	13	21.67
	Diploma	8	13.33
	Graduate and above	20	33.33
<b>3.</b>	<b>Occupational status</b>		
	Professional	2	3.33
	Technical	1	1.67
	Skilled	3	5.00
	Unskilled	0	0.00
	Home maker	54	90.00
<b>4.</b>	<b>Individual monthly income</b>		
	Rs.<5,000	4	6.67
	Rs.5,001 - Rs.10,000	1	1.67
	>Rs.10,001	1	1.67
	No income	54	90.00

Table 2(a) shows the frequency and percentage distribution of demographic variables with respect to age, religion, type of family and years of married life.

With regard to age, majority 39(65%) were in the age group of 21-25 yrs, 20(33.33%) of them were graduates, 54(90%) were home makers, and 54(90%) had no income

**Table 2(b): Frequency and percentage distribution of demographic variables with respect to antenatal registration, place of receiving MCH services, immunization status and presence of any maternal illness of the spouse.**

N = 60

S.NO.	Spouse details	No.	%
<b>1.</b>	<b>Antenatal registration</b>		
	Yes	55	91.67
	No	5	8.33
<b>2.</b>	<b>If yes, at what setup</b>		
	Government	1	1.67
	Private	59	98.33
<b>3.</b>	<b>Visits accompanied</b>		
	Yes	59	98.33
	No	1	1.67
<b>4.</b>	<b>Immunization</b>		
	Yes	33	55.00
	No	27	45.00
<b>5.</b>	<b>Any specific maternal illness</b>		
	Gestational diabetes mellitus	2	3.33
	Pre eclampsia	1	1.67
	Normal	54	90.00
	Others	3	5.00

Table 2(b) shows the frequency and percentage distribution of demographic variables with respect to antenatal registration, place where they were receiving MCH services, visits accompanied, immunization status and presence of any specific illness of the spouse.

With regard to antenatal registration, majority 55(91.67%) were registered, 59(98.33%) of them were receiving MCH services in private settings, 59(98.33%) of them accompanied the visit along with their spouse, and 54(90%) of their spouse were normal without any specific maternal illness.



**SECTION C: ASSESSMENT OF PRE AND POSTTEST LEVEL OF KNOWLEDGE AND ATTITUDE REGARDING MALE INVOLVEMENT IN MCH SERVICES AMONG MALES.**

**Table 3 : Frequency and percentage distribution of pretest and post test level of knowledge regarding male involvement in MCH services among males.**

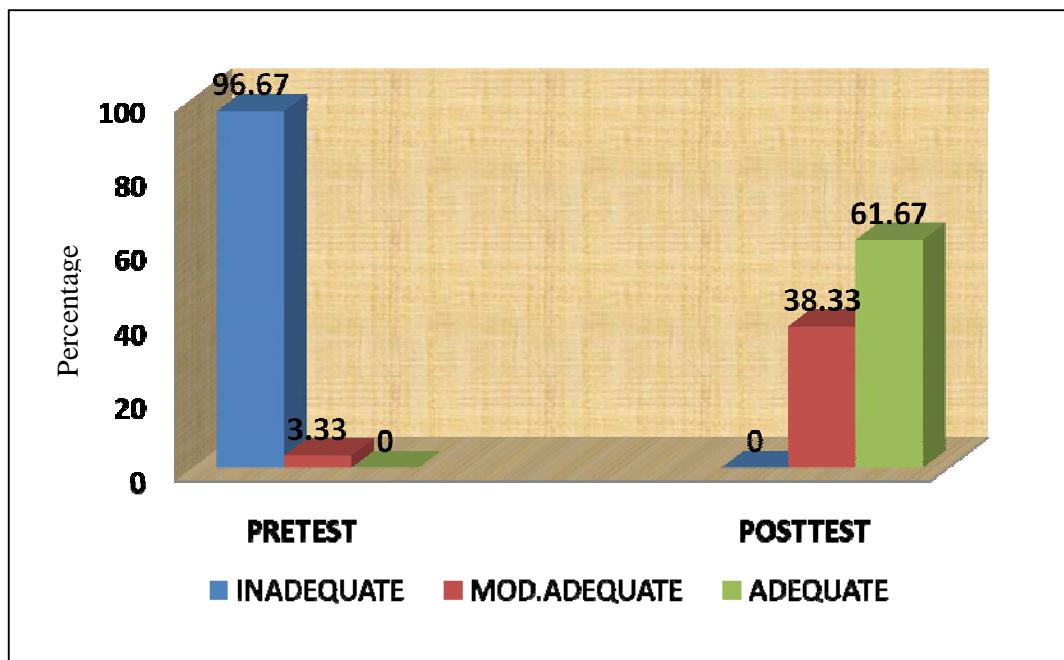
Knowledge	Pretest						Post Test					
	Inadequate		Moderately Adequate		Adequate		Inadequate		Moderately Adequate		Adequate	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Antenatal period	42	70.0	17	28.33	1	1.67	0	0	24	40.0	36	60.0
Intranatal period	56	93.33	4	6.67	0	0	13	21.67	30	50.0	17	28.33
Postnatal period	48	80.0	12	20.0	0	0	0	0	20	33.33	40	66.67
Child care	50	83.33	8	13.33	2	3.33	6	10.0	12	20.0	42	70.0

Table 3 shows the frequency and percentage distribution of level of pretest and post test level of knowledge of the males.

With regard to antenatal period in the pretest, majority 42(70%) had inadequate knowledge, 56(93.33%) had inadequate knowledge about intranatal period, 48(80%) had inadequate knowledge about postnatal period, 50(83.33%) had inadequate knowledge about child care.

With regard to antenatal period in the post test, majority 36(60%) had adequate knowledge, 30(50%) had moderately adequate knowledge about intranatal period, 40(66.67%) had adequate knowledge about postnatal period, 42(70%) had adequate knowledge about child care.

N=60

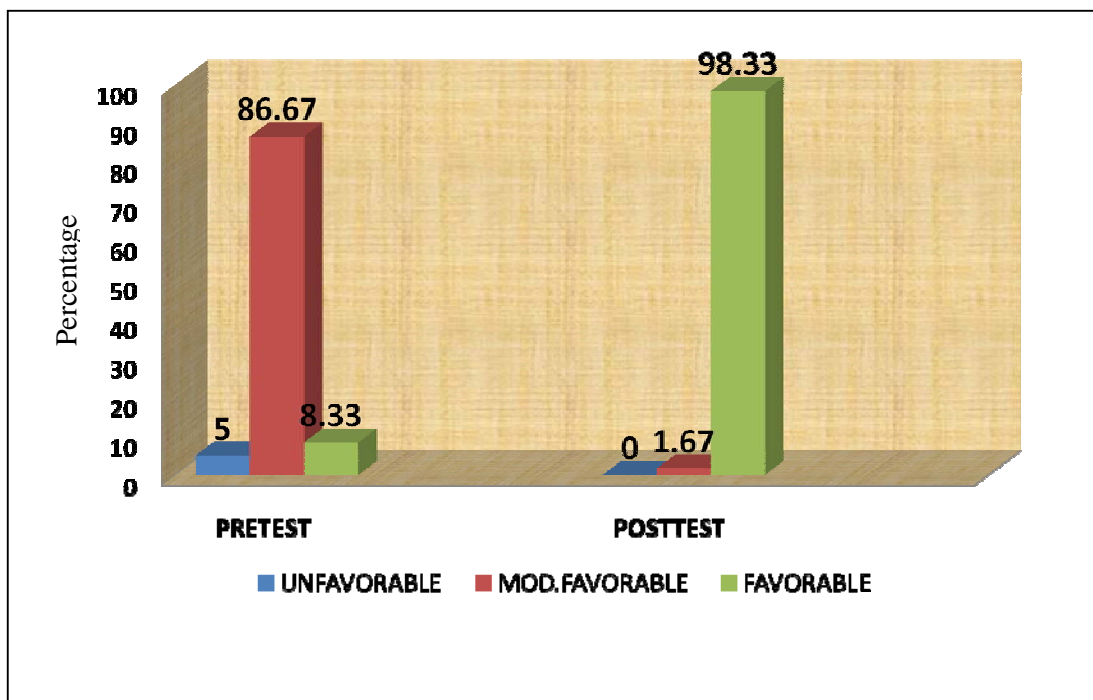


**Figure 2: Frequency and percentage distribution of overall level of knowledge regarding male involvement in MCH services among males in pre and post test**

Figure 2 shows the frequency and percentage distribution of overall level of knowledge regarding male involvement in MCH services among males in both pre and post test.

When considering overall knowledge in pretest, majority 58(96.66%) of the males had inadequate knowledge, 2(3.33%) of them had moderately adequate knowledge and none of them had adequate knowledge.

When considering over all knowledge in post test, majority 37(61.67%) of them had adequate knowledge, 23(38.33%) of them had moderately adequate knowledge and none of them had in adequate knowledge.



**Figure 3: Percentage distribution of pre and post test level of attitude regarding male involvement in MCH services**

Figure 3 shows the frequency and percentage distribution of pre and post test level of attitude regarding male involvement in MCH services among males.

With respect to the level of attitude in the pretest result revealed that, 52 (86.67%) of the males had moderately favorable attitude, 5 (8.33%) of them had favorable attitude, and 3 (5%) them had unfavorable attitude.

With respect to the level of attitude in the post test results revealed that, 59(98.33%) of the males had favorable attitude, 1(1.67%) of them had moderately favorable attitude, and none of them had unfavorable attitude

**SECTION D: COMPARISON OF PRE AND POST TEST LEVEL OF KNOWLEDGE AND ATTITUDE REGARDING MALE INVOLVEMENT IN MCH SERVICES AMONG MALES IN A SELECTED SETTING.**

**Table 4 : Comparison of pre and post test level of knowledge and attitude regarding male involvement in MCH services among males in a selected setting.**

Variables	Pretest		Post Test		't' Value
	Mean	S.D	Mean	S.D	
Knowledge	8.52	1.99	19.65	2.53	t = 31.404*** p = 0.001, (S)
Attitude	32.28	4.49	47.07	2.66	t = 23.849*** p = 0.000, (S)

\*\*\*p<0.001

\*\*p<0.01

\*p<0.05

Table 4 reveals the comparison of pre test and post test level of knowledge and attitude regarding male involvement in MCH services among males.

The pre test mean and standard deviation were 8.52 and 1.99 respectively. The post test mean and standard deviation were 19.65 and 2.53. The calculated 't' value was 31.404 and it revealed that there was high statistical difference at p<0.001 level.

The pretest mean and standard deviation were 32.28 and 4.49 respectively. The post test mean and standard deviation were 47.07 and 2.66 respectively. The calculated 't' value was 23.849 and it revealed that there was high statistical significance at p<0.001 level.

**SECTION E: CORRELATION BETWEEN MEAN IMPROVEMENT KNOWLEDGE SCORE AND ATTITUDE SCORE REGARDING MALE INVOLVEMENT IN MCH SERVICES AMONG MALES IN SELECTED SETTING**

**Figure 4: Correlation between mean improvement knowledge and attitude score regarding male involvement in MCH services among males in selected setting**

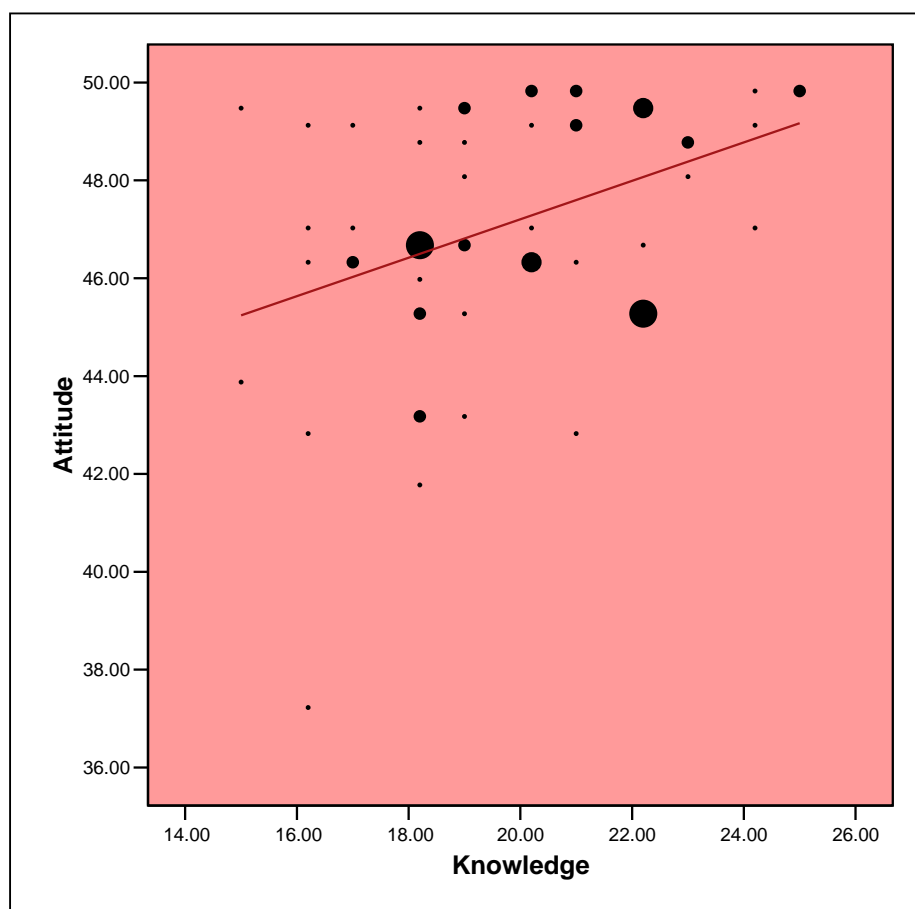


Figure 4 shows the correlation between post test knowledge score and attitude score regarding male involvement in MCH services among males in selected setting.

While analyzing the level of knowledge, the mean score was 19.65 and standard deviation was 2.53. In the level of attitude, the mean score was 47.07 and standard deviation was 2.66. The calculated 'r' value was 0.37 which showed that there was moderately positive correlation.

**SECTION F: ASSOCIATION OF MEAN DIFFERED KNOWLEDGE  
SCORE WITH SELECTED DEMOGRAPHIC VARIABLES**

**Table 5 : Association of mean differed knowledge score with selected demographic variables.**

S.No.	Demographic Variables	Unfavourable		Moderately Favourable		Favourable		Chi-Square Value
		No.	%	No.	%	No.	%	
1	<b>Age in years</b>							$\chi^2 = 3.617$ d.f = 6 p = 0.728 N.S
	20 – 25	0	0	11	18.3	1	1.7	
	26 – 30	1	1.7	29	48.3	3	5.0	
	31 – 35	2	3.3	11	18.3	1	1.7	
	Above 35	0	0	1	1.7	0	0	
2	<b>Type of family</b>							$\chi^2 = 3.539$ d.f = 2 p = 0.170 N.S
	Nuclear family	0	0	24	40.0	1	1.7	
	Joint family	3	5.0	28	46.7	4	6.7	
	Extended family	-	-	-	-	-	-	
	Others	-	-	-	-	-	-	

Table 5 reveals that there was no significant association between the knowledge score and the selected demographic variables included in the study.

**SECTION G: ASSOCIATION OF MEAN DIFFERED ATTITUDE SCORE  
WITH SELECTED DEMOGRAPHIC VARIABLES**

**Table 6 : Association of mean differed attitude score with selected demographic variables.**

S.NO.	Demographic Variables	Pretest		Post Test		Mean.Im		ANOVA/ 't' Value
		Mean	S.D	Mean	S.D	Mean	S.D	
<b>1.</b>	<b>Years of married life</b>							F = 3.329 p = 0.043 S*
	Within 3 years	32.57	4.02	47.11	2.69	14.53	4.62	
	4 - 6 years	40.00	-	50.00	-	10.00	-	
	7 - 10 years	24.33	5.13	45.33	0.58	21.00	4.58	
<b>2.</b>	<b>Educational Status</b>							F = 3.021 p = 0.025 S*
	No formal education	-	-	-	-	-	-	
	Primary	-	-	-	-	-	-	
	Elementary	28.33	5.78	47.17	2.32	18.83	4.71	
	High school	31.28	4.83	47.71	1.89	16.43	4.94	
	Higher secondary	33.17	3.92	46.67	2.94	13.50	2.07	
	Diploma	33.83	4.20	46.28	3.27	12.44	4.95	
	Graduate and above	32.56	3.56	47.50	2.56	14.94	4.07	

\*p<0.05, S – Significant, N.S – Not Significant

Table 6 reveals that the demographic variables such as years of married life of the couples and educational status of the males had shown a low significant association with the attitude score at the level of p< 0.005.

**Table 7: Association of mean differed attitude score with selected spouse details.**

S.NO.	Spouse Details	Pretest		Post Test		Mean.Im		ANOVA/ 't' Value
		Mean	S.D	Mean	S.D	Mean	S.D	
<b>1.</b>	<b>Educational Status</b>							F = 2.487 p = 0.034 S*
	No formal education	31.00	2.83	45.00	1.41	14.00	1.41	
	Primary	33.50	2.12	45.50	0.71	12.00	2.83	
	Elementary	30.14	6.96	47.57	2.37	17.43	5.47	
	High school	31.00	5.07	48.50	1.60	17.50	5.01	
	Higher secondary	30.61	3.71	47.15	2.82	16.54	4.29	
	Diploma	34.00	4.17	45.37	4.21	11.37	7.01	
	Graduate and above	33.95	3.68	47.30	2.15	13.35	2.62	

\*p<0.05, S – Significant, N.S – Not Significant

Table 7 reveals that with regard to spouse details, the demographic variable educational status had shown a significant association with the attitude score at the level of p<0.05.

The other demographic variables were not shown significant association with the attitude score.



## CHAPTER – V

### DISCUSSION

The study was conducted to evaluate the effectiveness of MCH care package on knowledge and attitude regarding male involvement in MCH services among males at selected setting.

The discussion was based on the objectives, the review of literature and the null hypotheses specified in this study.

**The first objective was to assess the existing pre and posttest level of knowledge and attitude regarding male involvement in MCH services among males.**

The analysis of the knowledge in pretest showed that, majority 58(96.66%) of the males had inadequate knowledge, 2(3.33%) of them had moderately adequate knowledge and none of them had adequate knowledge.

The analysis of the pre test level of knowledge on various aspects among males showed that, majority 42(70%) had inadequate knowledge about their involvement during antenatal period, 56(93.33%) had inadequate knowledge about intranatal period, 48(80%) had inadequate knowledge about postnatal period, 50(83.33%) had inadequate knowledge about child care.

The analysis of the knowledge in post test showed that, majority 37(61.67%) of them had adequate knowledge, 23(38.33%) of them had moderately adequate knowledge and none of them had in adequate knowledge.

The analysis of the post test level of knowledge on various aspects among males showed that majority 36(60%) had adequate knowledge about their involvement during antenatal period, 30(50%) had moderately adequate knowledge

about intranatal period, 40(66.67%) had adequate knowledge about postnatal period, 42(70%) had adequate knowledge about child care.

The data findings related to the level of attitude in the pretest result revealed that, 52(86.67%) of the males had moderately favorable attitude, 5(8.33%) of them had favorable attitude, and 3(5%) them had unfavorable attitude.

With respect to the level of attitude in the post test results revealed that, 59(98.33%) of the males had favorable attitude, 1(1.67%) of them had moderately favorable attitude, and none of them had unfavorable attitude

**The second objective was to assess the effectiveness of the MCH care package on knowledge and attitude regarding male involvement in the MCH services among males.**

The overall mean improvement shows a significant rise in the knowledge level of males from 8.52 to 19.65 in the pre and posttest respectively. The calculated 't' value was 31.404 and it revealed that there was statistically high significant difference at  $p < 0.001$  level.

The overall mean improvement shows a significant rise in the attitude level of males from 32.28 to 47.07 in the pre and post test respectively. The calculated 't' value was 23.849 and it revealed that there was statistically high significant difference at  $p < 0.001$  level.

**Hence the null hypotheses stated earlier that “there is no significant difference between pre and post test level of knowledge and attitude regarding male involvement in the MCH services” was rejected.**

**The third objective was to correlate mean differed knowledge score with the attitude score.**

The analysis revealed that the correlation of the post test level of knowledge and attitude was  $r=0.374$  which showed that there was a moderate positive correlation at the level of  $p<0.01$ .

**Therefore the null hypotheses  $NH_2$  stated earlier “there is no significant relationship between mean differenced knowledge and attitude score” was rejected.**

**The fourth objective was to associate the mean differed level of knowledge and attitude score with selected demographic variables.**

The analysis revealed that there was no significant association between the knowledge score and any of the selected demographic variables.

It was evident that there was significant association between attitude score and demographic variables such as years of married life and educational status of both the male and the spouse at the level of  $p<0.005$ .

**Hence the null hypotheses stated earlier that “there is no significant association of the mean improvement level of the knowledge and attitude score with the selected demographic variables was retained for the knowledge score.**

However, the study revealed that there was a significant association between attitude and the demographic variables such as years of married life, and educational status of the males and their spouse. **So out of 21 demographic variables only 3 variables were found to have association for which we reject the  $NH_3$  and for the remaining variables we accepted the  $NH_3$ .**

## **CHAPTER – VI**

### **SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS.**

This chapter presents the summary, conclusions, implications, recommendations and limitations of the study.

#### **SUMMARY**

The most important person to the pregnant women is usually the father of her child. Recent studies suggested that spousal support emerged as a significant factor influencing the quality of physical and emotional well being of the mother. In a women every pregnancy is considered to be precious after the concept of “small family norm” was evolved. Health care providers are in need of a better understanding of paternal support during pregnancy and develop interventions to assist in easing the transition of the role of the mothers as well as the fathers.

The investigator undertook the present study to assess the effectiveness of MCH Care Package on knowledge and attitude regarding male involvement in the MCH services among males at selected settings, Chennai.

The objectives of the study were

1. To assess the existing level of knowledge and attitude regarding male involvement in the MCH services among males
2. To assess the effectiveness of MCH Care package on knowledge and attitude regarding male involvement in the MCH services among males
3. To correlate mean differed knowledge score with attitude score.
4. To associate the mean differed level of knowledge and attitude score with selected demographic variables.

The assumptions of the study were

1. Males have a role to play in the maternal and child health services
2. Males may have some knowledge regarding their involvement in the maternal and child health services.
3. The maternal and child health care package may enhance the knowledge and attitude regarding male involvement in the maternal and child health services.
4. Knowledge on male involvement in MCH care may enhance the attitude on male involvement during MCH care practices.

The null hypotheses formulated were

- NH<sub>1</sub>** - There is no significant difference between pre & post test level of knowledge and attitude regarding male involvement in the MCH services
- NH<sub>2</sub>** - There is no significant relationship between mean difference knowledge and attitude score.
- NH<sub>3</sub>** - There is no significant association of the mean improvement level of knowledge and attitude score with the selected demographic variable.

The extensive review of literature, investigator professional experience and expert guidance from the field of community health nursing helped the investigator to design the methodology and to develop the tool for data collection.

The conceptual framework for the study was based on modified King goal's attainment and J.W. Kenney's open system model.

The researcher adopted a pre-experimental one group pretest and post test design to assess the knowledge and attitude of males regarding male involvement in the MCH services.

Non probability purposive sampling technique was used to select the participants

The investigator developed a tool consisted of demographic variables, structured questionnaire to assess the knowledge on male involvement and modified 5 point likert scale to assess the attitude of the males. A brief introduction was given about the study before conducting the pretest. Post test was conducted after the administration of MCH care package.

The content validity was obtained from the experts. The reliability of the tool was established by inter rater method ( $r=0.8$ ). The findings of the pilot study established the practicability and feasibility for the main study.

The ethical aspect of research was maintained throughout the study by getting formal permission from the authorities, and informed consent from the participants participated in the study. Confidentiality of the data was maintained throughout the study. The data collected was analyzed using descriptive and inferential statistics. Interpretation and discussions was done based on the objectives of the study, null hypotheses, conceptual framework and relevant studies from literature reviewed.

The collected data was analyzed and discussed.

The findings of the study were

In assessing the existing level of knowledge in pretest, majority 58(96.66%) of the males had inadequate knowledge, 2(3.33%) of them had moderately adequate knowledge and none of them had adequate knowledge.

The analysis of the pre test level of knowledge on various aspects among males showed that, majority 42(70%) had inadequate knowledge about their involvement during antenatal period, 56(93.33%) had inadequate knowledge about

intranatal period, 48(80%) had inadequate knowledge about postnatal period, 50(83.33%) had inadequate knowledge about child care.

The analysis of the knowledge in post test showed that, majority 37(61.67%) of them had adequate knowledge, 23(38.33%) of them had moderately adequate knowledge and none of them had in adequate knowledge.

The analysis of the post test level of knowledge on various aspects among males showed that majority 36(60%) had adequate knowledge about their involvement during antenatal period, 30(50%) had moderately adequate knowledge about intranatal period, 40(66.67%) had adequate knowledge about postnatal period, 42(70%) had adequate knowledge about child care.

The data findings related to the level of attitude in the pretest result revealed that, 52 (86.67%) of the males had moderately favorable attitude, 5 (8.33%) of them had favorable attitude, and 3 (5%) them had unfavorable attitude.

With respect to the level of attitude in the post test results revealed that, 59(98.33%) of the males had favorable attitude, 1(1.67%) of them had moderately favorable attitude, and none of them had unfavorable attitude

The overall mean improvement shows a significant rise in the knowledge level of males from 8.52 to 19.65 in the pre and post test respectively. The calculated 't' value was 31.404 and it revealed that there was statistically high significant difference at  $p < 0.001$  level.

The overall mean improvement shows a significant rise in the attitude level of males from 32.28 to 47.07 in the pre and post test respectively. The calculated 't' value was 23.849 and it revealed that there was statistically high significant difference at  $p < 0.001$  level.

Hence the null hypotheses stated earlier that “there is no significant difference between pre and post test level of knowledge and attitude regarding male involvement in the MCH services” was rejected.

The analysis revealed that the correlation of the post test level of knowledge and attitude was  $r=0.374$  which showed that there was a moderate positive correlation at the level of  $p<0.01$ .

Therefore the null hypotheses  $NH_2$  stated earlier “there is no significant relationship between mean differenced knowledge and attitude score” was rejected.

The analysis revealed that there was no significant association between the knowledge score and any of the selected demographic variables.

It was evident there was significant association between attitude score and demographic variables such as years of married life and educational status of both the male and the spouse at the level of  $p<0.005$ .

Hence the null hypotheses stated earlier that “there is no significant association of the mean improvement level of the knowledge and attitude score with the selected demographic variables was retained for the knowledge score.

However, the study revealed that there was a significant association between attitude and the demographic variables such as years of married life, and educational status of the males and their spouse. So out of 21 demographic variables only 3 variables were found to have association for which we reject the  $NH_3$  and for the remaining variables. We retained the null hypotheses.

## **CONCLUSION**

The findings of the study revealed that there was a significant improvement in the level of knowledge and attitude among males after providing MCH care



package and there was moderately positive correlation between the knowledge score and attitude score.

## **IMPLICATIONS**

The investigator had derived from the study, the following implications which are of a vital concern in the field of the nursing service, nursing administration, nursing education and nursing research.

### **Nursing Practice**

The community health nurse is playing a vital role in the community in creating awareness and improving the health status of the mother who are responsible for the foundation of the future generation. As primary care givers, they have to include the expectant fathers while providing antenatal education to the mothers there by helping the couples in their easy transition to parenthood. Materials in the form of booklets, flip charts to educate the expectant fathers regarding their involvement during MCH services have to be prepared and given during home visits for the field staffs.

### **Nursing Education**

The community health nurse as a nurse educator can incorporate the major study findings in nursing curriculum at all level in order to well equip the students to address the issues of male involvement in MCH services and nurses role in improving their involvement in order to holistic care.

### **Nursing Administration**

The community health nurse administrator should collaborate with governing bodies to create policies, building up and mobilizing resources, creating coalition with non-governmental organization in order to create awareness regarding importance of male involvement in MCH care aspects all the PHCs and subcentre level. She can organize a childbirth education programs for the couples.

She can make provisions in the hospital policy to allow husband in the delivery room and involve him as a labour coach if the mother permits to do so.

### **Nursing Research**

The findings of the study can be disseminated to the community health nursing practitioners and student nurses through internet, journals, literature etc. effort can be made by nurse researcher to conduct interactive sessions with the couples in order to find out the family dynamics after child birth. As nurse researcher, she can do studies in order to assess the involvement level of the males during the antenatal, intranatal and post natal period.

### **RECOMMENDATIONS**

The numbers of recommendations were drawn from the research that could improve the effectiveness of community health nurse working with families. These include

1. The community health nurse should emphasis on male involvement as an important component in MCH services while handling the target population at the time of home visits.
2. The package used must be video showcased in the antenatal opds of the hospitals and community set ups.
3. The child birth education programmes can be conducted for the couples in the hospitals and community set up
4. A qualitative study can be carried out to address the various issues prevailing in male involvement.
5. A similar study can be done on larger samples.
6. An experimental study can be conducted in the labour room on partner's support and maternal outcomes in terms of anxiety level and pain perception.
7. A longitudinal study can be done to improve husband's participation during antenatal, intranatal, post natal and in child rearing.

## **LIMITATIONS**

1. The investigator planned to do the research in the occupational settings, due to non-availability of samples among the permanent workers, the investigator changed the setting to the hospital.
2. Initially the samples hesitated to participate in the study, hence the investigator had to take a lot of time to make them understand about the need and purpose of the study.
3. Among 72 samples, 12 of them didn't turn up for posttest because of the distance and time constraints.

## APPENDIX – C

### LETTER SEEKING EXPERT'S OPINION FOR CONTENT VALIDITY

From

**Ms.SUBA PRIYA.S.,**  
M. Sc (N) II year,  
Omayal Achi College of Nursing,  
Puzhal, Chennai – 600 066

To

Respected Madam / Sir,

**Sub:** Requisition for expert opinion on suggestion for content validity of the tool

I am Ms.S.Suba Priya doing my M.Sc Nursing II year specializing in Community Health Nursing at Omayal Achi College of Nursing. As a part of my research project to be submitted to the Tamilnadu Dr.M.G.R University and in partial fulfillment of the University requirement for the award of M.Sc (N) degree, I am conducting **“A pre experimental study to assess the effectiveness of MCH Care package on knowledge and attitude regarding male involvement in MCH services among males in selected setting, Chennai.”**

I have enclosed my data collection tool and intervention tool for your expert guidance and validation. Kindly do the needful.

Thanking you,

Yours faithfully,

**(SUBA PRIYA.S)**

**Enclosures:**

1. Research proposal
2. Data collection tool
3. Intervention tool
4. Content validity form
5. Certificate for content validity

## **LIST OF EXPERTS FOR CONTENT VALIDITY**

- 1. Dr. S.Y.JAGANATHAN M.B.B.S., Dip. in community medicine.,**  
Stanley Hospital,  
Chennai.
  
- 2. Ms. SARADHA RAMESH M.Sc (N)., Ph.D.,**  
Principal,  
College of Nursing,  
Saveetha University.
  
- 3. Dr. SASIKALA, M.SC.,**  
Lecturer – Community Health Nursing,  
Sri Ramachandra College of Nursing,  
Porur.
  
- 4. Mr.DINESH.S M.Sc (N)., Ph.D**  
HOD of Community Health Nursing,  
Padmashree Institute of Nursing,  
Bangalore.











## **APPENDIX – D**

### **CERTIFICATE OF ENGLISH EDITING**

#### **TO WHOMEVER IT MAY CONCERN**

This is to certify that the dissertation work **“A pre-experimental study to assess the effectiveness of MCH Care package on knowledge and attitude regarding male involvement in MCH services among males in selected setting, Chennai, 2010-2012”** done by **Ms.SUBA PRIYA.S**, II year M.Sc. Nursing, in Omayal Achi College of Nursing, Puzhal, Chennai is edited for English language appropriateness by .....

## **APPENDIX – E**

### **CERTIFICATE OF TAMIL EDITING**

#### **TO WHOMEVER IT MAY CONCERN**

This is to certify that the dissertation work **“A pre-experimental study to assess the effectiveness of MCH Care package on knowledge and attitude regarding male involvement in MCH services among males in selected setting, Chennai, 2010-2012”** done by **Ms.SUBA PRIYA.S**, II year M.Sc. Nursing, in Omayal Achi College of Nursing, Puzhal, Chennai is edited for Tamil language appropriateness by .....

## **APPENDIX – F**

### **INFORMED CONSENT**

**Good Morning,**

I am S.Suba Priya, II year M.Sc. Nursing Student from Omayal Achi College of Nursing, Puzhal, Chennai. As a partial fulfillment of the programme, I am conducting **“A pre-experimental study to assess the effectiveness of MCH Care package on knowledge and attitude regarding male involvement in MCH services among males in selected setting, Chennai.** Kindly co-operate with me, by giving frank and free answer to my questions. Your answers will be kept confidential and will be used only for my study.

Thank you.

## INFORMED CONSENT FORM

I understand that I am being asked to participate in a research study conducted by **Ms.S.Subapriya.**, M.Sc.(N) student of Omayal Achi College of Nursing. This research study will assess the **“Effectiveness of MCH package on knowledge and attitude regarding male involvement in MCH Services at selected setting, Chennai”**. If I agree to participate in the study, I will be interviewed. The interview may be recorded and will take place in privacy. No identifying information will be included when the interview is transcribed. I understand that there are no risks associated with this study.

I realize that the knowledge gained from this study may help either me or other people in the future. I realize that my participation in this study is entirely voluntary, and I may withdraw from the study at any time I wish. If I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary fashion.

I understand that all study data will be kept confidential. However, this information may be used in nursing publication or presentations. If I need to, I can contact **Ms.S.Subrapriya** M.Sc.(N) II year student of Omayal Achi College of Nursing, #45 Ambattur road, Puzhal, Chennai at any time during the study.

The study has been explained to me. I have read and understood this consent form, all of my questions have been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form.

-----  
Signature of Participant

-----  
Date:

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Signature of Investigator

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Date:

# ÔÏ¼ø ÀÊÃõ

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# ¾.¼.Á.ø Ô.À.ó¾.¼. À.Ê.Ã.õ

“ÁĀĭū ĩŋĉ ĩŋĀĀĉĀ÷, øæĀĉĀĉý ÓĐ, “Ā ĩŋĀĀĉĀ÷ Áĭ½Āĉ Í.ÍĀĀĉĀĉĀĭ, ŞĀüĭĭŭŭō -ĀĭŋŋĉĀĉý ĭĭý ĀĭĭĀüŭŭŞĈý ±ýĀ”¼ ĩ¼ĀĉóĐ ĭĭĭŞ¼ý. Þó¼ -ĀĭŋŋĉĀĀĒĐ “¼ĭĭ §ŋö ĭĀö¼ĉø -ĭĭĈĉý Āĭĭ” -ĭö. Þó¼ -ĀĭŋŋĉĀĀĒĐ ò÷ ¾Āý Şĭ¼đŞĀĭ÷đ ĀŌðĐĀĀĒĒĀĉø ÒÈ ŞĭĭĀĭĈĉ, ŭ ĀĉĀĉĀĉø, ÷đĀĉ½ĉ ĀĭĭĈĉý, ½Ā÷, Ĉĉ¼ö ĭ¼đ¼đĀ¼ - ŭĈĐ.

ĭĭý Þó¼ -Āĭŋŋĉĭĭĭ, Āĭĭ ĀĒÈ ‘đŌĭĭĭĭ¼ĭø, ±Ēĭĭ Şĭ÷, ĭ½ø ĭ¼đ¼đĀĭö. «ó¼ Şĭ÷, ĭ½ø ¾Ēĉ «ĒĒĀĉø ĭ¼đ¼đĀđĭ Ā¾ĉx ĩöĀđĀĭö. Þó¼ Şĭ÷, ĭ½ø Ā¾ĉx ĩöĀđĀĭö ŞĀĭĐ ¾Ēĉ ĭĀĒĭ ĩĒĉðĐ «ĒĉĀĭŪĒĀ ¾, Āø, ŭ ÞŌĭĭĐ. ĭĭý Þó¼ -Āĭŋŋĉ ĀĒĉĀĉø, ĀóĐ ĭĭŭĀ¾ĭø ±ŭĀĉ¾ Āĭ¾ĉđŌð ÞøĒ. Þó¼ ĀĒĉĀĉý āĀö ĀĒĒĀđ¼, ŌðĐ, ŭ ±ĒĭŞĭĭ «ðĀĐ ĀüĒ Āĭ, ŭĭŞĭĭ ±¾ĉ÷, ĭĀö¼ĉø ĭĉĭĀĀĭ, -¾xö.

Þó¼ -ĀĭŋŋĉĀĉø ĀĭŌ”¼Ā āĭĭ¼Ōð ÞøĀĭĀø ¾ýĒĉĭŋĀĭ, ĭĭý, ĀóĐ ĭĭŭ, ĉŞĒý. ĭĭý ĀĉŌðĀĒĒĭø ±óŞĭĀð¾ĉŌð Þó¼ -ĀĭŋŋĉĀĉĀĉŌóĐ ĀĉĀ, ĉĭĭĭŭŞĀý. ±ýŪ”¼Ā Āĭĭ Þó¼ -ĀĭŋŋĉĀĉø ÞøĒ ±ýŪ ĭĭý ÓĒx ĩöŌö ŞĀĭĐ ĭĭŪö ĀüĒĀ÷, Ĉĉ ŞĀĭĀ Ā¾ĉĭ, ðĀĭŞĀý.

Þó¼ -Āĭŋŋĉ ĀĒĉĀĉý ŌŭĈĉ ĀĉĀĀĭ, ŭ «ĒĉðĐ ŀĭĐĭĭĭĀĭ, “Āĭ, ðĀĭö ±ýĀ”¼ ĭĭý «ĒĉŞĀý. Þó¼ -ĀĭŋŋĉĀĉý ¾, Āø, ŭ «ĒĉðĐ ĩŋĀĀĉĀ÷, ŋ÷ó¼ Þ¾ŭ, ŭ «ðĀĐ, ŌðĐĒĒ, Ĉĉø ĀĈĉĀŌö ±ýĀ”¼ «ĒĉŞĀý. -ĀĭŋŋĉĀĉø ¾, Āø, ŭ ±Ēĭĭò Ş¾ĀĀ ±ýĒĭŌð ĭĭý Í.ÍĀĀĉĀĉĀĀĀĀ ±ó¼ ŞĭĀð¾ĉŌð ĩ¼ĭ¼÷ò ĭĭŭĭĀý. (S.Subapriya, “ÁĀĭū ĩŋĉ ĩŋĀĀĉĀ÷, øæĀĉ, -ĀĒ, ĩŋĒĒĒ).

Þó¼ -Āĭŋŋĉ ĀĒĉĀĀĀüĒĒ ĀüĒĉ ±Ēĭĭ ĀĉĈĭ, ðĀđ¼Đ. Þó¼ ‘đĀó¼ ĀĒĀð”¼đ ĀüĒĉĀ Óð ĀĉĀĀĭ, Ĉĉ ĀüĒĉŌð ±Ēĭĭ ĩ¼ĀĉĀĉĭ, ðĀđ¼Đ. ĭĭý Þó¼ -ĀĭŋŋĉĀĉø Āĭĭ ĀĒÈ òđĀ¾ĉĭ, ĉŞĀý. Þó¼ “ĭĀðð¾ĉđ¼ ‘đĀó¼ ĀĒĀð¾ĉý ĭ, ø ±ýĒĉ¼ö ĭĭĭĭ, ðĀĭö ±ýĀ”¼ ĭĭý ĩ¼ĀĉóĐ ĭĭĭŞ¼ý.

ĀĭŞ, ŭĀĭĈĀĉý, ĭĀĭöĀö Ş¾¾ĉ:

-ĀĭŋŋĉĀĭĈĀĉý, ĭĀĭöĀö Ş¾¾ĉ:

**APPENDIX – G**  
**DATA COLLECTION TOOL**

**SECTION – A: DEMOGRAPHIC VARIABLES**

1. Age in years
  - a) 20-25
  - b) 26-30
  - c) 31-35
  
2. Type of family
  - a) Nuclear family
  - b) Joint family
  - c) Extended family
  - d) Others
  
3. Religion
  - a) Hindu
  - b) Muslim
  - c) Christian
  - d) Others
  
4. Years of married life
  - a) Within 3 years
  - b) 4-6 years
  - c) 7-10 years
  
5. Type of the marriage
  - a) Consanguineous
  - b) Non consanguineous
  
6. Educational status.
  - a) No formal education.
  - b) Primary



- c) Elementary
- d) High school
- e) Higher secondary
- f) Diploma
- g) Graduate and above

7. Occupational status

- a) Professional
- b) Technical
- c) Skilled
- d) Unskilled.

8. Conception

- a) Normal
- b) After medical intervention

9. Hours of working per day

- a) 8hours.
- b) More than 8hours

10. Shift system

- a) Yes
- b) No

11. Individual monthly income

- a) Rs<5,000.
- b)Rs. 5,001 – Rs. 10,000.
- c)> Rs. 10,001.

12. Area of residence

- a) Urban
- b) Semi urban

c) Rural

13. Involvement in household activities

- a) Within home
- b) Outside home
- c) Both

14. Previous experience in taking care of pregnant woman

- a) Yes
- b) No

**SPOUSE DETAILS**

1. Age of the mother in years

- a) 20-25
- b) 26-30
- c) 31-35

2. Educational status

- a) No formal education.
- b) Primary
- c) Elementary
- d) High school
- e) Higher secondary
- f) Diploma
- g) Graduate and above

3. Occupational status

- a) Professional
- b) Technical

- c) Skilled.
- d) Unskilled.
- e) Home maker.

4. Individual monthly income

- a) Rs<5,000.
- b) Rs. 5,001 – Rs. 10,000.
- c) >Rs. 10,001
- d) No income

5. Obstetrical score    G    P    L    A

6. Antenatal Registration

- a) Yes
- b) No

7. If yes, at what setup

- a) Government
- b) Private.

8. Visits accompanied

- a) Yes
- b) No

If yes, specify.

9. Immunization

- a) Yes
- b) No

10. Any specific maternal illness.

- a) Gestational diabetes mellitus.
- b) Pre eclampsia

- c) Normal
- d) Others

**PART II**  
**KNOWLEDGE QUESTIONNAIRE**

**ANTENATAL CARE**

1. Registration/Antenatal care should begin
  - a) After third month.
  - b) After fifth month.
  - c) After seventh month.
  - d) After conception and continue throughout pregnancy.
  
2. The immediate and the following investigations to be done to confirm pregnancy
  - a) Blood investigations
  - b) urine pregnancy test and ultrasonography.
  - c) X- ray and CT scan
  - d) Checking pulse rate
  
3. Antenatal mother should attend at least of
  - a) 2 visits
  - b) 3 visits
  - c) 4 visits
  - d) 5 visits.
  
4. What is the vaccine to be given during antenatal period?
  - a) Typhoid vaccine
  - b) Tetanus toxoid vaccine
  - c) DPT vaccine.
  - d) MMR Vaccine.
  
5. What is the type of antenatal diet a pregnant mother should consume
  - a) High caloric, iron and calcium rich
  - b) High caloric and iron rich

- c) High caloric and calcium rich
  - d) Iron rich only
6. A normal antenatal mother should gain an average weight at the end of pregnancy is of about
- a) 10-12kg
  - b) 8-9kg
  - c) 6-7kg
  - d) 4-5kg
7. While sleeping the pregnant mother should lie on her
- a) left lateral
  - b) right lateral
  - c) supine
  - d) prone
8. The average time duration for sleeping during antenatal period is
- a) 9hrs in the night alone.
  - b) 8hrs in the night and 2hrs in the day.
  - c) 5hrs in the night and 1hr in the day.
  - d) 10hrs in the night and 3hrs in the day.
9. Sexual contact is considered to be unsafe during
- a) I trimester
  - b) II trimester
  - c) III trimester
  - d) In all the trimesters
10. The Hb / iron level of the women during pregnancy should be above
- a) 7gms.
  - b) 8gms.

- c) 9gms
- d) 10gms

11. Habits to be considered harmful during pregnancy.

- A. Smoking
  - B. Alcoholism
  - C. Tobacco chewing
  - D. Taking self-medications
- a) A and B
  - b) A and C
  - c) A, B and D
  - d) A, B, C, and D.

### **INTRANATAL CARE**

12. Signs of true labor.

- A. Rhythmic uterine contraction
  - B. Cervical dilatation and effacement
  - C. Show presentation.
  - D. Rupture of the membrane.
- a) A, B and C
  - b) A, B and D.
  - c) B, C and D
  - d) A, B, C and D.

13. Immediately after the delivery of the baby, the following parts has to be delivered

- a) Blood clots
- b) Placenta
- c) Amniotic fluid
- d) Blood clots and placenta

14. During labor process partner should provide massage in

- a) Back and the abdomen.
- b) Calf muscles of the legs

- c) Shoulder and hands
- d) Forehead

## **POSTNATAL CARE**

15. Both liquid and solid diets can be given to the mother

- a) Immediately after delivery
- b) 24 hours after delivery
- c) 48 hours after delivery
- d) 72 hours after delivery

16. In the puerperium, the mother should attend postnatal visit of at least

- a) 3 visits
- b) 2 visits
- c) 4 visits
- d) 5 visits

17. The couples should have safe sexual contact after \_\_\_\_\_  
of delivery process.

- a) 6 weeks
- b) 7 weeks
- c) 8 weeks
- d) 9 weeks

18. The expected space between the first and second child should be of

- a) At least 6 months
- b) at least one year
- c) 2 years
- d) 3 years

19. The best temporary family planning method for women after first pregnancy  
is

- a) Spermicides



- b) Contraceptive pills
- c) IUCD (Copper T)
- d) Vaginal sponge.

20. The best temporary family planning method for men is

- a) Spermicides
- b) Contraceptive pills
- c) Abstinence
- d) Condom.

## **CHILD CARE**

21. Breast feeding should be initiated

- a) Immediately after birth
- b) One hour after birth
- c) Two hours after birth.
- d) Three hours after birth

22. Exclusive breast feeding should be given for

- a) 2 months
- b) 4 months
- c) 6 months
- d) 8 months

23. First vaccination which is given for the baby immediately after birth includes

- a) BCG and OPV
- b) BCG, OPV and Hep – B
- c) OPV and Hep-B
- d) only BCG

24. What are all the diseases against which the child should be immunized

- a) Six killer diseases
- b) Mumps and measles
- c) Tuberculosis and Tetanus
- d) diphtheria and typhoid

25. Baby should always be covered with protective clothing in order to

- a) Maintain body temperature
- b) Prevent Infection
- c) Prevent from dust
- d) Promote sleep

## **SECTION – C**

Sl.No	CONTENT	SA	A	UC	D	SD
	<b>ATTITUDE SCALE.</b>					
1.	It is the responsibility of the male partner to be aware of the health status of the wife during her pregnancy.					
2.	It is not necessary for a husband to accompany his wife for the entire antenatal visit.					
3.	It is not necessary to give honey or sugar water to the baby immediately after birth					
4.	In our culture, taking care of an antenatal mother is always the role of the women in the family.					
5.	Partner can be present in the labor room during delivery.					
6.	Child birth classes are essential only for the female partner.					
7.	The involvement of the male partner in the care of the pregnant mother is the strong psychological support.					
8.	Child birth is the normal process, there is no need for the male to be involved in that.					
9.	It is the responsibility of the male partner to be aware of the medications taken by his wife during pregnancy.					
10.	It is not necessary for the male partner to undergo any lab investigations during his wife's pregnancy.					

S.A - Strongly agree

A - Agree

U - Uncertain

D - Disagree

S.D - Strongly Disagree

¾Éç ¿À÷ ÅçÅÃõ

1.  $\text{Å}\hat{\text{Å}}\text{Ð} (\text{Å}\tilde{\text{O}}\frac{1}{4}\text{í}, \text{Ç}\text{ø})$ 
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  - ¬) 26-30
  - þ) 31-35
  
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  - ¬)  $\text{Ü}\tilde{\text{o}}\hat{\text{I}} \text{Ï}\tilde{\text{o}}\hat{\text{À}}\tilde{\text{o}}$
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  - ®)  $\text{Á}\tilde{\text{ü}}\hat{\text{È}}^{\cdot}\hat{\text{Å}}$
  
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  - ®)  $\text{Á}\tilde{\text{ü}}\hat{\text{È}}^{\cdot}\hat{\text{Å}}$
  
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  - ¬) 4-6  $\text{Å}\tilde{\text{O}}\frac{1}{4}\text{í}, \hat{\text{U}}$
  - þ) 7-10  $\text{Å}\tilde{\text{O}}\frac{1}{4}\text{í}, \hat{\text{U}}$
  
5.  $\frac{3}{4}\text{ø}\tilde{\text{O}}\hat{\text{Á}}\frac{1}{2} \text{Ó}^{\cdot}\hat{\text{È}}$ 
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  - ®)  $\text{¬} \hat{\text{A}}\div\text{¿}\text{ø}^{\cdot}\tilde{\text{Ä}}\text{i}, \text{ø}\hat{\text{Å}}\text{ø}$

- )  $\text{SÁÉç} \cdot \text{Äi} \cdot \text{øÁç}$   
 °)  $!^{3/4} \text{jAEçø}^0 \text{j} \div \text{ó}^{3/4} \cdot \text{øÁç}$   
 ±)  $\text{Àð}^{1/4} \text{ø}^{3/4} \text{j} \tilde{\text{Äç}} \text{ ÁüÜõ} \llcorner \text{ø}^{3/4} \text{üì} \text{ SÁø}$

7.  $\text{À}^{1/2} \text{ç} \text{Áç} \text{Ä} \tilde{\text{Ä}} \tilde{\text{õ}}$   
 «)  $\text{Àð}^{1/4} \text{ø} \text{ÄÊ} \text{ø} \text{Ö}^0 \text{j} \div \text{ó}^{3/4} \text{ À}^{1/2} \text{ç}$   
 -)  $!^{3/4} \text{jAEçø}^0 \text{j} \div \text{ó}^{3/4} \text{ À}^{1/2} \text{ç}$   
 þ)  $^{3/4} \text{ç} \text{È} \cdot \text{ÁÔ} \text{üÇ} \text{ À}^{1/2} \text{ç}$   
 ®)  $^{3/4} \text{ç} \text{È} \cdot \text{ÁÄ} \text{üÈ} \text{ À}^{1/2} \text{ç}$

8.  $\text{ø} \text{ÖxüÈ} \text{ Ó} \cdot \text{È}$   
 «)  $\text{þ} \text{Ä} \text{ø} \text{Äi} \cdot$   
 -)  $\text{ÁÖ} \text{ø} \text{Ð} \text{Ä}^0 \text{ç} \cdot \text{ç} \text{í} \cdot \text{ø} \text{ì} \text{ø} \text{Ä} \text{ç} \text{ý}$

9.  $\text{À}^{1/2} \text{ç} \text{ S} \text{ç} \tilde{\text{Ä}} \tilde{\text{õ}}$   
 «)  $8 \text{ À}^{1/2} \text{ç} \text{ S} \text{ç} \tilde{\text{Ä}} \tilde{\text{õ}}$   
 -)  $8 \text{ À}^{1/2} \text{ç} \text{ S} \text{ç} \tilde{\text{Ä}} \text{ø}^{3/4} \text{ç} \text{üì} \text{ SÁø}$

10.  $\text{ø} \text{ç} \text{ø} \text{ð} \text{ Ó} \cdot \text{È}$   
 «)  $\text{ñ} \text{í}$   
 -)  $\text{þ} \text{ø} \cdot \text{Ä}$

11.  $^{3/4} \text{Éç} \text{ç} \text{Ä} \div \text{Ái}^{3/4} \text{ ÁÖ} \text{Äj} \text{É} \tilde{\text{õ}}$   
 «)  $\text{<á} \text{Äj} \text{ö} \text{ 5,000}$   
 -)  $\text{á.5,001} - \text{á.10,000}$   
 þ)  $\text{>á.10,000}$

12.  $\text{Á}^0 \text{ç} \text{ø} \text{Ä} \text{ç}^{1/4} \tilde{\text{õ}}$   
 «)  $\text{ç} \cdot \tilde{\text{Ä}} \tilde{\text{õ}}$   
 -)  $\text{ÒÈ} \text{ç} \cdot \div$   
 þ)  $\text{ç} \tilde{\text{Ä}} \text{j} \text{Á} \tilde{\text{õ}}$

13.  $\text{Áç} \text{ð} \text{í} \text{S} \text{Ä} \cdot \text{Ä} \cdot \text{Ççø} \text{ ®} \text{í} \text{Äj} \text{í}$

«)  $\text{Å}\text{É}\text{ö}\text{Ë}\text{ü}\text{ì}\text{ù} \text{§}\text{Å}^{\text{~}}\text{Ä}$

¬)  $\text{!}\text{Å}\text{Ç}\text{ø} \text{§}\text{Å}^{\text{~}}\text{Ä}$

þ)  $\text{þ}\text{Ä}\text{ñ}\text{í}\text{õ}$

14.  $\text{,}\text{÷}\text{ø}\text{À}\text{ø}^{\text{1}\text{/}\text{2}}\text{ø}^{\text{ò}\text{3}\text{/}\text{4}}\text{ì}^{\text{~}}\text{Ä} \text{,}\text{Å}\text{É}\text{ø}^{\text{ò}\text{3}\text{/}\text{4}} \text{Ó}\text{ý} \text{«}\text{Û}\text{À}\text{Å}\text{õ}$

«)  $\text{~}\text{ñ}\text{í}$

¬)  $\text{þø}^{\text{~}}\text{Ä}$

### **Á<sup>~</sup>ÉÅçÂçý ÅçÄÃõ**

1.  $\text{Á}^{\text{~}}\text{É}\text{Å}\text{ç}\text{Â}\text{ç}\text{ý} \text{Å}\text{Ä}\text{Ð} \text{Å}\text{Õ}\text{¼}\text{í}\text{,}\text{Ç}\text{ø}$

«) 20-25

¬) 26-30

þ) 31-35

2.  $\text{,}\text{ø}\text{Å}\text{ø}^{\text{ò}\text{3}\text{/}\text{4}}\text{ì}\text{¾}\text{ø}$

«)  $\text{±}\text{ø}^{\text{3}\text{/}\text{4}} \text{Ä}\text{Ë}\text{ì} \text{,}\text{!}\text{¾}\text{Ä}\text{ç}\text{Ä}\text{ì}\text{¾}\text{Ä}\text{÷}$

¬)  $\text{~}\text{Ä}\text{õ}\text{Ä}\text{ì}\text{,}\text{ø}\text{Å}\text{ø}$

þ)  $\text{ç}\text{!}\text{ç}\text{ø}^{\text{~}}\text{Ä}\text{ø}\text{Ä}\text{ü}\text{Ç}\text{ø}$

®)  $\text{~}\text{Ä}\text{÷}\text{ç}\text{ø}^{\text{~}}\text{Ä}\text{ì}\text{,}\text{ø}\text{Å}\text{ø}$

¬)  $\text{§}\text{Á}\text{É}\text{ø}^{\text{~}}\text{Ä}\text{ì}\text{,}\text{ø}\text{Å}\text{ø}$

°)  $\text{!}\text{¾}\text{ì}\text{Æ}\text{ø}\text{ø} \text{°}\text{ì}\text{÷}\text{ó}\text{¾} \text{,}\text{ø}\text{Å}\text{ø}$

±)  $\text{Ä}\text{ð}\text{¼}\text{¾}\text{ì}\text{Ä}\text{ø} \text{Á}\text{ü}\text{Ü}\text{õ} \text{«}\text{¾}\text{ü}\text{ì} \text{§}\text{Á}\text{ø}$

3.  $\text{À}\text{½}\text{ø} \text{Å}\text{ø}\text{Ä}\text{Ã}\text{õ}$

«)  $\text{Ä}\text{ð}\text{¼}\text{ø}\text{Ä}\text{Ë}\text{ø}\text{Ø} \text{°}\text{ì}\text{÷}\text{ó}\text{¾} \text{À}\text{½}\text{ø}$

¬)  $\text{!}\text{¾}\text{ì}\text{Æ}\text{ø}\text{ø} \text{°}\text{ì}\text{÷}\text{ó}\text{¾} \text{À}\text{½}\text{ø}$

þ)  $\text{¾}\text{ø}\text{È}^{\text{~}}\text{Á}\text{Ö}\text{ü}\text{Ç} \text{À}\text{½}\text{ø}$

®)  $\text{¾}\text{ø}\text{È}^{\text{~}}\text{Á}\text{Ä}\text{ü}\text{È} \text{À}\text{½}\text{ø}$

¬)  $\text{þø}\text{Ä}\text{ø}^{\text{3}\text{/}\text{4}}\text{Ä}\text{ø}$

4.  $\frac{3}{4} \text{€} \leq \text{A} \leq \frac{3}{4} \text{€}$   $\text{A} \in \mathbb{R}$
- «)  $< \text{€} 5,000$   
 ¬)  $\text{€} 5,001 - \text{€} 10,000$   
 þ)  $> \text{€} 10,000$   
 ®)  $\text{A} \in \mathbb{R}$
5.  $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$
- G            p            L            A
6.  $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$
- «)  $\neg$   
 ¬)  $\text{A} \in \mathbb{R}$
7.  $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$
- «) « $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$ »  
 ¬)  $\frac{3}{4} \text{€} \leq \text{A} \leq \frac{3}{4} \text{€}$
8.  $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$
- «)  $\neg$   
 ¬)  $\text{A} \in \mathbb{R}$
9.  $\frac{3}{4} \text{€} \leq \text{A} \leq \frac{3}{4} \text{€}$   $\text{A} \in \mathbb{R}$
- «)  $\neg$   
 ¬)  $\text{A} \in \mathbb{R}$
10.  $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$
- «)  $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   
 ¬)  $\text{A} \in \mathbb{R}$  « $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$ »  
 þ)  $\text{A} \in \mathbb{R}$   $\text{A} \in \mathbb{R}$   
 ®)  $\text{A} \in \mathbb{R}$

**Àì¼¢ - II**  
**«È¢xò¼¢Èý °ì÷ó¼ §,ûÁ¢,û**

**„÷òÀ „ìÄ ÄÄìÁÄ¢òÒ**

1. „÷òÀ „ìÄ ÄÄìÁÄ¢òÒ ±ò§ÀìÐ ì¼ì¼í, §Åñîõ?
  - «) äýÚ Áì¼í, Ùì À¢ý
  - ¬) ³óÐ Áì¼í, Ùì À¢ý
  - þ) ²Ø Áì¼í, Ùì À¢ý
  - ®) „÷òÄÁìÉ À¢ý ÁüÚõ „÷òÀ „ìÄ ÒØÄÐõ
  
2. „÷òÄÁìÉ¼ - Ú¼¢òÀìò¼ - ¼ÉÊÄì,xõ ÁüÚõ ì¼ì¼÷óÐõ ì°öÄ §ÅñÊÄ ÄÄ¢§°ì¼¼É,û
  - «) þÃò¼ ÄÄ¢§°ì¼¼É
  - ¬) °¢Ú¿£÷ ÄÄ¢§°ì¼¼É ÁüÚõ Š§,ý
  - þ) ¿¢Æø À¼õ ÁüÚõ °¢.Ê.Š§,ý
  - ®) ¿ìÉ À¢ÉòÐ Äì÷ò¼ø
  
3. „÷òÄ¢½¢ò¼ìò „÷òÀ „ìÄò¼¢ý §ÀìÐ ìÈó¼Ð ±ò¼¼É ÓÈ ÄÕòÐÄÄ «ì, §Åñîõ?
  - «) 2 ÓÈ
  - ¬) 3 ÓÈ
  - þ) 4 ÓÈ
  - ®) 5 ÓÈ
  
4. „÷òÀ „ìÄò¼¢ý §ÀìÐ ì,ìì,òÀìõ ¼Íòâ°¢Á¢ý ìÄÄ÷ ±ýÉ?
  - «) ¼Äìõì ¼Íòâ°¢
  - ¬) þÃ½fñ½¢ ¼Íòâ°¢
  - þ) Óò¼Íòâ°¢
  - ®) ¼ð¼õÄ ¼Íòâ°¢





Ⓜ) ±øÄj Áj¼í,ÇøÖø

10. ÷øÀ,jÄø¼øý §ÀjÐ þÃø¼ø¼øø þÖøÖ øø¼øý «Çx ±ùÁÇx ,øÃjÁøùì §Áø þÖì, §Åñïø?

«) 7 ,øÃjø

¬) 8 ,øÃjø

þ) 9 ,øÃjø

Ⓜ) 10 ,øÃjø

11. ÷øÀ,jÄø¼øý §ÀjÐ ¼Æìì ¼Ã ÜÊÀ ÀÆì,ÁÆì,í,ù ±ý:ÉýÉ?

«) Ò, ÀøÊø¼øø

¬) ÁÐ «ÖóÐ¼øø

þ) Ò, Áø"Ä - ðì,jùÙ¼øø

Ⓜ) ¼j§Á ÁÖóÐ Ájø¼øø"Ä - ðì,jùÙ¼øø

1) «, ¬, Ⓜ      2) «, ¬, þ      3) « ÁüÜø ¬ 4) «, ¬, þ, Ⓜ

### ÀøÃøÅ§øÄ ÄÃjÁÃøø

12. ÀøÃøÅø¼øøü,jÉ - ñ"ÁÄjÉ «ÈøìÈø,ù?

«) Ó"ÈÄjÉ ,Öø"À íÖì,ø

¬) ,Öø"ÁÄjø ÀøÃøÄ"¼¼øø

þ) þÃø¼øø ,Äó¼ !Áü"Ç Áì¼øø

Ⓜ) ÀÈøì¼øø - "¼¼øø

1) «, ¬, þ, Ⓜ    2) «, ¬ ÁüÜø Ⓜ 3) «, ¬ ÁüÜø þ 4) « ÁüÜø -

13. ìÆó"¼ ÀøÊø¼øx¼ý !ÁÇø§ÅÈìÜÊÀ ÁüÈ"Á ±ýÉ?

«) þÃø¼ì ,ðÊ,ù

¬) çíìì ,jÉ

þ) ÀÈøì¼øçÆ÷

Ⓜ) þÃø¼ì,ðÊ,ù ÁüÜø çíìì ,jÉ

14. ÀøÃøÅø¼øøý §ÀjÐ ,½Á÷ ¼¼¼Äøìì ,jìì, §ÅñÊÀ - ¼üÄj,í,ù?

«) ÓÐì ÁüÜø ÁÄøÜ

¬) ,jø ¼"ø,ù

- b)  $\frac{3}{4}j\theta\dot{A}\ddot{\delta}^{-1/4}\dot{A}\ddot{u}\dot{U}\ddot{o}^{-1/2}\dot{u}$
- Ⓒ)  $\dot{O}\dot{y}\dot{l}\dot{z}\dot{u}\dot{E}\dot{\phi}$

**ÀçÃ°Ãð¼çüì Àçý ÀÃ¡ÁÃçðÒ**

15. ÀçÃ°Ãð¼çüì Àçý ±ð\$À¡Ð ç£÷ ÁüÜö ¼çÃÃ<sup>-1/2x</sup>,"Ç ¼jöì l,jî, \$Ãñíð?

- «)  $^{-1/4}\dot{E}\dot{E}\dot{A}_j$
- ¬)  $24\dot{A}^{1/2}\dot{\phi}\dot{\xi}\dot{A}\ddot{o}^{3/4}\dot{\phi}\dot{u}\dot{l}\dot{A}\dot{\phi}\dot{y}$
- b)  $48\dot{A}^{1/2}\dot{\phi}\dot{\xi}\dot{A}\ddot{o}^{3/4}\dot{\phi}\dot{u}\dot{l}\dot{A}\dot{\phi}\dot{y}$
- Ⓒ)  $72\dot{A}^{1/2}\dot{\phi}\dot{\xi}\dot{A}\ddot{o}^{3/4}\dot{\phi}\dot{u}\dot{l}\dot{A}\dot{\phi}\dot{y}$

16. ÀçÃ°Ãð¼çüì Àçý ì"Èó¼Ð, ¼jö ±ð¼"É Ó"È ÁÕðÐÃ"Ã «î, \$Ãñíð?

- «) 3 Ó"È
- ¬) 2 Ó"È
- b) 4 Ó"È
- Ⓒ) 5 Ó"È

17. ÀçÃ°Ãð¼çüì Àçý ±ð¼"É Å¡Ãí,û ,ÆçðÐ<sup>-1/4</sup>ÖÈx "Ãð l,jûÇÃjð?

- «)  $6\dot{A}_j\dot{A}\dot{i}_j\dot{u}$
- ¬)  $7\dot{A}_j\dot{A}\dot{i}_j\dot{u}$
- b)  $8\dot{A}_j\dot{A}\dot{i}_j\dot{u}$
- Ⓒ)  $9\dot{A}_j\dot{A}\dot{i}_j\dot{u}$

18. Ó¼ø ÌÆó"¼ìð þÃñ¼¡Ð ÌÆó"¼ìð ±ùÅÇx ,jÄ þ"¼!ÁÇç þÕì, \$Ãñíð?

- «) Ì"Èó¼Ð 6  $\dot{A}_j^{3/4}\dot{i}_j\dot{u}$
- ¬) Ì"Èó¼Ð 1  $\dot{A}\ddot{O}^{1/4}\dot{o}$
- b) 2  $\dot{A}\ddot{O}^{1/4}\dot{i}_j\dot{u}$
- Ⓒ) 8  $\dot{A}\ddot{O}^{1/4}\dot{i}_j\dot{u}$

19. !Àñ,Üìì Ó¼ø ÌÆó"¼ì Àçý °çÈó¼ Ì"Èó¼,jÄ ,Õð¼"¼ Ó"È ±Ð ?

- «)  $\dot{A}\dot{\phi}\dot{o}\dot{D}\dot{i}_j\dot{\phi}\dot{l}_j\dot{\theta}\ddot{O}\ddot{o}\dot{A}\ddot{O}\dot{o}\dot{D}$
- ¬)  $,\ddot{O}\ddot{o}^{3/4}\dot{A}_j\dot{\phi}\dot{\phi}\dot{A}_j\dot{u}$

- b) ,iôÀ÷ - Ê
- Ⓡ) !Á" fÉø ŠÀjýi

20. -ñ, Ùi, j, É ì" Èó¾, j, Ä °ç Èó¾, , Öò¾"¼ Ó"È ±Ð?

- «) Àçó¾lì, "Ç |, jøÖö ÁÕóÐ
- ) , Öò¾"¼ Ájò¾ç"Ä
- b) - ¼ÖÈx |, jûÇj"Á
- Ⓡ) -j"È

**ÌÆó"¾ ÄÃjÁÃçòÒ**

21. ÌÆó"¾ìl ¾j;öðÀjø ±ò\$ÀjÐ |, jlì, \$Åñlõ?

- «) - ¼ÉÉÄj,
- ) ÌÆó"¾ ÀçÈóÐ 1 Á½ç \$çÄõ ,ÆçòÐ
- b) ÌÆó"¾ ÀçÈóÐ 24 Á½ç \$çÄõ ,ÆçòÐ
- Ⓡ) ÌÆó"¾ ÀçÈóÐ 3 Á½ç \$çÄõ ,ÆçòÐ

22. ±ùÀÇx , j, Äò¾çùl ¾j;öðÀjø Áðlõ |, jlì, \$Åñlõ?

- «) 2 Á¾í, ù
- ) 4 Á¾í, ù
- b) 6 Á¾í, ù
- Ⓡ) 8 Á¾í, ù

23. ÌÆó"¾ ÀçÈó¾x¼ý \$Àj¼ðÀlõ ¾lôâ°ç, ù ±ýÉ?

- «) Àç. °ç. fç ÁüÜõ \$ÀjÄç\$Äj |°jðl ÁÕóÐ
- ) Àç. °ç. fç \$ÀjÄç\$Äj ÁüÜõ Áj°ù , j, Áj"Ä °ç
- b) \$ÀjÄç\$Äj ÁüÜõ Áj°ù , j, Áj"Ä
- Ⓡ) Àç. °ç. fç

24. ±ò¾"É \$çj;ö, Ùil ±¾çÄj, ÌÆó"¾ìl ¾lôâ°ç \$Àj¼ \$Åñlõ?

- «) 6 - Äçø |, jøÄç \$çj;öìl ±¾çÄj,
- ) ¾ð¼õ"Á, !Àjñlìl ÁÉj, ç ±¾çÄj,

b)  $\zeta \phi \sigma \xi \alpha \epsilon \hat{\alpha}_i \rho \tilde{\alpha} \frac{1}{2} f \gamma \epsilon \phi \pm \frac{3}{4} \phi \tilde{\alpha}_i$ ,

®)  $\acute{\alpha} \overset{\circ}{\rho} \sigma \rho \alpha \tilde{\alpha}_i \tilde{\alpha}, \rho \frac{3}{4} \rho \tilde{\alpha} \tilde{\alpha} \ll \tilde{\alpha} \frac{1}{4} \hat{\alpha} \rho \gamma \xi \zeta \rho \tilde{\alpha} \rho \pm \frac{3}{4} \phi \tilde{\alpha}_i$ ,

25.  $\lambda \epsilon \sigma \tilde{\alpha} \tilde{\alpha} \hat{\alpha} \pm \hat{\alpha} \xi \alpha \rho \delta \sigma \tilde{\alpha} \acute{\alpha} \rho \frac{3}{4} \alpha \epsilon \rho \frac{1}{2} \phi \hat{\alpha}_i \rho \xi \alpha \rho \div \delta \frac{3}{4} \phi \tilde{\alpha}_i$ ,  $\xi \hat{\alpha} \tilde{\alpha} \rho$ ,  $\rho \acute{\alpha} \epsilon \epsilon \phi \rho$

«)  $\tilde{\alpha} \rho \lambda \hat{\alpha} \hat{\alpha} \delta \tilde{\alpha} \tilde{\alpha} \tilde{\alpha} \rho \tilde{\alpha} \hat{\alpha} \rho \tilde{\alpha} \tilde{\alpha}_i$ ,

→)  $\xi \zeta \rho \tilde{\alpha} \rho \frac{3}{4} \rho \tilde{\alpha} \tilde{\alpha} \rho \tilde{\alpha}_i$ ,

b)  $\rho \rho \phi$ , « $\rho \tilde{\alpha} \hat{\alpha} \rho \alpha \rho \rho \tilde{\alpha}_i$ ,

®)  $\zeta \gamma \epsilon \rho$ ,  $\tilde{\alpha} \rho \lambda \hat{\alpha} \tilde{\alpha} \rho \tilde{\alpha}_i$ ,

## ÁÉôÀjì «Èç¼ø Ì¼i¼÷ÀjÉ §,úÂç,ú

Á.±ñ.	ÌÀjÒÇ¼ì, ò	Á.º	º	Ì¼	ÁÚ	Á.ÁÚ
1	÷òÀj, Ìò¼çý §ÀjÐ Á"ÉÀçÁçý -¼ø -§Áj, çÁò ÁüÈç, ½Á÷ Ì¼ÁçóÐ "ÁòÐ Ìj, ÌúÁÐ «ÁÁÐ ¼"Á.					
2	÷òÀj, Ìò¼çø ÁÒòÐÁ"Á Àj÷ì, ÌºÒò ±øÀj §¿Áj, ÇçÒò, ½Á÷ -¼ÉçÒì, §ÁñÉÁ «ÁºçÁò þø"Á.					
3	¿ò, Àjºj, Ìò¼çø, ÷òÀç½ç ÌÁñ"½, ÁÉçòÁÐ ÌòÁò¼çÒùÇ ÌÁñ, Ççý, ¼"ÁÁj, ò.					
4	¿ò, Àjºj, Á Ó"ÉòÁÉ, ÌÆó"¼ ÁçÉò¼x¼ý §¾ý «øÁÐ º÷ì, "Á ¾ñ½£÷ Ìj, ÌòÁÐ «ÁºçÁò.					
5	ÁçÁºÁò¼çý §ÀjÐ ÁçÁºÁ «"ÉÁçø, ½Á÷ þÒì, §ÁñÌò.					
6	ÌÆó"¼ ÁçÉòÒ ÁüÜò ÁÁj, ÁÁçòÒ ÁÌò, Ççø ¾j, ò ÁòÌò, ÁòÐ Ìj, ÌúÁÐ §Àj, ÐÁj, ÉÐ.					
7	÷òÀj, ÌÁ ÁÁj, ÁÁçòÁçø, ½ÁÁçý ©ÌÁj, ¾j, Áçý ÁÉ¿ç"Á - Ú¼çÁj, þÒì, -¾xò.					
8	÷òÁò¼çùì Áçý, ÌÆó"¼ ÁçÉòÒ ±ýÁÐ «ÉòÁ"¼Áçø ÌÁñ ºòÁó¼ÁjÉ ¿ç, úx, þ¾çø ½Áý ©ÌÁj, §ÁñÌò ±ýÚ «ÁºçÁçø"Á.					
9	÷òÀj, Ìò¼çý §ÀjÐ Á"ÉÀç - ò Ìj, ÌúÜò ÁÒòÐ, ú ÁüÈçÁ ÁçÆçòÒ½÷x, ½ÁÒì Ì¼ÁçóÐ þÒì, §ÁñÉÁÐ «ÁºçÁò.					
10	Á"ÉÀç, ÷òÁÁj, þÒìò §ÀjÐ, ½Á÷ ±ùÁç¾ÁjÉ þÁò¼, ÁÁç§º¼"ÉÒò ÌºÐ Ìj, ÌúÇ §ÁñÉÁ «ÁºçÁò þø"Á.					

### ÌÈçòÒ :

- Á.º - ÁÉôâ÷ÁÁj, ºòÁ¾çì, ç§Èý  
 º - ºòÁ¾çì, ç§Èý  
 Ì¼ - Ì¼ÁçÁçø"Á  
 ÁÚ - ÁÚì, ç§Èý  
 Á.ÁÚ - ÁÉôâ÷ÁÁj, ÁÚì, ç§Èý

**APPENDIX – I**  
**CODING FOR DEMOGRAPHIC VARIABLES**

<b>Demographic Variables</b>	<b>Code No.</b>
1. Age in years	
a) 20-25	1
b) 26-30	2
c) 31-35	3
2. Type of family	
a) Nuclear family	1
b) Joint family	2
c) Extended family	3
d) Others	4
3. Religion	
a) Hindu	1
b) Muslim	2
c) Christian	3
d) Others	4
4. Years of married life	
a) Within 3 years	1
b) 4-6 years	2
c) 7-10 years	3
5. Type of the marriage	
a) Consanguineous	1
b) Non consanguineous	2
6. Educational status.	
a) No formal education.	1
b) Primary	2



c) Elementary	3
d) High school	4
e) Higher secondary	5
f) Diploma	6
g) Graduate and above	7
7. Occupational status	
a) Professional	1
b) Technical	2
c) Skilled	3
d) Unskilled.	4
8. Conception	
a) Normal	1
b) After medical intervention	2
9. Hours of working per day	
a) 8hours.	1
b) More than 8hours	2
10. Shift system	
a) Yes	1
b) No	2
11. Individual monthly income	
a) Rs<5,000.	1
b) Rs. 5,001 – Rs. 10,000.	2
c) > Rs. 10,001.	3
12. Area of residence	
a) Urban	1
b) Semi urban	2

c) Rural	3
----------	---

### 13. Involvement in household activities

a) Within home	1
----------------	---

b) Outside home	2
-----------------	---

c) Both	3
---------	---

### 14. Previous experience in taking care of pregnant woman

a) Yes	1
--------	---

b) No	2
-------	---

## **SPOUSE DETAILS**

### 1. Age of the mother in years

a) 20-25	1
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b) 26-30	2
----------	---

c) 31-35	3
----------	---

### 2. Educational status

a) No formal education.	1
-------------------------	---

b) Primary	2
------------	---

c) Elementary	3
---------------	---

d) High school	4
----------------	---

e) Higher secondary	5
---------------------	---

f) Diploma	6
------------	---

g) Graduate and above	7
-----------------------	---

### 3. Occupational status

a) Professional	1
-----------------	---

b) Technical	2
--------------	---

c) Skilled.	3
d) Unskilled.	4
e) Home maker.	5
4. Individual monthly income	
e) Rs<5,000.	1
f) Rs. 5,001 – Rs. 10,000.	2
g) >Rs. 10,001	3
h) No income	4
5. Obstetrical score	G      P      L      A
6. Antenatal Registration	
c) Yes	1
d) No	2
7. If yes, at what setup	
c) Government	1
d) Private.	2
8. Visits accompanied	
c) Yes	1
d) No	2
If yes, specify.	
9. Immunization	
c) Yes	1
d) No	2
10. Any specific maternal illness.	
e) Gestational diabetes mellitus.	1
f) Pre eclampsia	2

g) Normal	3
h) Others	4

## **SCORING KEY**

**Section – B:**

**Part – I**

It consisted of knowledge questionnaire to assess the knowledge of males regarding their involvement in the MCH services, totally 25 questions were formulated.

Scoring key for the knowledge questionnaire was each correct answer carried '1' mark, incorrect answer '0' mark.

The scoring for level of knowledge was distributed as follows:

- <50% - Inadequate knowledge
- 50-75% - Moderate knowledge
- >74% - Adequate knowledge

A modified 5 point Likert scale consisting of 10 statements was used to assess the attitude regarding their involvement in the MCH services among males. Out of the 10 statements, 5 statements were positively worded statements and 5 statements were negatively worded statements.

S.NO	QUESTIONS	Strongly Agree	Agree	Uncertain	disagree	Strongly disagree
1	Positive	5	4	3	2	1
2	Negative	1	2	3	4	5

Maximum score: 50

**Scoring key:**

Scoring in percentage (%)	Level of attitude
<50%	Unfavorable
50-75%	Moderately favorable
>75%	Favorable

**APPENDIX – J**

## BLUE PRINT

<b>S.NO</b>	<b>Content</b>	<b>Item</b>	<b>Total Item</b>	<b>Percentage</b>
1	Demographic variables	1-14	14	
		1-10	10	
2	Knowledge			
	Antenatal period	1-11	11	31.48%
	Intranatal period	12-14	3	8.57%
	Postnatal period	14-20	6	17.14%
	Child care	21-25	5	14.28%
3	Attitude	1-10	10	28.57%
	<b>Total</b>		35	100%

## APPENDIX – K

# **INTERVENTION TOOL**

## **MATERNAL CHILD HEALTH CARE PACKAGE**

### **INTRODUCTION**

In Indian society, with traditional patriarchal dominance, men play an important role in decision making in almost all spheres of life including reproductive life. In such society where men as “gatekeepers” influence women’s reproductive health and to use reproductive health services, male involvement is essential for the improvement of women’s health and the overall status of women. Hence it is important to educate the males regarding the MCH Services in order to reduce the maternal mortality rate. This includes antenatal care, intranatal care, postnatal and child care.

### **ANTENATAL CARE:**

Antenatal care is the care of the women during pregnancy. Ideally this care should begin soon after conception and continue throughout pregnancy.

### **COMPONENTS:**

- Early registration.
- Investigations
- Antenatal visits.
- Immunisation.
- Diet.
- Rest and sleep.
- Personal hygiene.
- Safety.
- Antenatal exercises.
- Sexual contact.
- Warning signs of pregnancy.

### **EARLY REGISTRATION:**



The time for the first visit (or) of the pregnant women should take place immediately when the pregnancy is suspected. Every married woman in the reproductive age group should be encouraged to visit her health provider to inform you if she believes herself to be pregnant.

Ideally, the first visit should take place in the first trimester, before (or) at the 12<sup>th</sup> week of pregnancy. However, even if a woman comes late in her pregnancy for registration, she should be registered, and care given to her according to the gestational age.

### **INVESTIGATIONS:**

Urine pregnancy test is the foremost investigation which is done to the mothers who were suspected of pregnancy at 45 days in order to see the presence of HCG hormone. Following this in order to confirm pregnancy they have to undergo ultra sonography in the 5<sup>th</sup> and the 7<sup>th</sup> month of pregnancy. Other than this normal blood investigations to estimate blood counts, HB Level, blood glucose level, blood grouping and typing can also be done.

### **ANTENATAL VISITS:**

Ideally a mother should attend

- During first 7 months – once a month.
- During the 8<sup>th</sup> month – twice a month.
- During the 9<sup>th</sup> month – once in a week.

If this is not possible, at least 4 visits for Antenatal care including

- 1<sup>st</sup> visit – before 20<sup>th</sup> week of pregnancy, as soon as pregnancy is suspected.
- 2<sup>nd</sup> visit – between 4<sup>th</sup> and 6<sup>th</sup> month (around 26 weeks)
- 3<sup>rd</sup> visit – 8<sup>th</sup> month (32 weeks).
- 4<sup>th</sup> visit – 9<sup>th</sup> month (36 weeks)

### **IMMUNISATION:**

Immunization against tetanus, should be given to the mother in the antenatal period.

Early in pregnancy – TT.1

One month after - TT.1 and TT.2

In case of multigravida, one dose is enough, if previously immunized.

### **DIET:**

On an average, a normal healthy woman gains about 10-12kg of weight during pregnancy, several studies have indicated that weight gain of poor Indian women averaged 6.5kg during pregnancy. Thus pregnancy imposes the need for considerable extra calorie and nutrient requirements.

All pregnant woman need a balanced diet, which provides 300k cal over and above their normal requirements and 50 to 60% the calorie requirement should be fulfilled from carbohydrates.

50 to 60% - carbohydrates

15 to 20% - fats

15 to 20% - proteins

Besides this pregnant women need prophylactic elemental Iron in doses of 100mg, folic acid 500mcg and calcium 1mg per day. No special foods are recommended nor any food taken normally is restricted.

### **REST AND SLEEP:**

8 hours of sleep and at least 2 hours of rest after the mid-day meals should be advised.

### **PERSONAL HYGIENE:**

**a) Personal cleanliness:**

The need to bathe every day and to wear clean cloths should be explained. The hair should be kept clean and tidy.

**b) Bowels:**

Constipation should be avoided by regular intake of green leafy vegetables, fruits and extra fluids. Purgatives like castor oil should be avoided to relieve constipation.

**c)smoking:**

Smoking should be cut down to a minimum. Expectant mother who smokes heavily produce babies much smaller than average,it is because nicotine has a vasoconstrictor influence in the uterus and induces a degree of placental insufficiency.

**d) Alcohol:**

Evidence is mounting that alcohol can cause a range of fertility problems in women. Moderate to heavy drinkers who became pregnant have greater risk of pregnancy loss and if they do not abort, their children may end up with serious physical and mental problems. Heavy drinking has been associated with a fetal alcoholic syndrome(FAS) which includes intrauterine growth retardation and developmental delay.

**e) Dental care:**

Advice should also be given about oral hygiene.

**DRUGS:**

The use of drugs that are not absolutely essential should be discouraged. Certain drugs taken by the mother during pregnancy may affect the foetus adversely and cause foetal malformations. Later still in the puerperium, if the

mother is breast feeding, there are certain drugs which are excreted in the breast milk. A great deal of caution is required in the drug intake by the pregnant women.

### **RADIATION:**

Exposure to radiation is a positive danger to the developing foetus. The most common source of radiation exposure is the abdominal x-ray during pregnancy. Case cohort studies have shown that mortality rates from leukaemia and other neoplasms were significantly greater among children exposed to intra uterine x-ray. The x-ray in pregnancy should be carried out only for definite indications, and even then x-ray dosage must be kept to minimum.

### **ANTENATAL EXERCISES:**

#### **SEXUAL INTERCOURSE:**

For a normal pregnancy the sexual intercourse should be restricted in the third trimester alone. If the mother is said to have a problem with their pregnancy such as previous history of abortions, it should be restricted in both the I and the III trimesters. Before engaging in to the sexual activity woman's comfort should be kept as a prior importance.

### **WARNING SIGNS OF PREGNANCY:**

The partner should be given clear cut instructions that she should report immediately in case of the following warning signals.

Swelling of the feet

Fits

Headache

Blurring of vision

Bleeding (or) discharge per vagina

Any other unusual symptoms

**INTRA NATAL CARE:**

This includes accompanying the mother during the delivery process.

**PREPARATION FOR LABOR:**

- Last minute preparation
- Remember the hospital bag
- Provide the transportation
- Be a calming presence
- Be the coach -
- Call friends and family

**SIGNS OF THE LABOR:**

- Rhythmic uterine contractions.
- Cervical dilatation and effacement.
- Show presentation.
- Rupture of the membrane

**POSTNATAL CARE:****PUERPERIUM:**

It is the period following child birth during which the body tissues, especially pelvic organs, revert approximately to pre pregnant state both anatomically and physiologically.

First 6 weeks of delivery after child birth is considered as puerperial period.

**POSTNATAL VISIT:**

The postnatal checkups should be performed, first after the discharge i.e. within 7-10 days of the delivered woman and the second at 6 weeks after the delivery.

**PROMOTING PHYSICAL AND EMOTIONAL WELLBEING:**

This includes

**IMMEDIATE CARE:**

After the delivery, mother is exhausted. She should be observed carefully as this is the crucial period. Something light which may be solid or liquid diet should be given immediately to the mother to drink or to eat. In case if the mother is tired, sedatives can be given so that she can rest.

**REST AND AMBULATION:**

As the mother is tired, she requires rest. At the same time, early ambulation is also very important. The period of rest vary depending upon the intranatal period. If the labor process is normal, early ambulation with assistance is needed. A woman who had spinal or epidural anesthesia may have to rest 6-8 hours flat in bed to prevent spinal headache. In case, the woman is not properly alert and is very exhaustive, may be ordered bed rest for a specific period.

**DIET:**

A normal diet can be started after the delivery. During postnatal period, additional 550kcal are required so that it will enhance lactation. Woman who has hemorrhaged, high protein diet is recommended to promote tissue healing.

**CARE OF THE PERINEUM:**

Perineal area has to be washes and cleaned each time after urination and defecation. The perineal wound should be wiped from front to back across the stiches. Sterile pad should be applied properly.

**CARE OF THE BLADDER:**

The woman is encouraged to pass the urine 6-8 hours after delivery and thereafter at 4-6 hours interval. In case of severe perineal pain, catheterization can

be done. Attention should be given to bladder care to adequate drainage of urine so that infection may not occur.

### **CARE OF THE BOWEL:**

Early ambulation, sufficient roughage and fluids in the diet are required to treat the problem of constipation. If required mild laxatives such as milk of magnesia 4-6 teaspoons may be given at bed time.

### **CARE OF THE BREASTS:**

Proper inspection of the breasts has to be done by the midwife. Attention should be given to the proper washing and cleaning of the nipples before and after each feeding with lukewarm water.

### **ROOMING IN:**

To enhance the bond between the mother and the baby, the baby should be kept in a cot besides the mother, when the mother is awake.

### **POSTPARTUM EXERCISES:**

This includes exercises such as

Deep breathing

Head and shoulder raising

Leg raising

Pelvic tilt

Sit ups

Kegel exercises

### **CONTRACEPTION:**

Remind the woman and the partner that whenever she starts her menses and stops breast feeding, she can conceive even after a single act of unprotected sex.

Advise the couples to abstain from sex if the perineal wound has healed atleast for 6 weeks.

Ask the couple's plan for having more children. If they desire more, advise them that the a gap of 3-5 years between pregnancies is healthier for the mother and child. They should be given the range of family planning methods available to them such as

- Lactational amenorrhea method
- Intra uterine contraceptive devices
- Condoms
- Injectables
- Natural methods
- Oral contraceptive pills
- Permanent methods

## **CHILD CARE**

This includes emphasis should be given on

### **BREAST FEEDING:**

- Breast feeding initiation immediately after child birth
- Exclusive breast feeding for 6 months
- Demand feeding- whenever the baby needs.
- Complementary feeding at six months.

### **PREVENTION OF HYPOTHERMIA:**

Hypothermia which results in increased Oxygen and glucose consumption which results in hypoglycemia and metabolic acidosis. In order to prevent this wrap the baby in loose multiple layers of light warm cloth. Change the diapers immediately after each urination and defecation.



**IMMUNISATION:**

Immunization against six killer diseases should be given (diphtheria, pertussis, tetanus, tuberculosis, mumps, measles).

Immediately after birth child should be immunized with BCG, OPV AND HEP-B Vaccines.

### கர்ப்பகால பராமரிப்பு:

கர்ப்பகாலத்தில் ஒரு பெண்ணை கவனித்து கொள்வதே கர்ப்பகால பராமரிப்பு ஆகும். இது ஒரு பெண் கருவுற்ற காலம் முதல் கர்ப்பகாலம் முழுவதும் தொடர வேண்டும்.

### இதன் பாகங்களாவது

- முன்பதிவு
- பரிசோதனைகள்
- கர்ப்பகால கண்காணிப்பு வருகை
- தடுப்புசி
- உணவுமுறை
- ஓய்வு மற்றும் உறக்கம்
- தவிர்க்க வேண்டியவைகள்
- உடலுறவு வைத்துக்கொள்ளுதல் பற்றிய விளக்கம்
- கர்ப்பகாலத்தின் எச்சரிக்கை அறிகுறிகள்

### முன்பதிவு

கர்ப்பத்தை உறுதிப்படுத்த மருத்துவமனைக்கு வரும் முதல் வருகையில் கர்ப்பிணி பெண்கள் தங்களின் கர்ப்பத்தை முன்பதிவு செய்து கொள்வது அவசியம். இவ்வாறு செய்வது பின்வரும் காலங்களில் செய்யப்படும் தொடர் சிகிச்சைக்கு உதவியாக இருக்கும்.

### பரிசோதனைகள்

கர்ப்பமானதை உறுதிப்படுத்த உடனடியாக செய்ய வேண்டியது சிறுநீர் பரிசோதனையாகும். இப்பரிசோதனை பொதுவாக 45 நாட்களுக்கு பிறகு தங்களது வீட்டிலேயே ப்ரக்கார்டு மூலம் செய்து கொள்ளலாம். இதை தொடர்ந்து கர்ப்பத்தை உறுதிப்படுத்த ஐந்தாவது மற்றும் ஏழாவது மாதத்தில் ஸ்கேன் எடுத்துக்கொள்வது அவசியம்

இதை தவிர அவர்கள் செய்ய வேண்டிய மற்ற பரிசோதனைகள்

- முழு இரத்த பரிசோதனை
- இரத்தத்தில் சர்க்கரை மற்றும் இரும்புசத்தின் அளவு

### கர்ப்பகால கண்காணிப்பு வருகை

முதல் 7 மாதங்களில் - மாதத்திற்கு ஒருமுறை

8வது மாதத்தில் - மாதத்திற்கு இரண்டு முறை

9வது மாதத்தில் - வாரத்திற்கு ஒருமுறை

இவை சாத்தியம் இல்லாதபோது ஒரு கர்ப்பிணித்தாய் அவளது கர்ப்பக்காலத்தின் போது குறைந்தது நான்கு முறையாவது மருத்துவரை பார்த்தாக வேண்டும்.

முதலாம் வருகை - இருவது வாரங்களுக்கு முன்னால் அல்லது கர்ப்பம் உறுதியான உடனே

இரண்டாம் வருகை - நான்கு மற்றும் ஆறு மாதங்களுக்கு இடையில்

மூன்றாம் வருகை - எட்டாவது மாதத்தில்

நான்காம் வருகை - எட்டாவது மாதத்தில்

### தடுப்புசி:

ஒவ்வொரு கர்ப்பிணி பெண்களும் இரணஜன்னி நோய்க்கு எதிராக தடுப்புசி போடவேண்டும்.

ஒவ்வொரு கர்ப்பம் உறுதியான உடன்- டி.டி தடுப்புசி ஒருமாத இடைவிடையில் இரண்டு தவணைகள் போட வேண்டும்.

### உணவுமுறை:

கர்ப்பிணி பெண்கள் தங்கள் கர்ப்பகாலத்தின்போது சராசரியாக 10-12 கிலோ எடை கூட வேண்டும்.

50 – 60 % -  
 15- 20 % -  
 15- 20 % -  
 1000

:

8

:

➤

➤

➤

➤

:

➤

8, 9, 10

➤

➤ 8, 9, 10

கர்பகாலத்தில் எச்சரிக்கை அறிகுறிகள்:

- பாதத்தில் வீக்கம்
- வலிப்பு
- தலைவலி

- பார்வைமன்குதல்
- உதிரம் படிதல்
- தகாத அறிகுறிகள்

இவைகளில் ஏதேனும் ஒரு அறிகுறி இருக்குமானால், கர்பினிபென்கள் உடனடியாக மருத்துவரை அணுக வேண்டும்.

பிரசவநேர கவனிப்பு :

- பிரசவத்திற்கான சரியான அறிகுறிகள்
- முறையான கருப்பை சுருக்கம்
- கருபைவாய் விரிவடைதல் .
- இரத்தம் கலந்த வெள்ளைபடுதல்.
- பனிக்குடம் உடைதல்.

- பிரசவத்தின் போது கணவர் உடனிருப்பது அவசியம். அவ்வாறு இருப்பதின் மூலம் தங்கள் மனைவியின் தேவை இல்லாத பயத்தை நீக்கி அவர்களுக்கு ஆறுதலாக இருக்கும்.
- கணவர், பிரசவத்தின் போது உடனிருக்கும் வேளையில் மனைவியின் வயிறு மற்றும் முதுகு பகுதியை தடவிக்கொடுப்பது அவசியம்.

பிரசவத்திற்கு பின் கண்காணிப்பு வருகை:

- முதல் வருகை - 7 - 10 வது நாட்களுக்குள்
- இரண்டாம் வருகை -6 வாரங்களுக்கு பின்

உணவு முறை :

- குழந்தை பிறந்தவுடன் உடனடியாக தாய்க்கு நீர் மற்றும் திட உணவு வகைகளை கொடுப்பது அவசியம்.
- பிரசவத்திற்கு பின் தாய்மார்கள் சராசரியாக உட்கொள்ளும் உணவை விட , 500 கிலோ கலோரிகள் தினமும் கூடுதலாக சேர்த்துகொள்ளவேண்டும்.
- அதிக கலோரி, கொழுப்பு மற்றும் புரத சத்து நிறைந்த உணவை உட்கொண்டால் தாய்க்கு பால் சுரப்பது அதிகரிக்கும்.
- தங்களது உணவில் முக்கியமான கீரை வகைகளை சேர்த்துகொள்வதின் மூலம் மலச்சிக்கலை போக்கும்.

உடலுறவு பற்றிய விளக்கம் :

- பிரசவத்திற்கு பின் முதல் ஆறு வாரங்கள் உடலுறவை தவிர்க்க வேண்டும்.

கருத்தடை முறைகள் :

- முதல் குழந்தைக்கு பின் குறைந்தது மூன்று வருட இடைவெளிக்கு பிறகு கருத்தரிப்பது அவசியம். அவ்வாறு செய்வதால் தாயின் உடல்நலமும் பிறகும் குழந்தையின் அறிவுத்திறனும் சரியாக இருக்கும்
- அந்த மூன்று வருட இடைவெளியின் போது ஆண் / பெண் இருவரும் தற்காலிக கருத்தடை முறையை கைகொள்வது அவசியம்.
- இதில் ஆண்களுக்கான சிறந்த தற்காலிக கருத்தடை முறை - ஆணுறை அணிவதாகும்.
- பெண்களுக்கான சிறந்த தற்காலிக கருத்தடை முறை - காப்பர் டி உபயோகிப்பதாகும்.

குழந்தை பராமரிப்பு :

- குழந்தை பிறந்தவுடனே உடனடியாக குழந்தைக்கு தாய்ப்பால் தருவது அவசியம்.
- குறைந்தது ஆறு மாதகாலம் வரை குழந்தைக்கு தாய்ப்பால் மட்டுமே உணவாக கொடுக்க வேண்டும்.
- குழந்தை பிறந்தவுடனே பி. சி. ஜி, போலியோ மற்றும் மஞ்சள்க்காமலை தடுப்பூசி போட வேண்டும்.
- எப்பொழுதும் குழந்தையை ஒரு துணியால் போர்த்தி வைப்பதின் மூலம் அதின் தட்டவேப்பநிலையை சிராக வைக்கும்.

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