

**DISSERTATION ON**  
**“A STUDY TO ASSESS THE EFFECTIVENESS OF VIDEO  
TEACHING MODULES REGARDING KNOWLEDGE AND  
ATTITUDE OF PARENTS (CARE GIVERS) OF CLHIV (CHILD  
LIVING WITH HUMAN IMMUNO DEFICIENCY VIRUS) TOWARDS  
THE QUALITY OF LIFE IN ANTI- RETRO VIRAL TREATMENT  
CENTER, INSTITUTE OF CHILD HEALTH AND HOSPITAL FOR  
CHILDREN, EGMORE, CHENNAI-08”.**

**M. Sc (NURSING) DEGREE EXAMINATION  
BRANCH –II CHILD HEALTH NURSING**

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**MASTER OF SCIENCE IN NURSING**

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# **C E R T I F I C A T E**

This is to certify that this dissertation “is a bonafide work done by **MR. R. JAYAKUMAR** , College of Nursing, Madras Medical College, Chennai – 600003 Submitted to **THE TAMILNADU DR.M.G.R. MEDICAL UNIVERSITY, CHENNAI-032**. in Partial fulfilment of the requirements for the award of **Degree of Master of Science in Nursing, Branch - II**, “**A Study To Assess The Effectiveness Of Video Teaching Modules Regarding Knowledge And Attitude Of parents (care givers) Of CLHIV(Child Living With Human Immuno Deficiency Virus)Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children, Egmore, Chennai-08**”. Child Health Nursing, under our guidance and supervision during the academic period from 2012 – 2014.

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**- Swami Vivekananda**

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I.	Research Consent Form.
G.	Research Information Form.
H.	Certificate of English Editing.

## LIST OF ABBREVIATIONS

SLNO	ABBREVIATIONS	EXPANSION
1.	HIV.	Human Immuno Virus.
2.	AIDS.	Acquired Immuno Deficiency syndrome.
3.	CLHIV.	Child Living With Human Immuno Virus.
4.	QOL.	Quality Of Life.
5.	HRQOL.	Health Related Quality Of Life.
6	SD.	Standard Deviation.
7	ANOVA.	Analysis Of Variance.
8	Fig	Figure.
9	H1 & H2.	Research Hypothesis.
10	M. Sc (N).	Master of Science in Nursing.
11	$\chi^2$ .	Chi-square test.
12	ART.	Anti-Retroviral Treatment.
13.	CI.	Confidence Interval.

## ABSTRACT

With an alarming increase of Human Immunodeficiency Virus (HIV) /Acquired Immunodeficiency Syndrome (AIDS) Global Problem in developing countries. “A Study To Assess The Effectiveness Of Video Teaching Modules Regarding Knowledge And Attitude Of parents (care givers) Of CLHIV (children Living with Human Immunodeficiency Virus) Positive Children Towards The Quality Of Life” **DESIGN:** Study was pre-experimental one group pre-test and post-test design. **SETTING.** Study conducted in the ART centre ICH&H Egmore, Chennai-08. Considering General health perception aspects ,in pretest, caregivers are having 28.28 score where as in posttest they are having 40.75 score , so the difference is 12.47. This difference between pre-test and post-test is large and it is statistically significant. Considering Physical resilience aspects, in pre-test , caregivers are having 28.50 score where as in posttest they are having 39.88 score , so the difference is 11.38. This difference between pre-test and post-test is large and it is statistically significant. Considering Psychological well being aspects ,in pretest, caregivers are having 28.15 score where as in posttest they are having 39.38 score , so the difference is 11.23. This difference between pre-test and post-test is large and it is statistically significant. Considering Social and Role playing aspects ,in pre-test , caregivers are having 24.47 score where as in posttest they are having 42.35 score , so the difference is 13.83. This difference between pre-test and post-test is large and it is statistically significant. Considering Educational aspects ,in pre-test , caregivers are having 24.47 score where as in post-test they are having 42.35 score , so the difference is 17.88. The overall pre-test score was 54.4% and overall post-test score was 81.1%. This difference between pretest and post-test is 26.7%. large and it is statistically significant. Statistical significance was calculated by using student’s paired ‘t’ test. After pilot study reliability of the tool was assessed by using **Split-half** method. knowledge and attitude score reliability correlation coefficient value is 0.85.

This correlation coefficient is very high and it is a good tool for assessing the effectiveness of Video Teaching Modules. This study concludes that video teaching modules are effective in improving the Quality Of Life of Children Living With Human Immunodeficiency Virus positive children.

## **CHAPTER-I**

### **INTRODUCTION**

**“I have seen what a laugh can do. It can transform almost unbearable Tears into something bearable, even hopeful. ”**

**- Bob Hope (1903-2003) Comedian, Actor**

**“Even small children are known by their actions, so is their conduct really pure and upright? ..... Bible**

With an alarming increase of human immunodeficiency virus (HIV) /Acquired Immunodeficiency syndrome (AIDS) in developing countries (estimated prevalence in India=0. 91%) and inability to afford highly active anti-retroviral therapy, key issues like the quality of life (QOL) has come to the force. Determining the impact on the quality of life in HIV/AIDS patients is important for estimating the manifestation of the disease. This is true because aids have a chronic debilitating course and the long-term adverse side effects of current treatment modalities are uncertain. The social stigma attached the proclamation of HIV zero positivity may at times force the individual to change the job the place of living, putting further strain on the already weak economic situation. This further leads to progressive deterioration of health, low morale, repeated consultation, abstinence from work and low productivity. Quality of life (QOL) is a multi-dimensional concept whose definition and assessment domains controversial. Quality of life is conceptualized in terms of "an absence of pain or an ability to function in day to day life. Several researchers report quality of life (QOL) as a "fighting spirit “associated with longer survival time for individuals. "Quality of life relates both to adequacy of material circumstances and to personal feelings about these circumstances. It includes "overall subjective feelings of well being that are closely related to morale, happiness and satisfaction. Further as health is generally cited as one of

the most important determinants of overall quality of life, it has been suggested that quality of life may be uniquely affected by a specific disease process such as AIDS. There is lack of clarity in defining quality of life and concomitant operational difficulties in it. But there is urgency in evaluating the quality of life in HIV positive individual. Since 1989, more than six (6) Health related quality of life (HRQOL) instruments have been used in research with HIV infected individuals. These researches have documented relationships of HRQOL and HIV status, level of symptoms, use of antiretroviral drugs and use of drugs for prophylaxis of opportunistic infections separately. This study investigates the quality of life of patients with HIV/AIDS in a hospital based set-up in the Institute of Child Health And Hospital for Children, Egmore, Chennai-08

In a descriptive study, consecutive HIV/AIDS parents (care givers) of children attending anti- retro viral treatment centre, institute of child health and hospital for children Egmore. Chennai-08 were enrolled. Parents (care givers) visit this hospital from across the country, mainly from the state of Tamilnadu. The respondents were evaluated according to a pre-designed protocol. The parents were administered a structured questionnaire by the HIV nurse co-coordinator. The patients filled an additional questionnaire providing data about requiring their socio-demographic profile.

The standard for high constructs validity is ( $\geq 0.7$ ). Only 2 were moderate (0.3-0.7), both for the younger age group: food security (0.4) and wellness (0.36). All other relationships were weak or negative. In most subcategories, a substantial proportion of surveyed children indicated distress that was not evident from CSI scores. In the abuse and exploitation sub domain, all children were rated as "good" or "fair" by the CSI, but among surveyed children aged 11-17, 20% or more reported being beaten, kicked, locked out of the house, threatened with

abandonment, cursed, and made to feel ashamed. Quality of life (QOL) was evaluated using the World Health Organization Quality of Life (WHOQOL) brief instrument the WHOQOL brief consists of 26 items. Each item uses a Lickers- five-point scale. These items are distributed in five domains. The five domains of QOL are, vise (a) physical resilience and b) General health condition (seven items assessing areas such as the presence of pain and discomfort; dependence on substances or treatments; energy and fatigue; mobility; sleep and rest; activities of daily living; perceived working capacity); (c) psychological well being (eight items assessing areas such as affect, both positive and negative self concept, higher cognitive functions; body image and spirituality), (d) Educational aspects (three items assessing areas such as social contacts, family support and ability to look after the family; sexual activity) and (e) social and role playing (eight items assessing areas such as freedom; quality of home environment; physical safety and security and financial status; involvement in recreational activity; health and social care: quality and accessibility). There are also two items that were examined separately: one which asked about the individual's overall perception of QOL and the other which asked about the individual's overall perception of his or her health.

Current rate of child living with HIV/AIDS (CLHIV) positive in the worldwide population is 3,4 million.

Current child living with HIV/AIDS (CLHIV) positive in India is nearly 323560 and

Current child living with HIV/AIDS (CLHIV) positive in Tamilnadu is 6510 given by NACU Phase to status (Male Children is 3386 and female children is 3124).

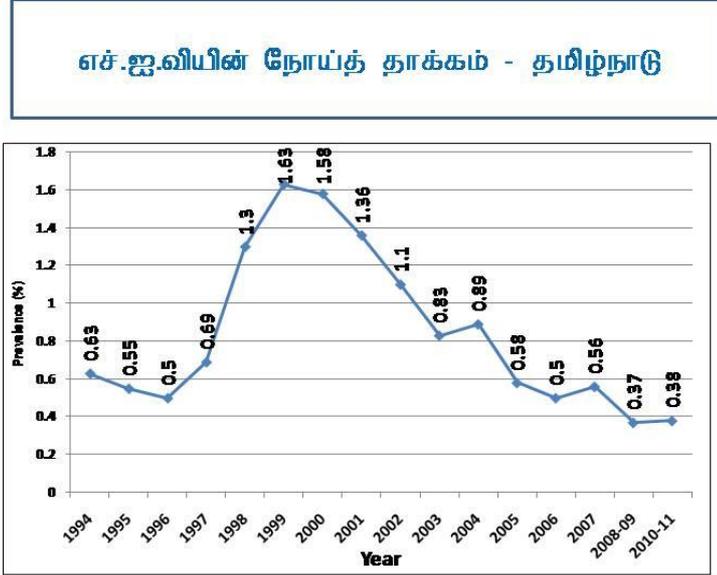
Current child living with HIV/AIDS (CLHIV) positive Children taking treatment in the ART center at the Institute of child health and hospital for children is 458 and new case registration for a month is 6.8 cases.

### **1.1 Need for the Study :**

An estimated 3.4 million children were living with HIV at the end of 2011, 91% of them in Sub-Saharan Africa. Most of these children acquire HIV from their HIV-infected mothers during pregnancy process and during birth or breastfeeding. With efficacious interventions the risk of mother-to-child HIV transmission can be reduced to 2%. However, such interventions are still not widely accessible or available in most resource-limited countries where the burden of HIV is highest. The number of children receiving ART increased from about 456 000 in 2010 to 562 000 in 2011, but this represents a coverage rate of only 28% among children in need of pediatric ART as per the HIV estimations 2010, India is estimated to have 23.9 lacks people infected with HIV in 2009 in an estimated adult HIV prevalence of 0.31%. Adult HIV prevalence among male is 0.36%, while among women, it is 0.25%. In India as per the statement of National Aids Control Society stated like 35% of female are suffering and 4.4% of children are suffering with HIV/AIDS. Receiving ART in Tamilnadu as per Jan. 2012 data 6510 children were taken treatment (Male Children is 3386 and Female Children is 3124). In our Institute Child Health and Hospital for Children 458 children were receiving ART. Daily children were attending the ART clinic is 15 receiving treatment and new cases registration were in 6-8 cases per month.

So I had interest in this study to assess the effectiveness of video teaching modules regarding knowledge and attitude of mothers of (CLHIV) children Living With Human Immunodeficiency virus positive Children's towards the Quality Of Life (QOL) attending the

Anti-Retro Viral treatment center, Institute of Child Health and Hospital for Children Egmore. Chennai-08



எச்.ஐ.வியின் தாக்கம் சிறப்பு கண்காணிப்பு ஆய்வின் மூலமே மதிப்பீடு செய்யப்பட்டு வருகிறது. எச்.ஐ.வி திட்டம் மூலமாக பெறப்படும் தகவல்களால் இது மதிப்பீடு செய்யப்படுவதில்லை

**FIG:1 PREVELANCE RATE OF HIV IN TAMILNAD**

### Tamil Nadu AIDS Control Society

### Status note on implementation of NACP in Tamil Nadu

2012-13

#### **Epidemiological Profile of HIV/AIDS in Tamil Nadu:**

Tamil Nadu state AIDS Control Society was set up to respond to HIV epidemic in Tamil Nadu in accordance with the guidelines of the National AIDS Control Organization. According to HIV Estimations 2012, estimated adult HIV prevalence in Tamil Nadu is 0.28%, and the estimated number of People Living with HIV/AIDS is 1,32,590 while the estimated number of deaths due to AIDS-related causes in the state is 8582.

## 1.2.STATEMENT OF THE PROBLEM

“A Study To Assess The Effectiveness Of Video Teaching Modules Regarding Knowledge And Attitude Of Parents (Care Givers) Of CLHIV (Child Living With Human Immunodeficiency Virus)Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children Egmore. Chennai-08”.

### 1.3. Objective

1. To assess (pre-test) the knowledge and attitude of **parents having (care givers) CLHIV** positive children regarding attainment of quality of life.
2. To educate the **parents having (care givers) CLHIV** positive children regarding quality of life by using video teaching module.
3. To Reassess (post-test) the knowledge and attitude of **parents having (care givers) CLHIV** positive children towards quality of life after the video teaching module.
4. To correlate the results with selected demographic variables.

### 1.4.ASSUMPTION

1. The video teaching module helps the mother to have increase in the knowledge and attitude towards rearing of CLHIV positive children.
2. Children will improve the quality of life which enhances their life span.

### 1.5 HYPOTHESES

**H1-** the video teaching modules will have effect on knowledge and attitude.

H2-there will be a substantial relationship between demographic variables and semi structured questionnaire regarding quality of life of the HIV infected children.

## **1.6.DELIMITATION:**

1. The study is delimited to only HIV positive babies
2. The study is conducted only in ICH Egmore, Chennai-8.
3. The field is delimited for a period of 4 weeks only.

## **1.7.OPERATIONAL DEFINITIONS**

### **EFFECTIVENESS**

“Effectiveness is defined as the capability of producing a desired result. When something is deemed effective, it means it has an intended or expected outcome, or produces a deep, vivid impression.”

### **VIDEO TEACHING MODULES**

“Video teaching modules for learners 5 to 20 minutes in length and guide by using specialized instruments of electrical and electronic items”.

### **KNOWLEDGE**

“Knowledge is shaped by one’s ontological and epistemological perspectives of understanding a phenomenon (Kincheloe, 2008). Understanding is grounded in an epistemological perspective of what knowledge is, "how we get it, how we roll in it”.

### **ATTITUDE**

Gall, Borg and Gall (1996) define attitude as “an individual’s viewpoint or disposition towards a particular object (a person, a thing, or an idea) (p. 273). They consider attitude to be an individual’s way of seeing and reacting to a social phenomenon, and assert that it varies from person to person cognize it, how it relates to the truth, how it is entangled with power”

## **HUMAN IMMUNODEFICIENCY VIRUS:**

Human immunodeficiency virus; a retrovirus that causes AIDS by infecting helper 't' cells of the immune system. The most common stereotype, HIV-1, is distributed worldwide, while HIV-2 is primarily confined to West Africa. Also called AIDS virus, human t-cell leukemia virus type III, human t-cell lymphotropic virus type III, the lymphadenopathy-associated virus.

## **INFECTION**

The invasion of the torso of a human or an animal by a pathogen such as a bacterium, fungus, or virus. Infections can be localized, as in pharyngitis, or widespread as in sepsis, and are often accompanied by fever and an increased number of leukocytes. People with immunodeficiency syndromes are predisposed to certain infections

## **QUALITY OF LIFE**

WHO defines quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concern? It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.

## **CHILDREN**

Biologically, a child (plural: children) is a human between the stages of birth and puberty. The legal definition of child generally refers to a minor, otherwise known as a person younger than the age of adulthood.

## CHAPTER-II

### REVIEW OF LITERATURE

*“Literature adds to reality, it does not simply describe it. It enriches the necessary competencies that daily life requires and provides; and in this respect, it irrigates the deserts that our lives have already become.”*

#### **C.S. LEWIS QUOTES (BRITISH SCHOLAR AND NOVELIST. 1898-1963).**

According to Nancy Burns (2005), a literature review is an organized written presentation of what has been published on a topic by scholars. The purpose of literature is to convey to the reader what is presently known as regards the issue of interest. The review is not describing or summarizing one published study after another, but rather that requires that the author critically analyses the available literature on the subject.

The review of literature entails a systemic identification, location, scrutiny and summary if a written material contains information relevant to the problem under study. An extensive review of literature relevant to the research topic was done to gain insight and to collect to maximum information for laying of the foundation of the discipline. The purpose of review of literature is to obtain comprehensive knowledge and in depth information about the “Study to Assess The Effectiveness Of Video Teaching modules regarding knowledge And Attitude Of parents (care givers) CLHIV (Children Living With Human Immuno Deficiency) Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children Egmore. Chennai-08”. A critical summary of research on a topic of interest, often prepares to put the research problem in context.

## **Part I: Literature for CLHIV positive children.**

The literature was divided into four parts.

SECTION -1 Literature related to CLHIV positive Children.

SECTION-II Literature related to ART treatment.

SECTION-III Literature related to the CLHIV positive Quality  
Of Life.

SECTION-IV Literature related to Video Teaching Modules.

## **PART-II: conceptual framework.**

### **PART-I:**

#### **Part –I: Literature related to CLHIV positive Children.**

**WILSON CM, Wright PF, (2010)** In Uganda and Kenya – the geographical areas of this study –46000 and 42000 new HIV infections were reported among adolescents in 2009 (aged 15–24) As do their uninfected counterparts, adolescents living with HIV/AIDS (ALH) struggle with the biologic, cognitive and social developmental challenges related to adolescent transition, but growing evidence suggests that ALH are also confronted with the challenges of living with a chronic disease which is potentially fatal and socially stigmatizing, e.g. Coping with HIV-stigma, and adopting preventive behaviours.

**WOLTERS KLUWER (2011).**No relationships exceeded the standard for high construct validity ( $\geq 0.7$ ). Only 2 were moderate (0.3-0.7), both for the younger age group: food security (0.4) and wellness (0.36). All other relationships were weak or negative. Domain, all children was rated as “good” or “fair” by the CSI, but among surveyed children aged 11-17, 20% or more reported being beaten, kicked, locked out of the house, threatened with abandonment, cursed, and made to feel ashamed.

**Susan S, MOHR J, (1999)** There was defining illnesses ( $p < 0.001$ ) and asymptomatic and early symptomatic (12) patients ( $p = 0.014$ ). QOL in the psychological domain was significantly poorer in early symptomatic (12.1) ( $p < 0.05$ ) and AIDS patients (12.4) ( $p < 0.006$ ) as compared to asymptomatic individuals (14.2). A significant difference in QOL scores in the psychological domain was observed with respect to the educational status ( $p < 0.037$ ) and income of patients ( $p < 0.048$ ). Significantly better QOL scores in the physical ( $p < 0.040$ ) and environmental domain ( $p < 0.017$ ) were present with respect to the occupation of the patients. Patients with family support had better QOL scores in the environmental domain. Conclusions: 0 In our study, QOL is associated with education, income, occupation, family support and clinical categories of the patients.

**SAFRIT JT, Rudy B (2008).** A significant difference of quality of life in psychological domain scores was observed between respondents educated till high school and those with more education than high school ( $p = 0.037$ ). However, in the social domain ( $p = 0.053$ ), environmental domain ( $p = 0.573$ ) and the physical domain ( $p = 0.358$ ), there was no significant difference in the quality of life between respondents from different levels of education. A significant difference was observed with respect to the occupation of the respondent in the physical domain ( $p = 0.04$ ) And environmental domain ( $p = 0.02$ ). The significant difference of quality of life in physical domain scores was observed between the categories of skilled worker and business persons ( $p = 0.02$ ). Additionally, in the environmental domain too, a significant difference of quality of life was observed between the categories of skilled worker and business persons ( $p = 0.03$ ).

**J. Marian den Boer van DerKolk (2004).** The median follow-up was 8.4 years. Sixty-six patients (11.8%) died during follow-up. We found a significant relation between quartiles of PHS and survival ( $P < .001$ , log-rank test). Of patients with a PHS, 26 (20%) died in quartile 1 (indicating worst HRQL), 17 (13%) died in quartile 2, 10 (8%) died in quartile 3, and 5 (4%)

died in quartile 4 (indicating best HRQL) ( $P < .001$ ). The prediction of PHS on survival was independent of other (clinical) parameters ( $P < .001$ ).

**Sabin, Lora (2011.)**The results: No relationships exceeded the standard for high construct validity ( $\geq 0.7$ ). Only 2 were moderate (0.3-0.7), both for the younger age group: food security (0.4) and wellness (0.36). All other relationships were weak or negative. In most subcategories, a substantial proportion of surveyed children indicated distress that was not evident from CSI scores. In the abuse and exploitation sub-domain, all children were rated as “good” or “fair” by the CSI, but among surveyed children aged 11-17, 20% or more reported being beaten, kicked, locked out of the house, threatened with abandonment, cursed, and made to feel ashamed.

**BENHAMSMITH (2005)** Heterosexual transmission was found to be the most common. The majority of the patients (53.6%) were in the Category B (CD4: 200-499 cells/ml) while the rest of the patients belong to the clinical category C (46.3%): AIDS indicator illness, according to the Centre for Disease Control (CDC) classification (1993 Revised classification system for HIV infection and expanded AIDS surveillance case definition for adolescents and adults). Tuberculosis (38.5%) were the most common HIV related illness, followed by oral candidiasis (28.2%) and then persistent diarrhoea (17.9%). The socio-demographic and medical illness related profile of the patients is outlined in.

**SMITHHAN (2005)** The mean scores in the four domains of QOL was the maximum for the social domain, followed by the psychological domain, physical domain and the environmental domain in descending order. QOL domain scores have been summarized in the internal consistency between the four domains of the instrument (WHOQOL-Bref) was found to be excellent (Chronbach's  $\alpha = 0.91$ ). The inter-domain correlation was found positively significant, between all pairs of the four

domains using two tailed test at  $p < 0.001$  (Pearson coefficient varied between + 0.52 to + 0.71 between the domain parse).

## **SECTION-II: LITERATURE RELATED TO QUALITY OF LIFE FOR CLHIV POSITIVE CHILDREN**

**Ross Thoeun (2006).** The results showed that the Thai version of the GHAC, a measure of QOL for use in HIV-infected Children, showed a fairly good internal reliability (mean 0.84) and discriminated between HIV infected Children with normal and suppressed levels Of CD4 cells. Physical functioning, Psychological well being, symptoms related to HIV Infection, and social and role functioning. Moreover, the study shows that the QOL in the main fields of Physical functioning, symptoms, and social and role Functions related to HIV infection significantly correlated With use of health care among all children. The mean score for general wellness among all children was reported to be 30 (out of 40). Up to 84.2% of those kids had some degree of symptoms related to HIV Infection. A total of 33.8% of caregivers reported that they self-administered medication to the child theme at least once in the past month. In comparison to the GHAC modules used once ACTG 219 study.

**Baltimore (2007).** The overall QOL mean score on a scale of 0-100 was found to be 25.8. Similarly, on the scale of 0-100 the mean scores in the four domains of QOL in descending order were social (80.9); psychological (27.5); physics (17.7) and environmental domain (11.65). There was a significant difference of quality of life in the physical domain between asymptomatic patients (14.6) and patients with AIDS (10.43) defining illnesses ( $p < 0.001$ ) and asymptomatic and early symptomatic (12) patients ( $p = 0.014$ ). QOL in the psychological domain was significantly poorer in early symptomatic (12.1) ( $p < 0.05$ ) and AIDS patients (12.4) ( $p < 0.006$ ) as compared to asymptomatic individuals (14.2). A significant difference in QOL scores in the psychological

domain was observed with regard to the educational status ( $p < 0.037$ ) and income of patients ( $p < 0.048$ ). Significantly better QOL scores in the physical ( $p < 0.040$ ) and environmental domain ( $p < 0.017$ ) were present with respect to the occupation of the patients. Patients with family support had better QOL scores in the environmental field. Conclusions: In our study, QOL is associated with education, income, occupation, family support and clinical categories of the patients.

**Lekshmi R. (2012)** The impact of HIV/AIDS on the quality of life: A cross sectional study in north India. No relationships exceeded the standard for high construct validity ( $\geq 0.7$ ). Only 2 were moderate (0.3-0.7), both for the younger age group: food security (0.4) and wellness (0.36). All other relationships were weak or negative. In most subcategories, a substantial proportion of surveyed children indicated distress that was not evident from CSI scores. In the abuse and exploitation sub-domain, all children were rated as “good” or “fair” by the CSI, but among surveyed children aged 11-17, 20% or more reported being beaten, kicked, locked out of the house, threatened with abandonment, cursed, and made to feel ashamed.

**Muscular C. Et al (2012)** The CFA results showed that without adjustments, the KIDSCREEN cannot be utilized for measuring the HRQOL of HIV-positive adolescents. After comparison, the most suitable version for low-resource settings - the 27-item version - was adapted further. The introduction of a negative wording factor was required for the Dholuo model. The Dholuo (CFI: 0.93; RMSEA: 0.039) and the Luganda model (CFI: 0.90; RMSEA: 0.052) showed a good fit. All Cronbach's alphas of the factors were 0.70 or above. The alpha value of the Dholuo and Lugandan HRQOL second-order factor was respectively 0.84 and 0.87. The study showed that the adapted KIDSCREEN-27 is an adequate tool for measuring HRQOL in low-resource settings with high HIV prevalence.

**Lora Margherita Johnson (2010).** Descriptive, comparative. *Methods.* A symptom diary was produced utilizing a previously validated fatigue assessment scale, modified for use with children. Content validity of the diary was established by a panel of 5 experts in child development Paediatric and adolescent HIV disease. Children were required to fill in the diary each morning and evening for 3 days. Each child wore a wrist actigraph during the same period. Results. The HIV-infected children had significantly more wake time after sleep onset, compared with non-infected children (13.55% vs 7.47%). The HIV-infected children had more awakenings (25.33 vs 16.71) and were awake for longer periods (3.01 vs 1.01 minutes), compared with non-infected children

**Michael D. Hughes (2010)** Cool domain scores were assessed for subjects 6 months to 4 years, 5 to 11 years, and 12 to 21 years of age, and the impact of infection status and alternative treatment regimens on QOL domains was evaluated. HIV infection was associated with significantly worse mean adjusted scores for functional status among children 6 months to 4 years of age and health perceptions, physical resilience, physical performance, and social/role functioning among those 5 to 11 years of age. However, uninfected children 5 to 11 years of (5–11 years of age) and adolescents (12–21 years of age) receiving no antiretroviral treatment had worse health perceptions.

**Kaplan-Meier (2008)**The median follow-up was 8.4 years. Sixty-six patients (11.8%) died during follow-up. We found a significant relation between quartiles of PHS and survival ( $P < .001$ , log-rank test). Of patients with a PHS, 26 (20%) died in quartile 1 (indicating worst HRQL), 17 (13%) died in quartile 2, 10 (8%) died in quartile 3, and 5 (4%) died in quartile 4 (indicating best HRQL) ( $P < .001$ ). The prediction of PHS on survival was independent of other (clinical) parameters ( $P < .001$ ). No relation was found between MHS and survival ( $P = .13$ ).

### SECTION-III

#### LITERATURE RELATED TO ART TREATMENT.

**Edward L. Machtinger, (2004).** Studies report conflicting evidence about the association between social, demographic factors and adherence behaviour. However, when a connection is found, the direction is consistent: younger age, non-white race/ethnicity, lower income, lower literacy, and unstable housing are associated with non adherence in resource-rich settings. Gender, educational level, insurance status, and HIV risk factors generally are not associated with adherence behaviour more consistent associations are found between certain psychosocial factors and adherence behaviour. Common predictors of non adherence include depression/psychiatric morbidity, active drug or alcohol use, stressful life events, lack of social support, and the inability to correctly identify the drug regimen or describe the relationship between adherence and drug resistance

**Fassinou, (2010).** The results highlight the need for interventions to address these barriers, through focused awareness campaigns and interventions to improve livelihoods and access to ART and related the majority of children aged less than 15 years, living with HIV, are from sub-Saharan Africa (Joint United Nations Program on HIV/AIDS (UNAIDS), 2010). Although the prevention of mother-to-child-transmission is the most efficient and cost-effective way of preventing paediatric HIV, it is also critical that HIV is diagnosed and treated early in children because it progresses rapidly (European Collaborative Study, 1994). ART improves immunological outcomes, morbidity and survival and should be started early.

**Susanna. (2005).** Children determined, positive and those with determinate results were referred to community health facilities for further investigations and support. In total, 841 (96%) of notes

consented to testing, and all but two received the test results: 35 (4.2%) children tested HIV positive and one had indeterminate results. A year later, we followed-up the caregivers of those children identified as HIV positive. In this article, we describe the barriers to ART and related care for these children, from the perspective of the caregivers and other **Dorrington, et al. (2006)**. There were to be universal access to effective treatment, there would be a widespread improvement in the productivity of adults affected by HIV, and of their households; the number of children orphaned because of HIV would be limited; the need for costly hospital treatment would be reduced and the economies and overall human development of badly affected countries would improve. Christian Aid has evidence from various countries that, while the rapid scale-up of access to ART currently underway is a positive thing, starting patients on ART then they don't have adequate nutrition is likely to lead to treatment failure. This report examines the need to ensure that people on ART are able to take their medicines with food.

**Dholuo (2006)** The CFA results showed that without adjustments, the KIDSCREEN cannot be used for measuring the HRQOL of HIV-positive adolescents. After comparison, the most suitable version for low-resource settings - the 27-item version - was adapted further. The introduction of a negative wording factor was required for the Dholuo model. The Dholuo (CFI: 0.93; RMSEA: 0.039) and the Luganda model (CFI: 0.90; RMSEA: 0.052) showed a good fit. All cronbach's alphas of the factors were 0.70 or above. The alpha value of the Dholuo and Lugandan HRQOL second-order factor was respectively 0.84 and 0.87.

**Kisumu. (2011)** The adapted questionnaire was administered between February and April 2011 to 582 HIV-positive adolescents (aged 13–17) in Kenya (Kisumu, Gem and Asembo: n = 283) and Uganda (Kampala: n = 299). In the Kenyan sample, boys (n = 141) and girls (n = 142) were equally distributed, whereas the Ugandan sample consisted of

more female (n = 177) than male (n = 122) adolescents. The mean age of participants in our study was 14.7 years. Results revealed that the average HRQOL of HIV-positive adolescents was above the neutral point of the scale, indicating good HRQOL. Boys scored slightly higher than girls in each domain. However, significant gender differences were only found in relation to physical well-being, peers and the overall *HRQOL* score.

**SECTION IV:**  
**LITERATURE RELATED TO VIDEO TEACHING**  
**MODULE.**

**Wright and Belt (2001).** revealed that the senior citizens were faster in completing a procedural task and used the “help” feature less often when the instructions consisted of both animation and language, as compared to having only one or the other. However, the authors mentioned, “Procedural tasks, making fewer demands on visual-spatial ability might not show the advantage of combining animation and language” (Wright & Belt, 2001, p. 61). In other words, successive visual instructions supported by spoken or written instruction has proven to be beneficial to older adults while performing tasks that rely heavily on sight and space, but not necessarily for tasks that rely less on these elements.

**Lin and Hsieh (2006).** multimedia has become a mainstream information platform adopted in most computer-aided training systems” In today’s age, instruction that is transferred through computers is often presented using this means of information transfer. The technology allows for differentiation as information can be transferred visually, audibly, and even kinaesthetically to meet the needs of unique learners and specific desired outcomes.

**Aragon and Zibrowski (2008)** found that instructional videos were beneficial in allowing students to view fine details of procedures. Many times in live-instructor demonstrations, students need to be divided into groups to view the instruction from a decent distance. However, it is still difficult for students to view the intricate details of the steps in this way. Students often have to take turns viewing close ups of the procedures during live demonstrations, and thus, it is not possible for each of them to view

the entire procedure adequately. With instructional videos, all learners can view the demonstration from an up-close perspective. This is also ideal for students with visual disabilities as images and text can be enlarged on a computer screen.

**Bradley & Boyle (2004).** “Videos also allow for fluid movements of the progressive steps to be demonstrated. On paper-based handouts, step-by-step instructions are usually typed out with screen captures of the significant steps to provide supplementary assistance. Although the textual instructions may explain exactly to how to get from one step to the next, those who are visual learners are at a disadvantage because they will not be able to see the fluid equations between each step. Dynamic graphics through instructional videos enable recordings of actual demonstrations to be presented, therefore; students can see the exact actions that were taken to perform a task. The animations provide opportunities for students to take greater control of their learning. They can be played step-by-step and they can be replayed until they are fully understood. Interactive models are used to help make abstract concepts more tangible.

**Beudin. (1996),** “The video should stimulate, motivate and inform the learner to act on the information” The design of the instruction is a very critical aspect of the effectiveness of the videos. First of all, the content must be accurate, unbiased, and useful for the intended audience. The main part of the strategy should present the instruction logically. As with any other instructional method, when using videos, breaking up general instructional objectives (GIOs) into smaller video learning objectives (VLOs) can aid in the learning process.

**Lam (2005)** “These smaller VLOs will enable students to perform a task or certain sets of tasks leading to the GIOs” (p. 2). Tackling small learning tasks that build up to the main objective, allows students to ingest manageable chunks of information at a time. The conclusion of the instruction should provide learners with review or practice to encourage retention and application of the material. The evaluation step covers how the product or instructional method will be assessed.

**Zhang et al (2006)**, defined as “the use of computer systems to allow proactive and random access to video content based on queries or search targets” (p. 17). This includes providing control buttons for the learners to manage the pace of the instruction. Surprise and Mitchell (1994) suggested that “Interactive video instruction is particularly effective for training motor skills, procedures or processes” (p. 531) due to videos’ capability of providing learners with simulations and tactile experiences, which offer hands-on learning opportunities. These types of experiences to be active learners who “do” rather than passive learners who simply “watch.”

**Zhang et al. (2006)**, results indicated that there were no significant learning differences between students who learned a concept through videos with no interaction, and students who did not learn through any type of video. Meanwhile, those who learned through interactive videos showed the most improvement in their learning. These results proved that instructional videos are most effective when they allow opportunities for interaction.

**Segrist (2004)**. The question to be examined in this study is, “Is an instructional video module an effective means through which to transfer step-by-step instructions for completing a computer task to senior citizen computer users while accommodating their needs?” Previous research has been conducted to determine the effectiveness of instructional videos

on learning in general, but there is limited literature about the effects of using videos that incorporate specific instructional strategies for teaching senior citizens computer tasks. Individuals who are 55-years of age and older will be constituted as “senior citizens” or “older adults” for the purpose of this research study

## **PART-II:**

### **2.2 .CONCEPTUAL FRAMEWORK.**

#### **GENERAL SYSTEM THEORY.**

General system theory serves as model for viewing people as interacting with the environment. Their hypothesis was developed by Ludwig Von Bertalanffy (1968). The framework for this study will be based upon General System's Theory. System theory is concerned with change due to interaction with all the factors (variable) in a situation. A system is defined as a whole with interrelated parts in which the components have a function and the organization as a totality to function. Change in any parts affects the whole system.

In General System's Theory, the main concepts are input, throughput, and yield. Input and output are the process by which an organization is able to communicate and react with its environment. Input can be defined as any form, of information or material that is transferred to the process.

- Input
- Throughput
- Output

#### **INPUT**

In this study, the Input process includes the demographic variables like Age, Sex, Education, Occupation, Religion, Family type, Income, Type of care givers, Living standards of caregivers of children with HIV positive and also the input process included HIV positive children demographic variables like Age, Sex, Religion, Educational Standard, Place of birth and Order of Birth etc. In the input process pre- assess the assessment of knowledge and attitude of CLHIV positive children's

caregivers through the following Domains such General health, physical resilience, psychological domains, social wellbeing, and health education etc. This domain is evaluated by using modified structured questionnaire through Likert's scale.

### **THROUGH PUT**

It denotes that the different operating procedures are utilized in the study. In this study, video teaching module is an intervention along with routine comprehensive nursing care like polite talk, comfortable environment, explanation of the causes, prevention, safe life period, care and psychological support.

### **OUTPUT**

Output is any information that leaves the system and enters the environment through the organization boundaries. Output is the result of promoting the knowledge and attitude of caregivers of **CLHIV** positive children. In **Ludwig Von Bertalanffy's System** is categorized as a general system theory. Adaptive responses are used when a person demonstrates behaviours that achieve the goals. These responses or output provides feedback for the system. In this output process will be provide positive knowledge and attitude of caregivers of **CLHIV** positive children in the effectiveness of video teaching module following five domains evaluated by the standardized five points **Likert's Scale** of strongly disagree, disagree, uncertain, agree, strongly agree, with the numerical order of 1,2,3,4,5 respectively.

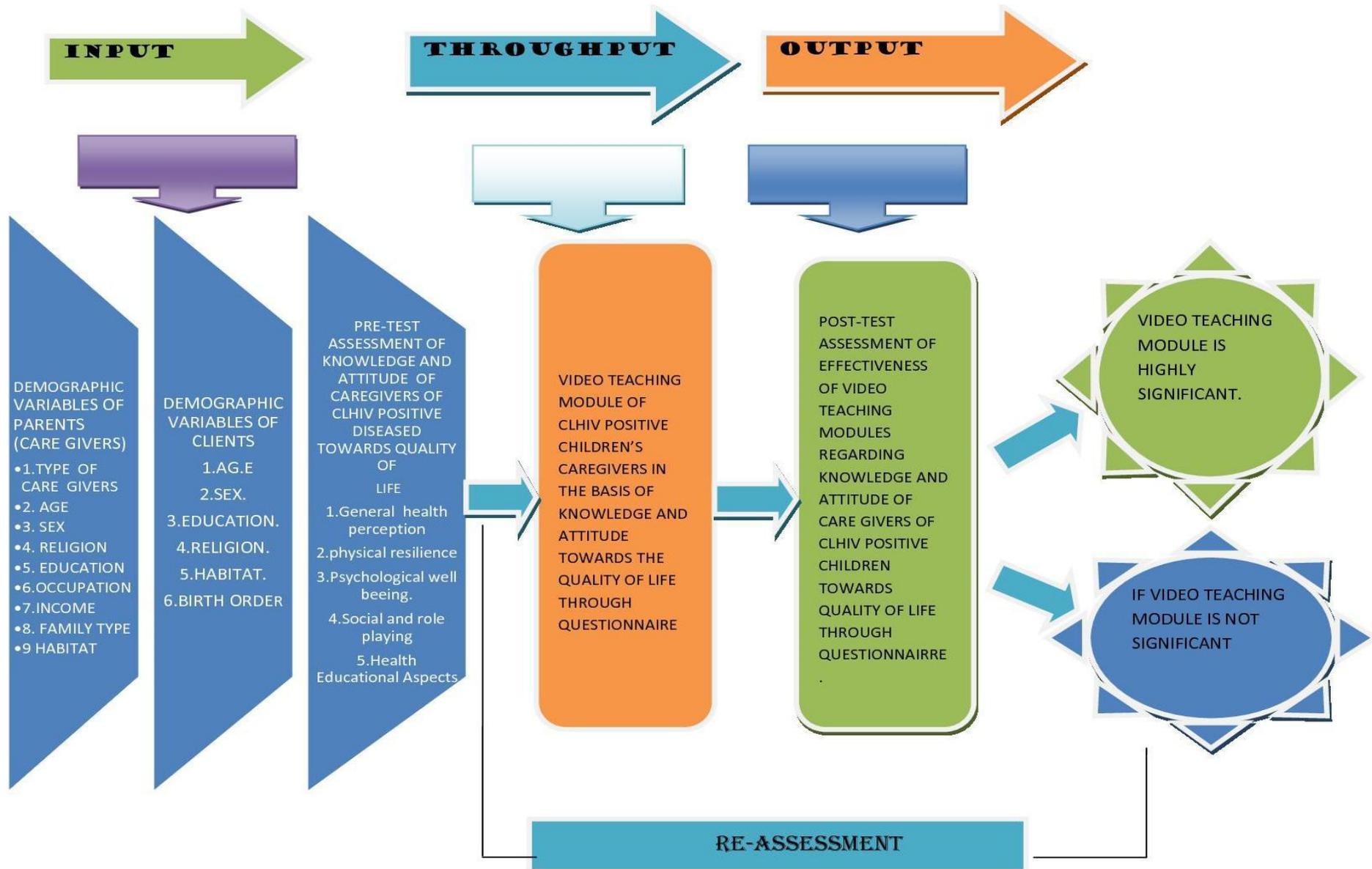


FIG:1. CONCEPTUAL FRAMEWORK (ADOPTED AND MODIFIED FROM LUDWIG VON BERTALANFFY'S GENERAL SYSTEM THEORY(1968).

## **CHAPTER-III**

### **RESEARCH METHODOLOGY**

#### **(MATERIALS & METHODS)**

#### **INTRODUCTION**

This chapter deals with the methodology “**Study To Assess The Effectiveness Of Video Teaching modules regarding knowledge And Attitude Of parents (care givers)of(CLHIV) Children Living with Human Immunodeficiency Virus Positive Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children., Egmore, Chennai-08**”.

Research methodology includes the research design, variables of the study, the setting, population, sample, criteria for sample selection, sampling technique, sample size, development and description of the tool, scoring procedure, content validity, pilot study, reliability and procedure for the data collection and plan for statistical analysis.

The research methodology is aimed to assess the effectiveness of the video teaching module program on regarding knowledge And Attitude Of parents (care givers) Of Human Immunodeficiency Virus Positive Children Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children Egmore. Chennai- 08”.

#### **3.1. RESEARCH APPROACHES:- Descriptive study.**

Research approach guides the researcher in the nature of data to be collected and the methods of analysis. To achieve the objectives of the current study quantitative research approach had been taken by the investigator.

### **3.2. RESEARCH DESIGN:-**

The research design used in this study was pre-experimental one group pretest post test design. The design the most suitable design for the present study because it helps the researcher to assess the effectiveness of video assisted program on improving the knowledge and attitude of CLHIV positive children.

One group pre test and post test design is adopted for the present study.

### **3.3. RESEARCH VARIABLES:-**

Research variable is a characteristic or attributed of a person or an object that varies within the population under the study. The variables of the study include

**Independent Variable:-** The Video teaching modules variable that is believed promotion of knowledge and attitude of CLHIV positive children.

**Dependent Variables:-** This variable hypothesized to depend on the questionnaire is of CLHIV positive children.

**Demographic variables:-** Demographic variables are Type of caregivers, Age, Sex, Religion, Educational standards, Job, Monthly income, Family type and Habitat and CLHIV positive Children Demographic variables such as Sex, Age, Religion, Educational standards, Habitat and their order of birth.

**3.4. SETTING OF THE STUDY:** The study is conducted in the ART centre at ICH&HC, Egmore, Chennai- 08. The ART Centre has been offering meritorious service to the children those who are **CLHIV** positive children for the past years. ART Center at institute of child health and hospital for children, Egmore, Chennai- 08. Is one of the human nature and the kind, attentive place which comes under the ICH&CH Egmore Chennai-08. Here individual medical advice and

consultation, pre and post counseling of ART, play therapy for affected children, data entry, monitoring of vitals, nutritive counseling for both youngsters and their parents, distribution of drugs including choice of opportunistic infection, routine and laboratory investigation and records and reporting are conducted.

### **3.5. POPULATION:-**

The populations included in the study are children in the age group 6-12 years ART –centre at Institute Of Child Health And Hospital For Children, Egmore, and Chennai.08.

### **3.6. SAMPLE:-**

Out of a sample of 60, 6-12 years care givers of **CLHIV** positive children who met the inclusion criteria were selected from ART –centre at Institute Of Child Health And Hospital For Children, Egmore, Chennai. 08.

### **3.7. SAMPLE SIZE:-**

A total of 60 care givers of **CLHIV** positive children were the chosen sample for this study. The sample size of this study comprises 60 of care givers of **CLHIV** positive children in the user group of 6-12 years.

### **3.8. SAMPLING TECHNIQUE:-**

The convenient sampling technique is used to select the sample. The investigator collected the care givers of **CLHIV** positive children attended the ART –centre at Institute Of Child Health And Hospital For Children, Egmore, Chennai.08, who fulfilled the inclusion criteria and who attended the presentation of the investigator. The care givers of **CLHIV** positive children were approached and explained regarding the work and its intentions. Those consented to take part in the survey were selected.

### **3.9. CRITERIA FOR SELECTION SAMPLE**

#### **Inclusion Criteria:**

**The study includes both boys and girls of caregivers.**

- Children who need treatment in the ART centre.
- Those mothers who are willing to participate in the survey.
- Children of age group of 6 to 12 years.
- Know to speak Tamil and English languages.

#### **Exclusion Criteria:**

- Children who are not taking treatment in the ART centre
- Those mothers who are not willing to take part in the survey
- Children above the age bracket of 6 to 12 years
- Did not known to speak Tamil and English languages.

### **3.10. INSTRUMENTS:**

The tool is developed by the investigator after receiving the related literature and observing from experts in the field. A modified LIKERT'S scale and semi structured questionnaire is the instrument, which consist of the following sections.

### **3.11. PLAN FOR DATA ANALYSIS:**

The data collected will be organized, tabulated and analysed by using descriptive and inferential statistics.

- ❖ Independent “t” test.
- ❖ Paired “t” test was used for statistical analysis.
- ❖ Values were compared using the “Chi square” tes.t

### **3.12. DESCRIPTION OF THE TOOL:-**

It has two sections A and B.

**Section A** – demographic variable (age, sex, and place of birth, order of family, type of family, religion, age of the caregivers, occupation of the caregivers and demographic variables of patients).

**Section B** – LIKERT's scale regarding the knowledge, attitude of caregivers of CLHIV positive children towards the quality of life.

### **3.13. VALIDITY AND RELIABILITY:-**

The content of the instrument is reviewed by the expert in the field of medicine (1). Nursing department (2). Statistics and (3) medical department. The pilot study was conducted to determine the validity and feasibility of the puppet. The robustness of the tool were assessed using content validity. The content validity was determined by an expert from the Nursing and Medical. They suggested certain modification in too. After the modification they agreed the tool for assessing the effectiveness of video assisted programs on Study To Assess The Effectiveness Of Video Teaching modules regarding knowledge And Attitude Of parents (Care Givers) of (CLHIV) Children Living With Human Immunodeficiency Virus Positive Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children Egmore. Chennai-08”.

After pilot study reliability of the tool was assessed by using split-half method. Knowledge and attitude score reliability correlation coefficient value is 0.85. This correlation coefficient is very high and it is a good tool to assessing the effectiveness of Video Teaching Modules Regarding Knowledge And Attitude Of parents (care givers) Of Human Immunodeficiency Virus Positive Children Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children.

### **3.14. PILOT STUDY**

In order to the practicably for the field, the pilot study was conducted at Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children Egmore. Chennai-08”,from 11.09.13 to 15.09.13. Permission obtained from the Nodal Officer of PCOE-ART Centre. Initially this pilot study was the total number of 10 care givers of **CLHIV** positive children for assessment of the effectiveness of video teaching module for **CLHIV** children pre and post test, that fulfilled the inclusion criteria were included in this study. One group Pretest and post test was conducted for the experimental group. Video teaching module conducted on QOL of **CLHIV** children for pre and post assessment. The resulting protocols were analysed and compared. Reliability was tested by using a score in of Likert’s Scale pre and post test. It shows adequate correlation between pre and post test. The finding was accepted by the expert that no change was made. The instrument was found to be feasible for the main subject.

### **3.15. DEVELOPMENT OF VIDEO TEACHING MODULE:-**

A structured video assisted module was developed to assess the knowledge and attitude of **CLHIV** children during the animation process. A video assisted module was developed based on the review of related literature and the notion of any department expert. The main factors that were kept in mind in making the video assisted module were simplicity of knowledge and attitude areas covered in developing awareness of **CLHIV** children. Video teaching module was organized in sequence and in continuity. This video teaching module was developed to enhance the QOL of **CLHIV** positive care givers knowledge and attitude assessment helped to increase status among 6-12 year of **CLHIV** children those who are attending the ART Clinic in ICH&H.

**The Video Teaching Module consists of five Domains.**

Domain I - General health perception-10 questions.

Domain II - Physical resilience-10 questions.

Domain III - Psychological well being. -10 queries.

Domain IV - Social and Role playing-10 questions

Domain V - Educational aspects-10 questions.

### **3.16. DATA COLLECTION PROCEDURE:-**

Formal permission was obtained from the administrative office of the infirmary. Data collection procedure was done for a period of four weeks in the month of September 11 to October 11 in the year of 2013.

Initial work on pre-experimental group was undertaken at the ART centre in an institute of child health and hospital for children, Egmore, Chennai-8. For availability of 1 to 3 samples were selected per day. A small interval of after 7 days interval shown of video teaching module I conducted post test of same care givers of CLHIV children. The confidentiality of the respondents was assured and with their willingness data was collected from the samples by the use of modified structured questionnaires, tools that last for 20 minutes for each care givers. The pre-test assessed the knowledge and attitude level assessed. Video assisted programmed was shown and investigator clarified the doubts whenever necessary to the quasi-experimental group.

The post test was conducted after 7 days interval and reassessed the knowledge and attitude level of the same group.

### **3.17. PLAN FOR DATA ANALYSIS.**

#### **1. DESCRIPTIVE STATISTICS.**

A). Frequency and percentage distribution were to describe the demographic variables.

B). Mean and standard deviation were used to determine the degree of effectiveness of video teaching module regarding assessment of knowledge and attitude of care givers of the CLHIV children status of pre and post test.

#### **2. INFERENTIAL STATISTICS.**

A). Paired 't' test was used to examine the difference between pre and post test.

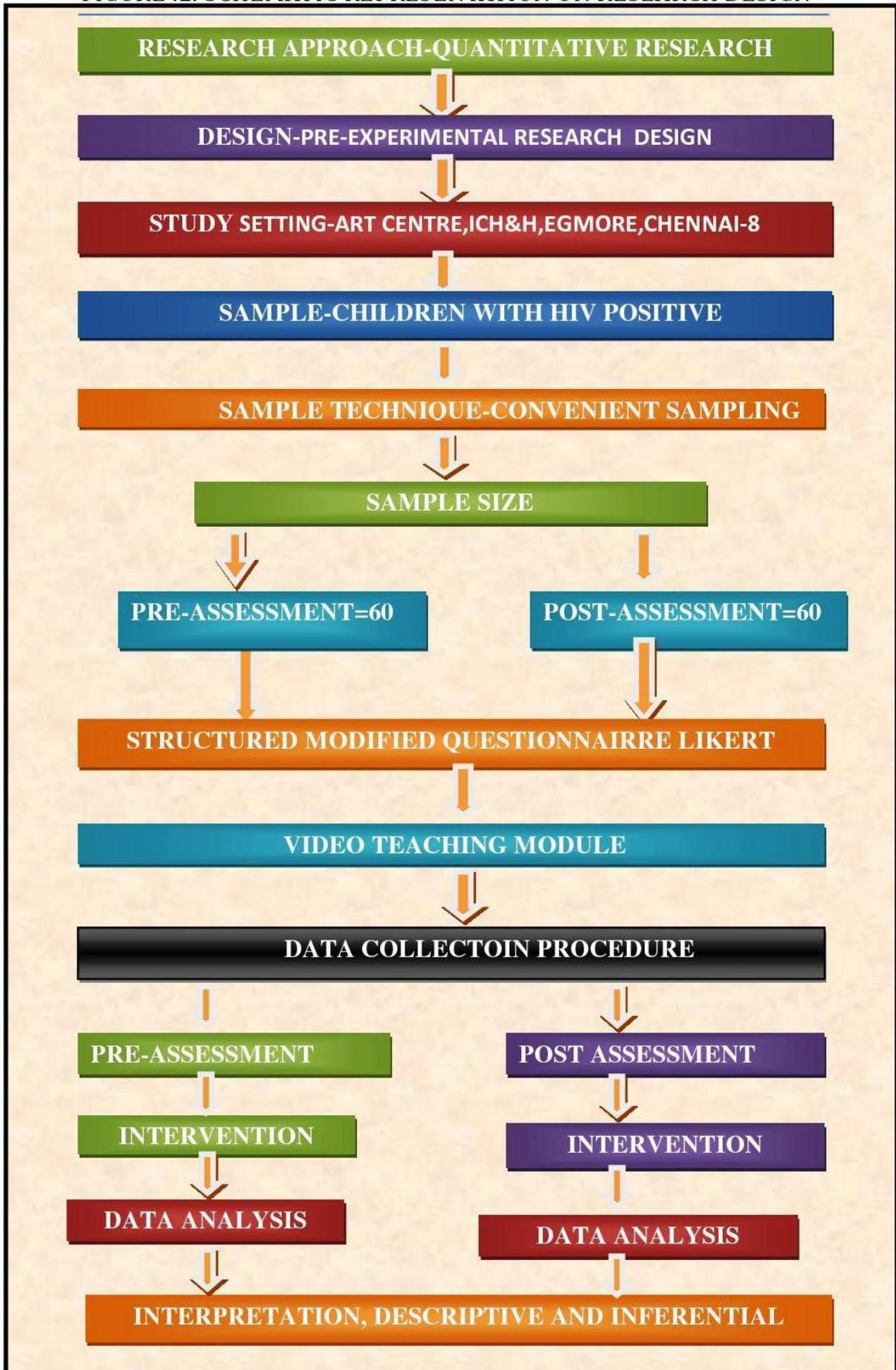
B). Pearson 'chi' square test/Yates corrected chi-square test was used to associate the post test of the effectiveness of video teaching module regarding assessment of knowledge and attitude of caregivers of CLHIV children with selected demographic variables of care givers and CLHIV children demographic variables.

C). The difference between pre and post test score was analyzed using 'students' independent' test.

### **3.18. ETHICAL CONSIDERATION:-**

This study was conducted after the approval from the ethics committee, board of Madras Medical College. Permission was obtained from the nodal officer of PCOE-ART Centre, ICH&H, Egmore. Permission was obtained from project director of 'TANSAC' Egmore, Chennai-8. Informed consent for the study was obtained from all participants. Confidentiality of the subject's information was held.

FIGURE :2. SCHEMATIC REPRESENTATION ON RESEARCH DESIGN



## CHAPTER IV

### DATA ANALYSIS & INTERPRETATION

**“Analysis is a process of organizing synthesizing data in such a way that a research question can be answered and hypothesis tested”.**

*POLIT AND HUNGLER (1999).*

That data collected from 60 pre and post test for the care givers of CLHIV children who were being given the treatment for ART. This study was conducted to ascertain the effectiveness of video assisted teaching programme on ART centre at ICH&H , Chennai. This chapter deals with the description of the samples, analysis and interpretation of data collected and achievement of the objectives of the survey.

**The Objective of the study was:-**

1. To assess (pre-test) the knowledge and attitude of parents having (care givers) CLHIV positive children regarding attainment of quality of life.
2. To educate the parents having (care givers) CLHIV positive children regarding quality of life by using video teaching module.
3. To Reassess (post-test) the knowledge and attitude of parents having (care givers) CLHIV positive children towards quality of life after the video teaching module.
4. To correlate the results with selected demographic variables.

**The outcome of the survey is presented under the following sections:-**

### **SECTION-I**

Description of CLHIV positive children caregivers and their demographic variables.

### **SECTION-II**

Description of CLHIV positive children with demographic information participated in this study.

### **SECTION-III**

Assessment the level of pre-test percentage of knowledge and attitude of parents (care givers) positive children regarding attainment of quality of life.

### **SECTION-V**

Shows the each domain aspect wise percentage of post-test knowledge and attitude of parents having (care givers) CLHIV positive children regarding attainment of quality of life.

### **SECTION-VI.**

Represented the level percentage of post-test knowledge and attitude of parents of having (care givers) CLHIV children regarding attainment of quality of life.

### **SECTION-VII**

Reveal the compared pre-test and post-test knowledge and attitude scores of considering General health, Physical resilience, Psychological Well being, social and role playing , educational aspect.

## **SECTION-VIII**

Views the comparison of overall knowledge score between pre-test and post-test.

## **SECTION-IX**

Association between caregivers knowledge gain and patients demographic variables.

**SECTION-I:** Description of CLHIV positive children caregivers  
and their demographic variables.

**Table 1: CAREGIVERS DEMOGRAPHIC PROFILE**

Demographic variables	Categories	No. of caregivers	%
Care givers	Mother	39	65.0%
	Father	18	30.0%
	Sister	3	5.0%
Age	20 years old	4	6.7%
	21 - 30 years	15	25.0%
	31 - 40 years	29	48.3%
	41 - 50 years	12	20.0%
Sex	Male	17	28.3%
	Female	43	71.7%
Religion	Hindu	48	80.0%
	Muslim	2	3.3%
	Christian	10	16.7%
Educational standard	Primary	16	26.7%
	Secondary	32	53.3%
	Non formal	12	20.0%
occupation	Govt employee	1	1.7%
	Private employee	14	23.3%
	Laborer	34	56.7%
	Unemployed	11	18.3%
Monthly income	< Rs.3000	39	65.0%
	Rs.3001 -5000	16	26.7%
	Rs.5001 -7000	3	5.0%
	>Rs.7000	2	3.3%
Family type	Nuclear family	17	28.3%
	Joint family	43	71.7%
Habitat	Rural	28	46.7%
	Urban	18	30.0%
	Semi urban	14	23.3%

The table 1 depicts the distribution of demographic variable among 60 care givers of CLHIV positive children in pre-test assessment.

Majority of the care givers of mother was (39).father was (18) and sister is (3).

In demographic variables care giver's age group is less than 20 years was 6.7%, 21-30 year was 25%. 31-40 years was 48.3% and 41-50 years was 20%.

The distribution of sex male and female wise is 17 and 43. Religion wise most of them belongs to Hinduism and they were 80%. Muslim was 3.3% and Christian was 16.7%.

The educational standard of caregivers was the primary education level is 26.7% %, the secondary education level was 53,3% , Non formal was 20 %.

The job description of the caregivers are government status 1.7%, private employee is 23.3% and daily the laborers are 56.75% and unemployment was 18.3%.

Their monthly income range within Rs 3000 was 65%, 3001 to 5000 is 26.7%, 5001to7000 is 3.3% and above 7000 is 5.0.

The table number1 should that there is nuclear family 28.3% and joint family is 71.7%.And their habitat of rural was 46.7%, from urban 30.0% and semi-urban was 23.35 in the research study.

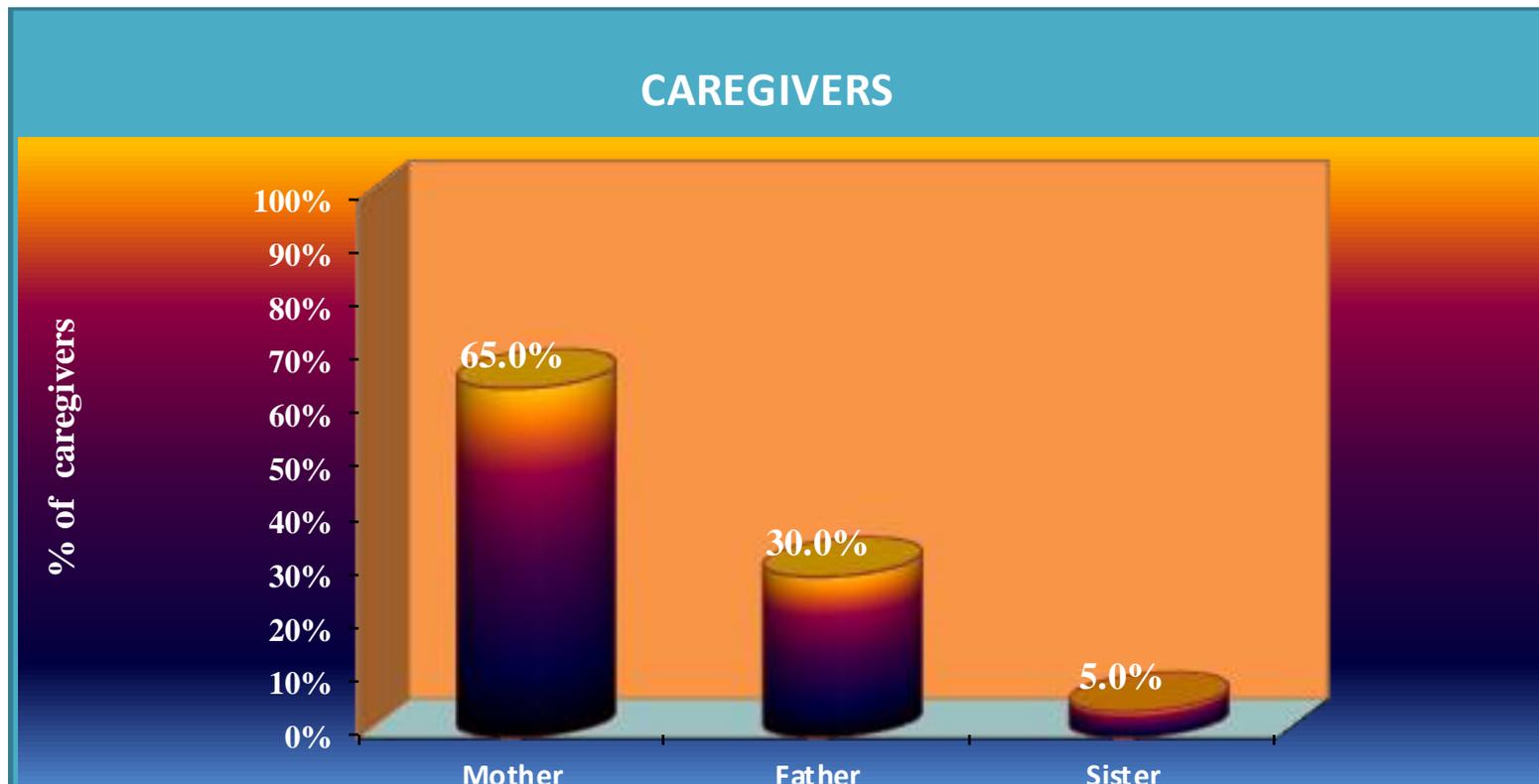


FIG-4. Figure shows type of caregivers.

The figure illustrates the caregiver's ratio in this study. The X-axis denoted as % of care givers and Y-axis denoted as types of care givers. Most of them mother participant were 65.0%, father participants were 30.0% and sister participants were 5.0% respectively.

## CAREGIVERS SEX DISTRIBUTION

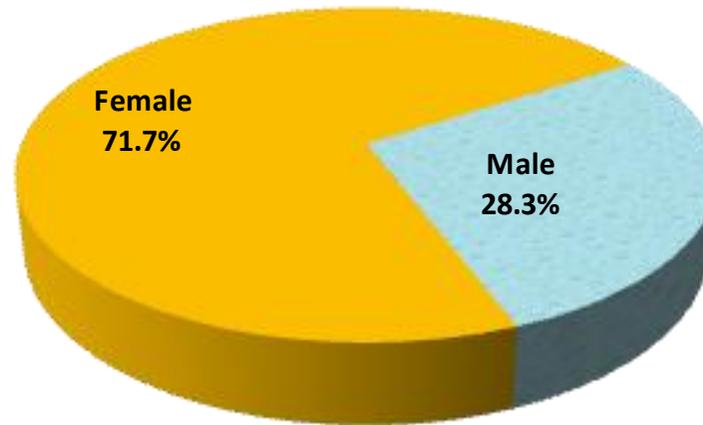


FIG-5. Distribution of caregiver's sex.

Therefore Pie-diagram illustrates that shows caregivers sex distribution of male and female wise distributions were 28.3% and 71.7%.

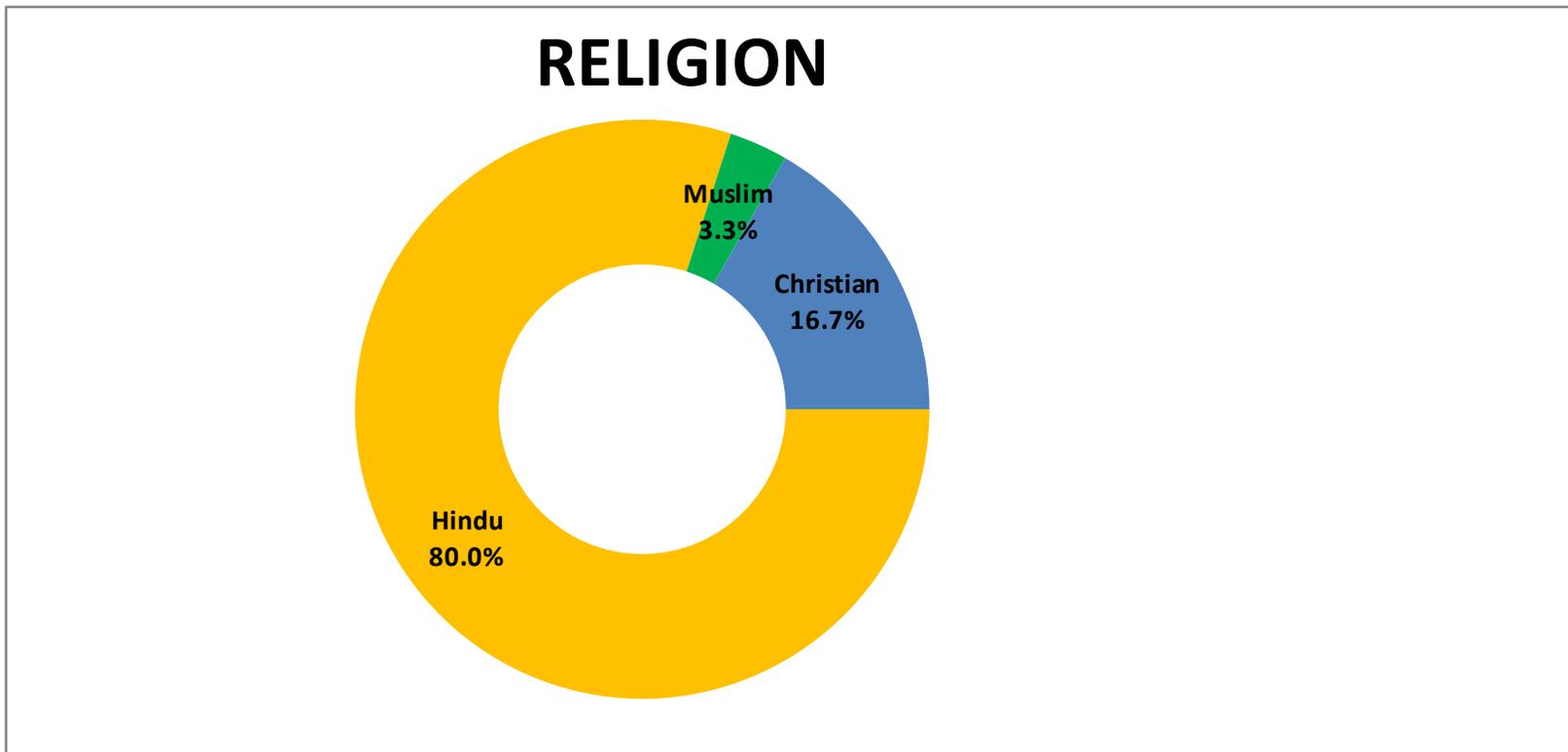


FIG-6.Distribution of religion.

Figure shows the religion wise distribution in this study. Most of them were Hindu participants 80.9%, Christian participants were 16.7% and Muslim participants were 3.3%.

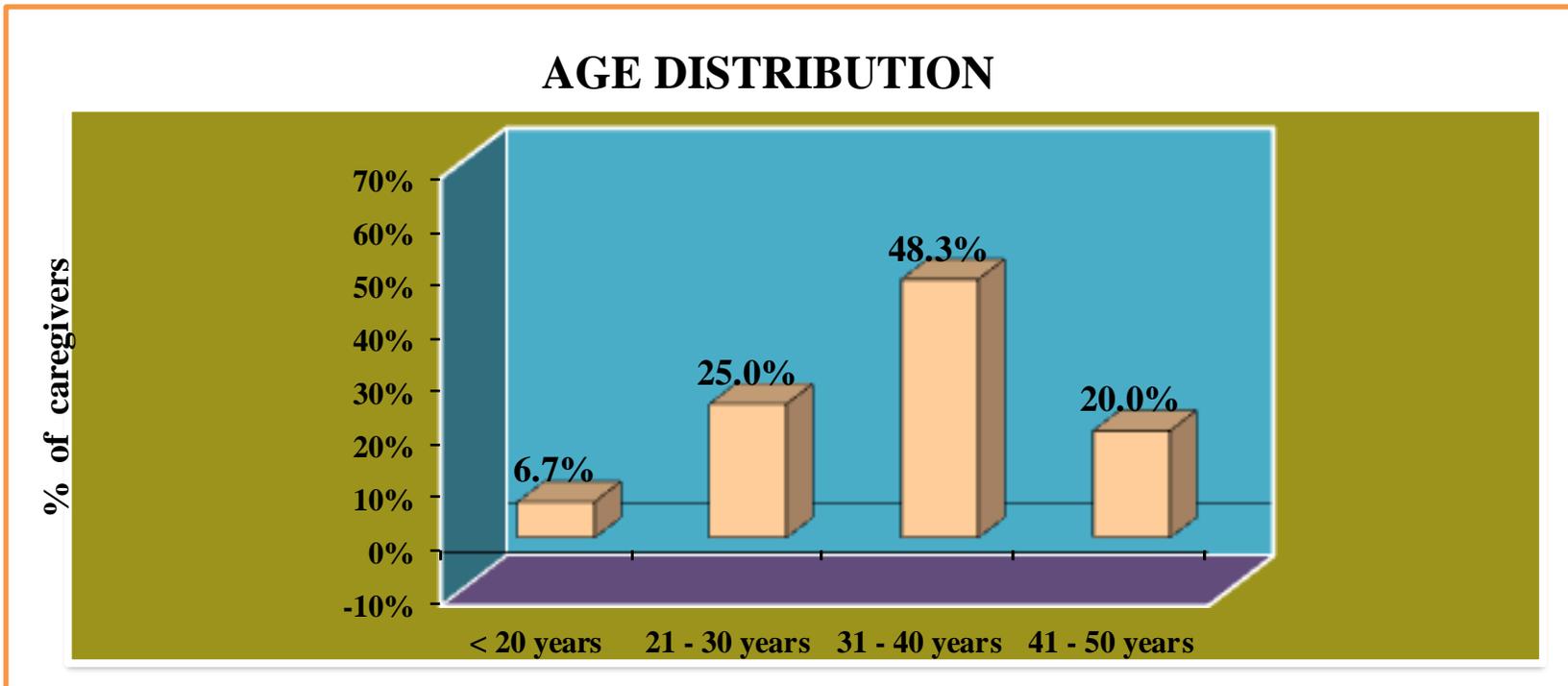


FIG-7. Distribution of age of caregivers. The figure illustrates the age distribution of caregivers in this study. Most of the caregivers were 31-40 years of age, Less than 20 years of the caregivers was 6.7%, 21-31 years was 25.0% and 41-50 years was 20.0%. There is the X-axis denoted as % of care givers of CLHIV positive patients and Y-axis is denoted as the age group of care givers. < 20 years of age group participated were 6.7%, 21-30 years of age groups participated were near by 25.0%, 31-40 years of age group are participated nearly were 48.3% and 41-50 years of age group are participated nearly were 20.0%. Therefore 31-40 years of age groups are participated higher than the other age group.

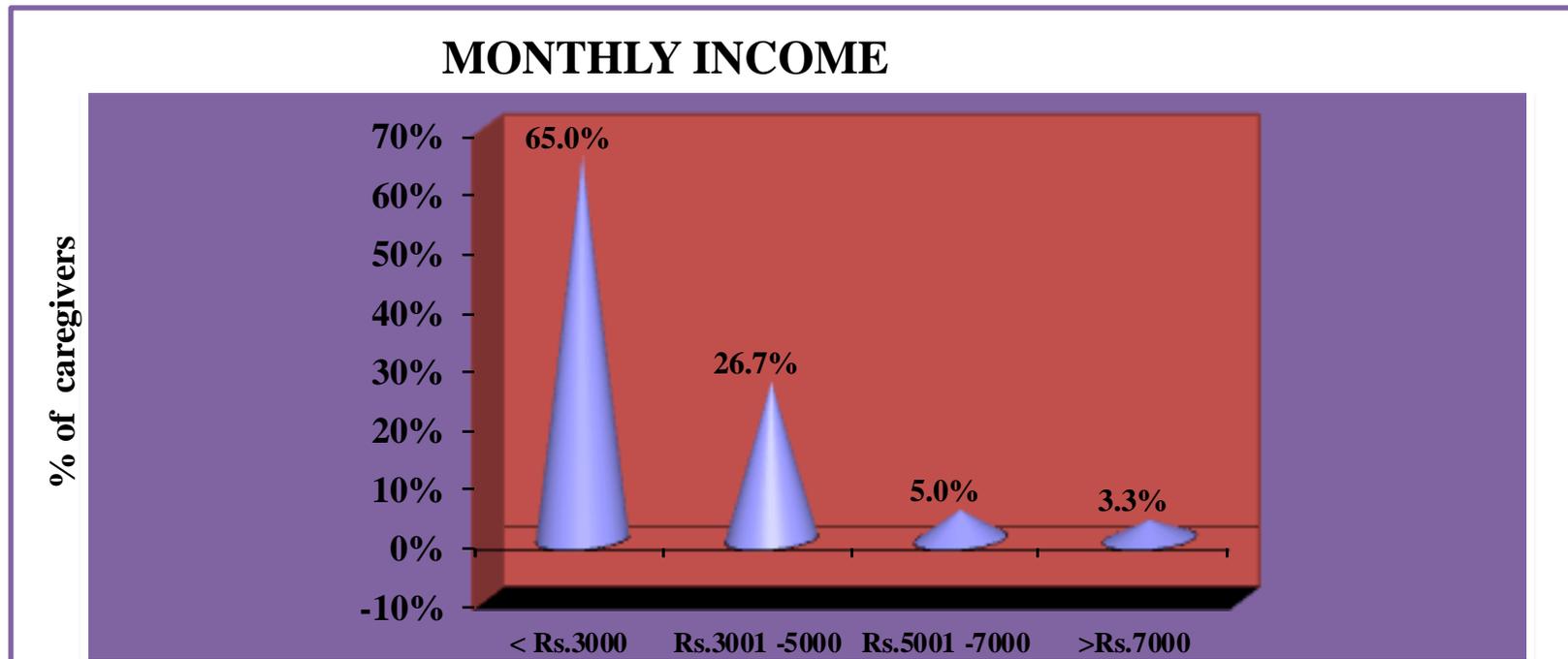


FIG-8. Distribution of caregivers Monthly Income .The above cone diagram shows that the monthly income of caregivers in this study. In which majority of caregiver's monthly income was less than Rs 3000/ was 65.0% and highest income Rs.7000/ was 3.3%.

## SECTION-II

Description of CLHIV positive children with demographic information participated in this study.

Table 2: PATIENTS DEMOGRAPHIC PROFILE

Demographic variables		No. of patients	%
Sex	Male	32	53.3%
	Female	28	46.7%
Patient's Age	6 - 7 years	21	35.0%
	8 - 9 years	16	26.7%
	10 - 11 years	9	15.0%
	11 - 12 years	14	23.3%
Religion	Hindu	48	80.0%
	Muslim	2	3.3%
	Christian	10	16.7%
Educational standards	Kinder garden	11	18.3%
	Primary education	33	55.0%
	Middle school	16	26.7%
Habitat	Rural	28	46.7%
	Urban	16	26.7%
	Semi urban	16	26.6%
Order of birth	First child	40	66.7%
	Second child	20	33.3%

Table 2 shows the demographic information of patients those who are participated in this study. Most of them that participated were male children d 32 in number and female participated 28, the majority of patients age 6-7 years and lowest age group of participants are 10-11 years. Nearly half of them were Hindu participants 48, Muslim participants were 2 and Christian participants were 10. The educational standards of participants majority were primary education was 33, middle schooleducation was 16 and Kinder garden is 11. The habitat of participants mostly from rural were 28, from urban were 16 and semi urban were 16. In order of birth, most of them were First child was 40 and second child is 20.

## PATIENTS SEX DISTRIBUTION

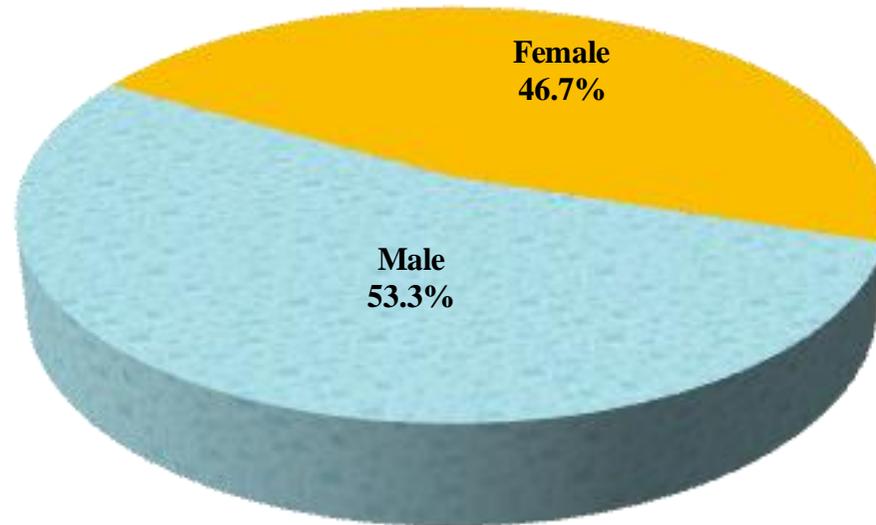


FIG- 9. Distribution of patient's sexratio.

Figure views that the sex distribution of patients in this study .Nearly half of them were male participants 53.3% and female 46.7%.

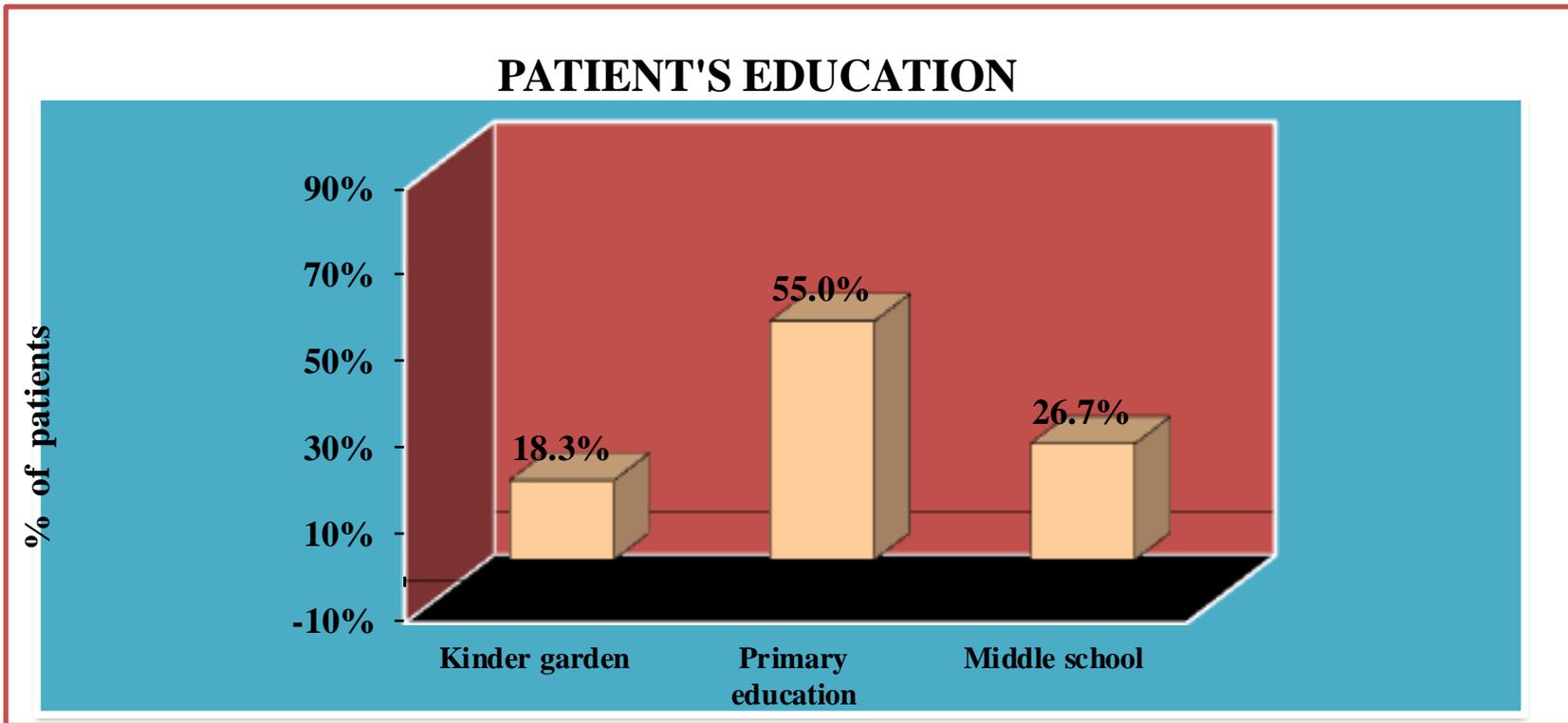


FIG-10. Distribution of patient's education.

The figure reveals the patient education level. The majority of the participant's education in primary education that was 55.0% middle school education was 26.7% and kinder garden education was 18.3%.

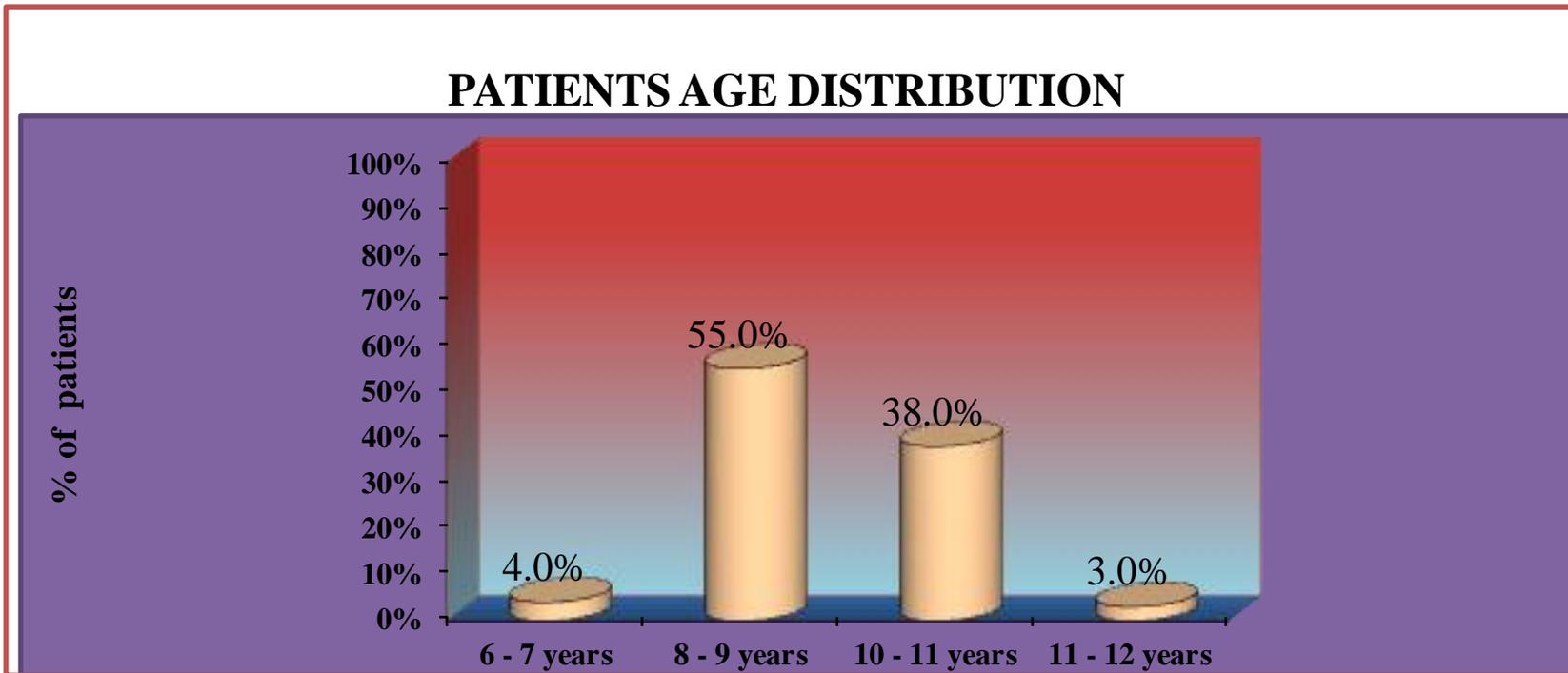


FIG-11. Distribution of patient's age distribution.

The figure illustrates the patient's age distribution showing the majority of participant's age as 8-9 years 55.0%. The lowest level of participants age 11-12 years was 3.0% , 10-11 existence of participants are 38.0% and 6-7 years participants are 4.0% only.

# ORDER OF BIRTH

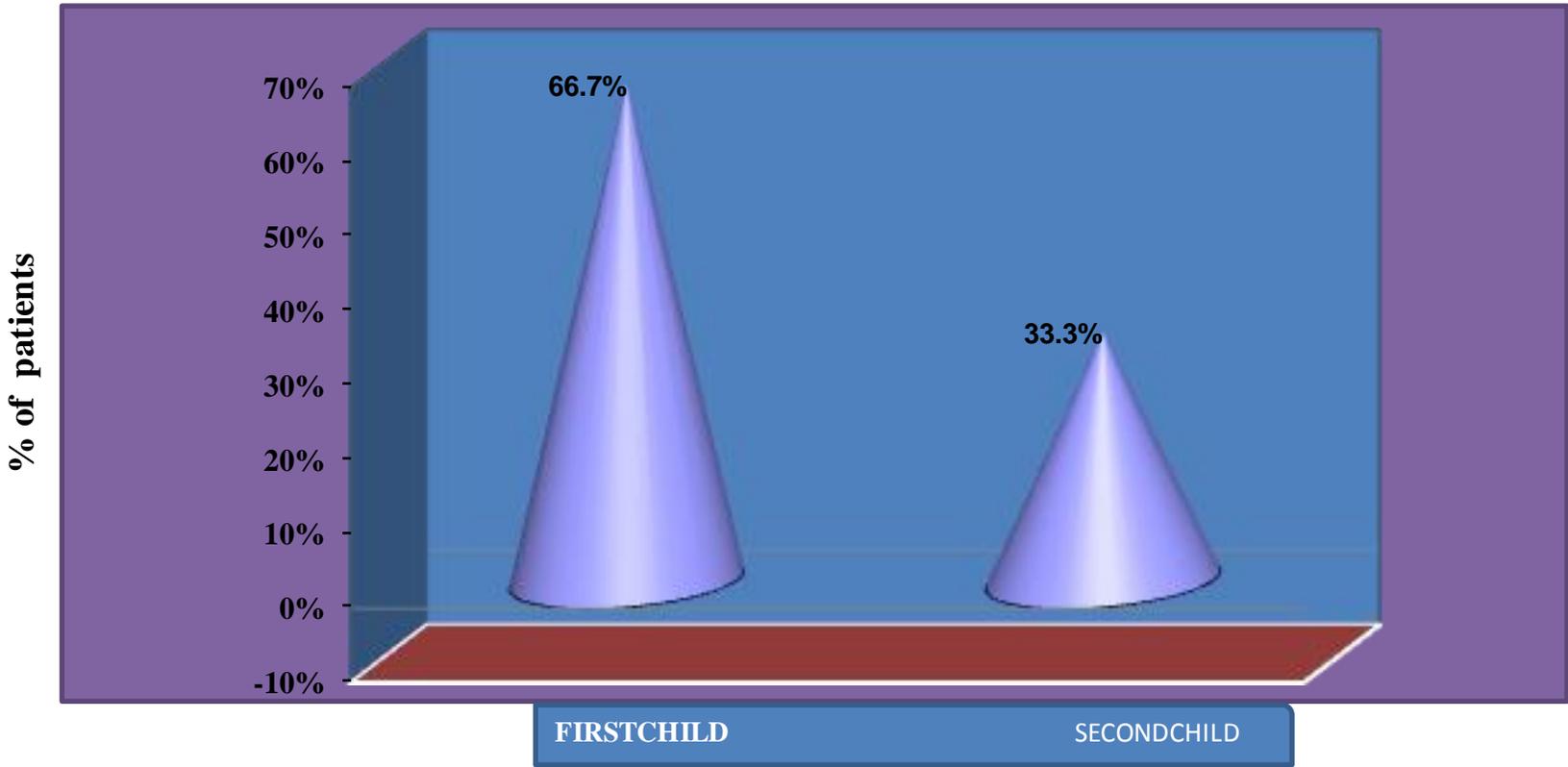


FIG-12. Distribution of order of birth. Figure shows that most of their order of birth was first child is 66.7% and second child was 33.3% in this study.

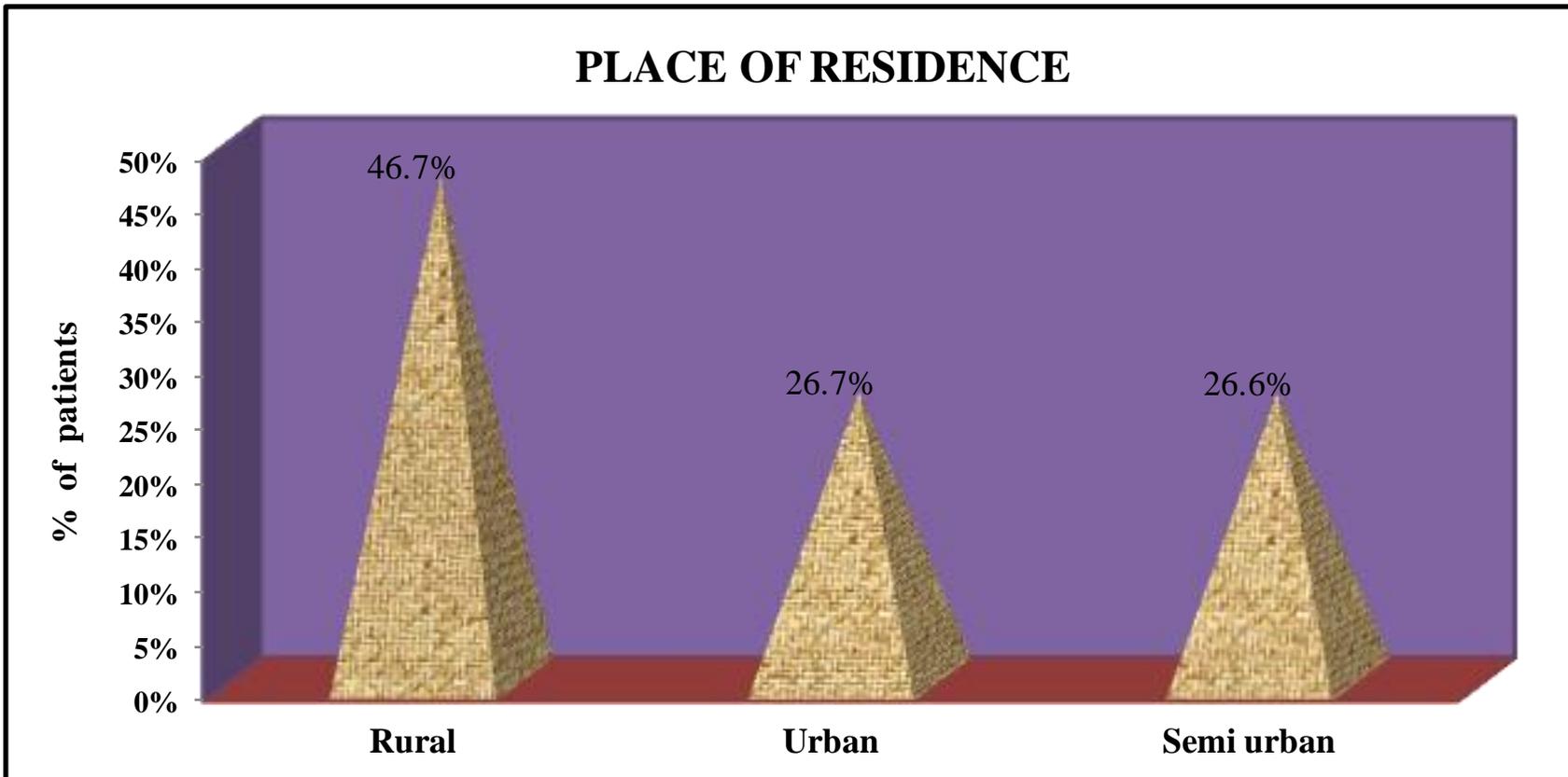


FIG-13. Distribution of place of residence. The above cone bar-diagram illustrates the figure showing the place of residence or habitat of participant. It shows the majority of participants from rural 46.7% and from urban and from semi-urban 26.6% and 26.6% respectively.

**SECTION-III:** Assessment the level of pretest percentage of knowledge and attitude of parents (care givers) CLHIV positive children regarding attainment of quality of life.

**Table 3: PRETEST PERCENTAGE OF KNOWLEDGE AND ATTITUDE**

<b>Knowledge and Attitude</b>	No.of questions	Min – Max score	Mean	SD	% of mean score
General health perception	10	10 -50	28.28	7.81	56.6%
Physical resilience	10	10 -50	28.50	4.60	57.0%
Psychological well being	10	10-50	28.15	4.47	56.3%
Social and Role playing	10	10-50	26.63	6.04	53.3%
Educational aspects	10	10-50	24.47	6.04	48.9%
<b>OVERALL</b>	50	50-250	136.03	17.43	54.4%

Table 3 shows each aspects wise pre-test percentage of knowledge and attitude of **parents (care givers) CLHIV** positive children regarding attainment of quality of life. They have more knowledge in physical resilience (57.0%) and less knowledge in Education (48.9%). Overall they had 54.4% of knowledge and attitude score. This study has five domains, each domain had 10 Questions respectively towards knowledge and attitude .The minimum score of pre-test was 10 and the maximum score of pre-test was 50. In this field, what they had scored of general health perception is 56.6%, physical resilience is 56.0%, psychological well being is 56.3%, social well being is 53% and educational aspect is 48.9%. Therefore care givers had more knowledge in physical resilience 57% and less knowledge in general health education aspect was 48.9% overall they are had 54.4% of knowledge score. It indicates low level of knowledge and attitude.

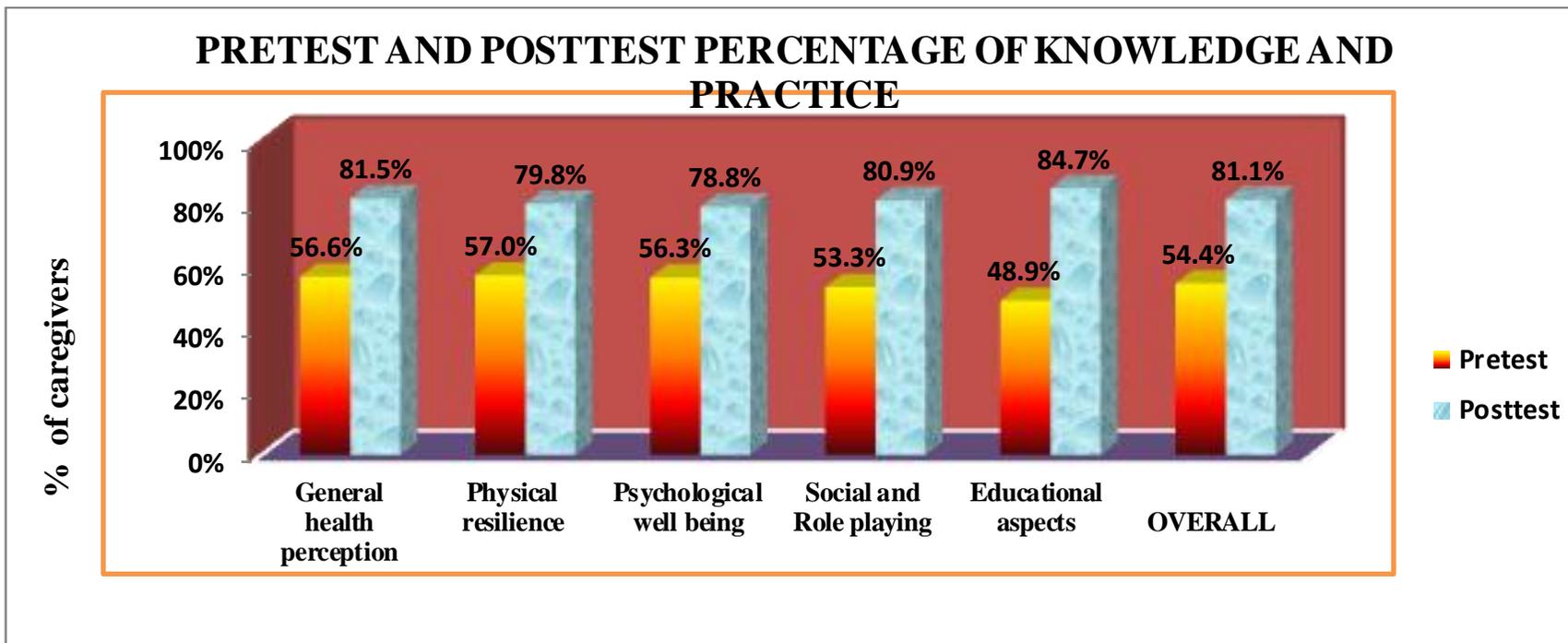


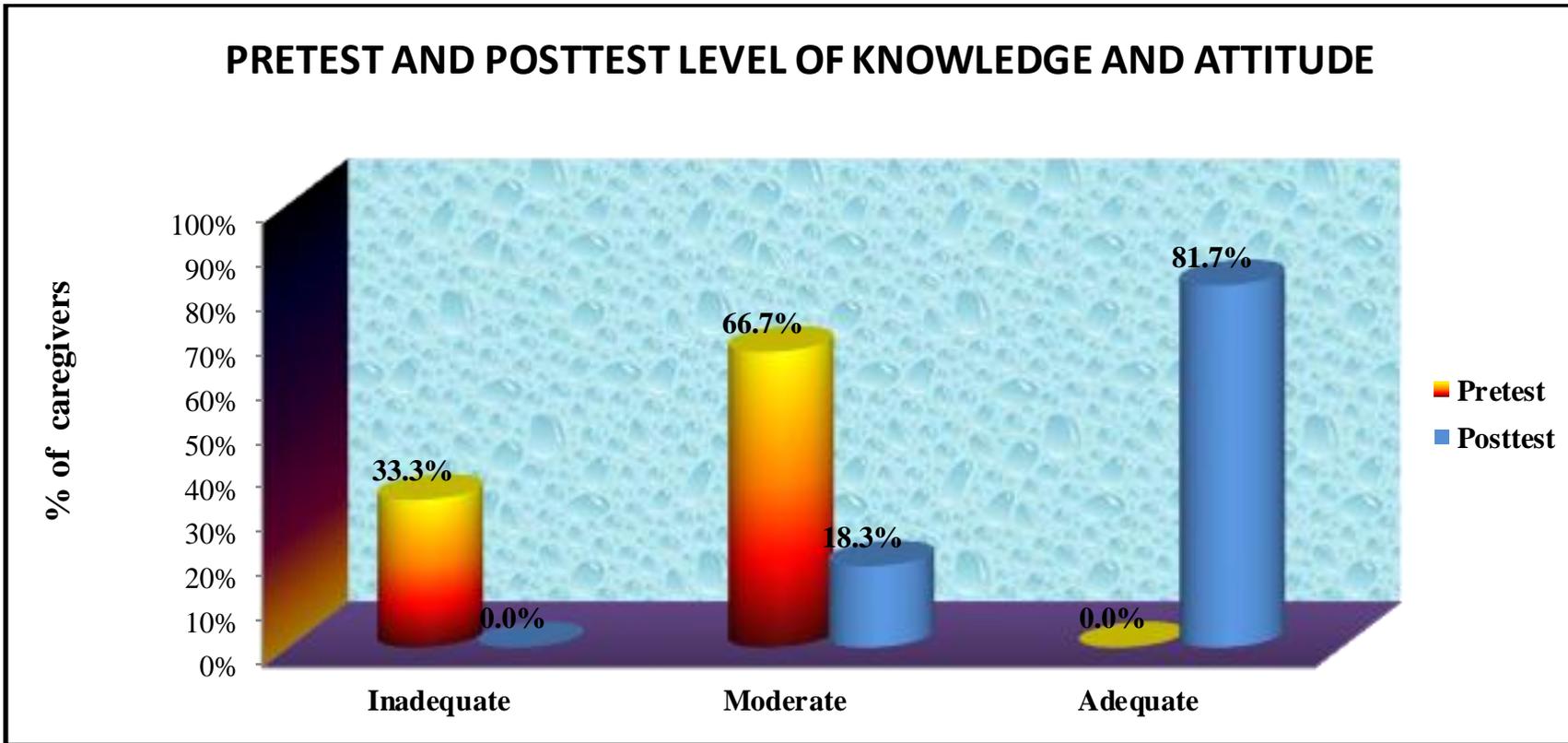
Fig14. Post- test knowledge and practice is highest condition of each domain of this study. The pre- test show General health perception is 56.6%, physical resilience is 57.0%, psychological well-being is 56.3%, social and role playing is 53.3%, educational aspect 48.9% and overall score is 54.4%. Instead of that post-test show the General health perception is 81.5%, Physical resilience is 79.8%, Psychological well-being is 78. 8%, Social wellbeing is 80.9%, Educational aspects are 84.7% and overall score is 81.19%. Therefore level of knowledge and practice of care givers after video teaching modules is very effective in this research.

**SECTION-V:** Shows each domain aspect wise percentage of post test knowledge and attitude of parents having (care givers) **CLHIV** positive children regarding attainment of quality of life.

**Table 4: PRETEST LEVEL OF KNOWLEDGE AND ATTITUDE**

Level of knowledge	No. of caregivers	%
Inadequate	20	33.3%
Moderate	40	66.7%
Adequate	0	0.0%
Total	60	100%

Table 4 shows that the level of percentage of pre-test knowledge and attitude of **parents (care givers)** **CLHIV** positive children regarding attainment of quality of life. 33.3% of the caregivers had inadequate knowledge, 66.7% of them had moderate knowledge and none of them had adequate knowledge. We debated the level of knowledge as inadequate, moderate, and adequate. 20 numbers of care givers were at inadequate level of knowledge, 40 numbers of care givers is moderate level of knowledge and none of them caregiver was at adequate level of knowledge and attitude. Therefore from this table 33.3% of the caregiver had inadequate knowledge, 66.7% of them are having moderate knowledge and none of them have adequate knowledge.



**FIG-15.** Pre-test and post-test level of knowledge and attitude. This figure shows pre-test and post-test level of knowledge and attitude. Here X-axis is denoted as % of caregivers and Y-axis denoted as level of knowledge and attitude in Inadequate, moderate and adequate. It shows that majority of caregivers gained more adequate knowledge and attitude , after video teaching module were 81.07%, Moderate 66.7%,and inadequate were 33.3%.

### SCORE INTERPRETATION :

**Minimum score = 1 Maximum score =5 questions= 50 Total score=250**

<b>S no.</b>	<b>Grade</b>	<b>Score</b>	<b>%</b>
1.	Inadequate	< 125	<50%
2.	Moderate	126-187.5	51-75%
3.	Adequate	187.5-250	76-100%

The score is interpretation the minimum score 1 and the maximum score 5, since the total number of scores is 250. The grading level of knowledge was inadequate lesser than 125 and percentage was within 50% moderate grading of score was 126-187.5 and the percentage 51-75% and adequate grading level of knowledge score was 187.5-250 and percentage wise 76-100%.

**SECTION-VI** Represented the level percentage of post-test knowledge and attitude of parents of having (care givers) **CLHIV** children regarding attainment of quality of life.

**Table 5: POSTTEST PERCENTAGE OF KNOWLEDGE AND ATTITUDE**

<b>Knowledge and Attitude</b>	No.of questions	Min – Max score	Mean	SD	% of mean score
General health perception	10	10 -50	40.75	5.59	81.5%
Physical resilience	10	10 -50	39.88	5.36	79.8%
Psychological well being	10	10-50	39.38	3.25	78.8%
Social and Role playing	10	10-50	40.47	6.04	80.9%
Educational aspects	10	10-50	42.35	4.36	84.7%
<b>OVERALL</b>	<b>50</b>	<b>50-250</b>	<b>202.83</b>	<b>9.36</b>	<b>81.1%</b>

Table 5 shows each aspect wise percentage of post-test knowledge and attitude of **parents (care givers) CLHIV** positive children regarding attainment of quality of life. The post- test also had 5 domains, each domain had 10 question also same as pre-test wise versa. After showing of video teaching modules they are obtained more knowledge in educational aspects 84.7%, general health perception score was 81.5%, physicalresilience was 79.8%, and social and role playing was 80.9%.They had more knowledge in Educational aspects (84.7%) and less knowledge in psychological well being (78.8%). Overall they are having 81.1% of knowledge score.

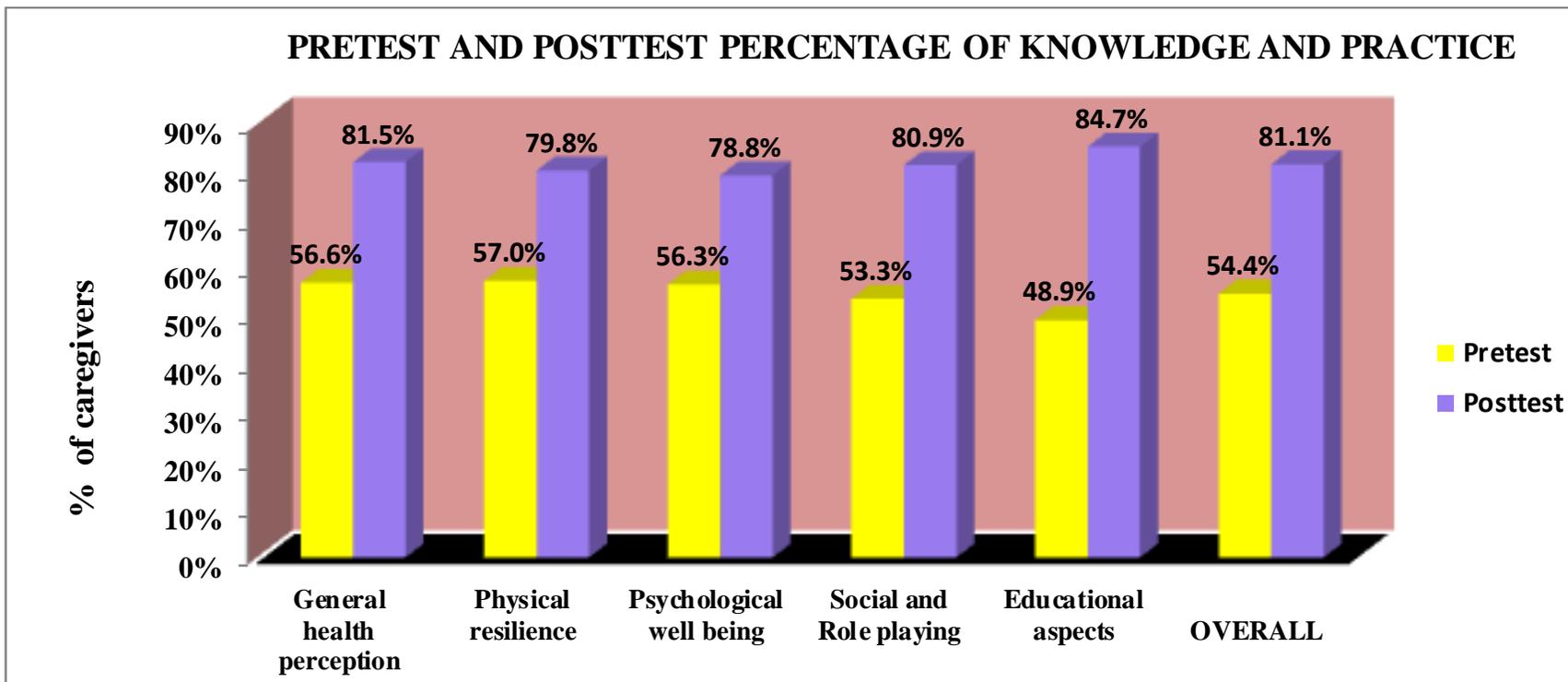


FIG-16. Pre-test and post-test level of knowledge and attitude.

Figure shows X-axis denotes as % of care givers from 0% to 100% and Y-axis denotes as level of knowledge and attitude of pre-test and post-test. There is given differentiated level of knowledge and attitude of pre-test and post-test. The overall score of pre-test and post-test is 54.4% and 81.1%. Therefore after showing the video teaching the caregivers gained maximum level of knowledge and attitude.

**SECTION-V:** Shows the each domain aspect wise percentage of post test knowledge and attitude of parents having (care givers) **CLHIV** positive children regarding attainment of quality of life.

**Table 6: POSTTEST LEVEL OF KNOWLEDGE AND ATTITUDE**

Level of knowledge	No. of caregivers	%
Inadequate	0	0.0%
Moderate	11	18.3%
Adequate	49	81.7%
Total	60	100%

Table 6 shows the level of the percentage of post-test knowledge and attitude of **parents (care givers) CLHIV** positive children regarding attainment of quality of life. None of the caregivers gained inadequate knowledge, 18.3% of them are gained moderate knowledge and 81.7% of them gained adequate knowledge. Therefore the video teaching modules is very effective to of parents of CLHIV children.

**SECTION VI:** Views the comparison of overall knowledge score between pre-test and post-test.

**Table 7: COMPARISON OF MEAN KNOWLEDGE AND ATTITUDE**

	Knowledge score				Student's paired t-test
	Pre-test		Post-test		
	Mean	SD	Mean	SD	
General health perception	28.28	7.81	40.75	5.59	t=10.50, P=0.001*** significant
Physical resilience	28.50	4.60	39.88	5.36	t=11.98, P=0.001*** significant
Psychological well being	28.15	4.47	39.38	3.25	t=16.75, P=0.001*** significant
Social and Role playing	26.63	6.04	40.47	6.04	t=13.61, P=0.001*** significant
Educational aspects	24.47	6.04	42.35	4.36	t=18.78, P=0.001*** significant

*Table no. 7 Compares pre-test and post-test mean knowledge score .*

Considering **General health perception** aspect, in the pretest, caregivers are having 28.28 score where as in protest they are having 40.75 scores so the difference is 12.47. This difference between pretest and posttest is large and it is statistically significant.

Considering **Physical resilience** aspect, in the pre-test, caregivers are having 28.50score where as in pre-test they are having 39.88 scores , so the difference is 11.38. This difference between pretest and post-test is large and it is statistically significant.

Considering **Psychological well being aspects**, in the pre-test, caregivers are having 28.15 score where as in pre-test they are having 39.38 scores , so the difference is 11.23. This difference between pre-test and post-test is large and it is statistically significant.

Considering **Social and Role playing aspects**, in the pre-test , caregivers are having 24.47 score where as in pre-test they are having 42.35 scores , so the difference is 13.83. This difference between pretest and post-test is large and it is statistically significant.

Considering **Educational aspects**, in the pre-test, caregivers are having 24.47 score where as in pre-test they are having 42.35 scores , so the difference is 17.88. This difference between pre-test and post-test is large and it is statistically significant.

Statistical significance was calculated by using students' paired "t" test.

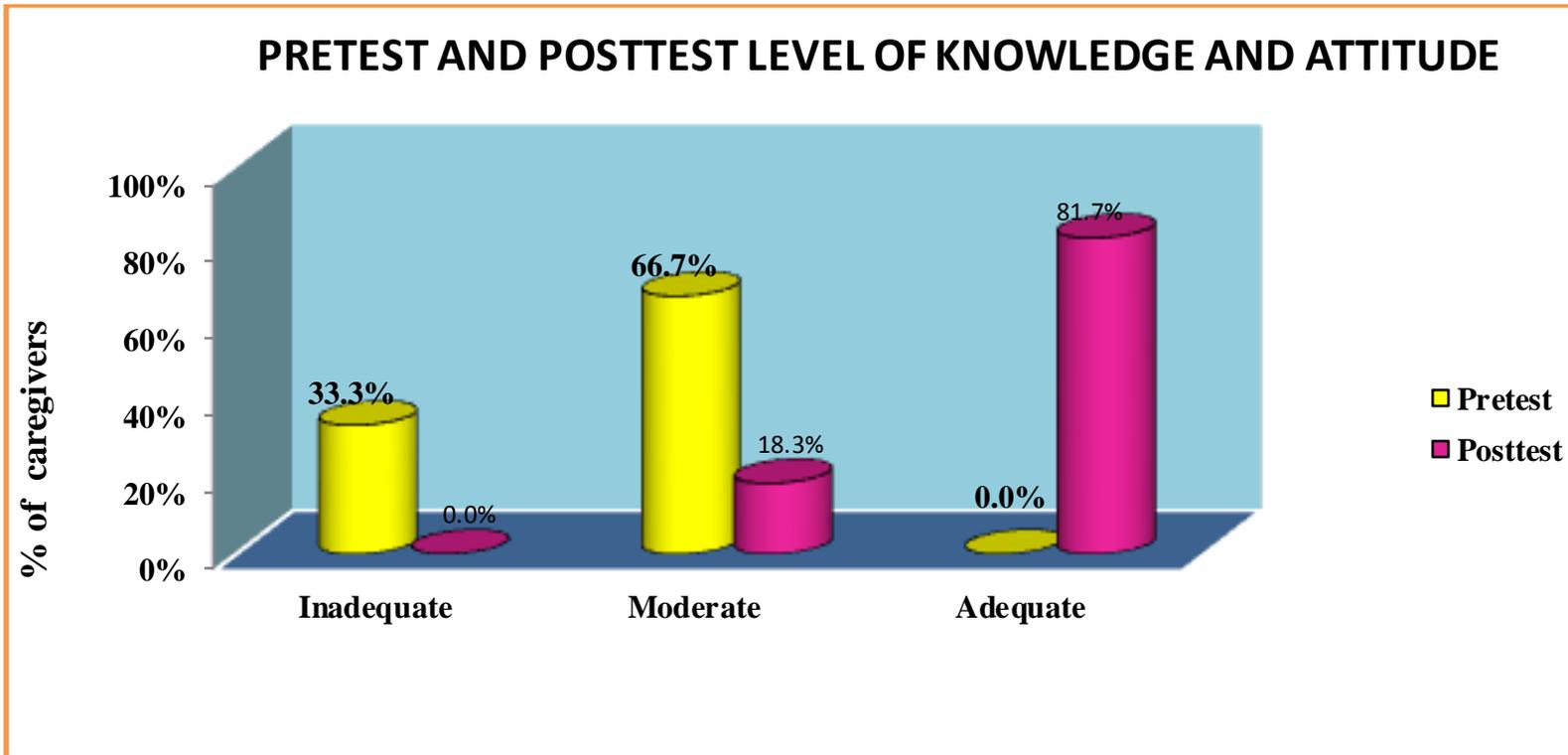


FIG-17. pre-test and post-test level of knowledge and attitude. The figure shows that the majority of caregivers knowledge and attitude of pre-test was inadequate 33.3% ,moderate was 66.6% and none of them had adequacy of knowledge and attitude, but post-test showed none of them inadequate of knowledge and attitude moderate was 18.3% and adequately gained the knowledge and attitude was 81. 7%. Therefore it shows the effectiveness of video teaching module.

**SECTION-VIII:** Views the comparison of overall knowledge score between pre test and posttest.

**Table 8: COMPARISON OF OVERALL KNOWLEDGE AND ATTITUDE**

	No. of caregivers	Mean $\pm$ SD	Student's paired t-test
Pretest	60	136.03 $\pm$ 17.42	t=26.54 P=0.001*** significant
posttest	60	202.83 $\pm$ 9.36	

Table no 8 shows the comparison of overall knowledge score between pre-test and post-test. Considering **overall** in pre-test , caregivers are having 136.03 score where as in post-test they are having 202.83 score , so the difference is 66.80. The difference between pre-test and post-test knowledge score is large and it is statistically significant Differences between pre-test and post-test knowledge was analyzed using paired t-test.

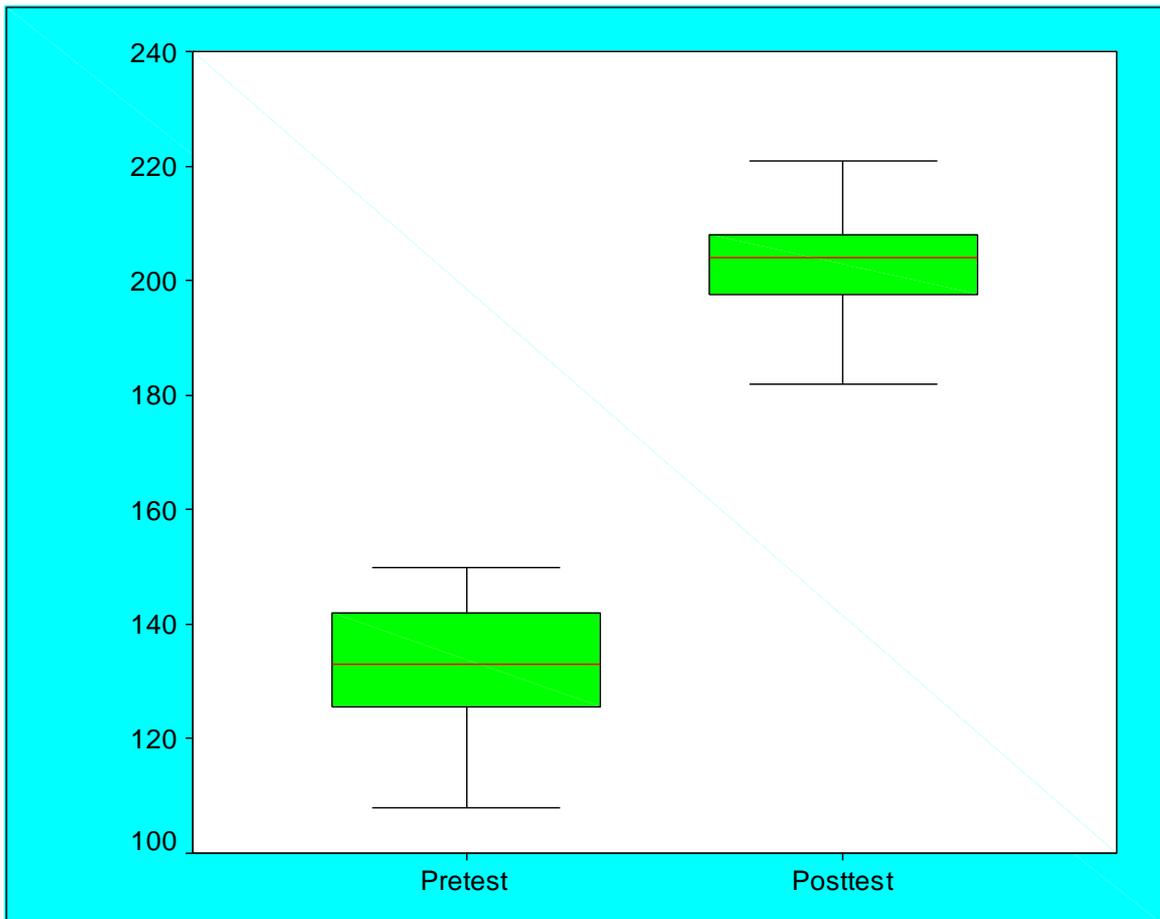


Fig 18. Boxplot compares pre-test and post-test knowledge & attitude score regarding attainment of quality of life among care givers having CLHIV positive children .Here the post-test knowledge & attitude score was high.

**Table 9: COMPARISON OF PRETEST AND POSTTEST LEVEL OF KNOWLEDGE.**

	Pretest		Posttest		Chi-square test
	No. of caregivers	%	No. of caregivers	%	
Inadequate	20	33.3%	0	0.0%	$\chi^2=146.51$ P=0.001*** Significant
Moderate	40	66.7%	11	18.3%	
Adequate	0	0.0%	49	81.7%	
Total	60	100%	60	100%	

Table no. 9 shows the pretest and posttest knowledge & attitude score regarding attainment of quality of life among care givers having CLHIV positive children .

Before **Video Teaching Modules** , 33.3% of the caregivers have inadequate knowledge , 66.7% of them are having moderate knowledge and none of them are having adequate knowledge.

After the administration of **Video Teaching Modules** , none of the caregivers are having inadequate knowledge , 18.3% of them are having moderate knowledge and 81.7% of them are having adequate knowledge.

“Chi square” test was used to prove that statistical significance.

**Table 10: COMPARISON OF OVERALL KNOWLEDGE SCORE**

	<i>Max score</i>	<i>Mean knowledge score</i>	Mean Difference in knowledge with 95% Confidence interval	Percentage of knowledge gain with 95% Confidence interval
Pretest	250	136.03	66.80(61.76 – 71.83)	26.7% (24.7% – 28.7%)
Posttest	250	202.83		

Table no 10 shows the comparison of overall knowledge score between pre-test and post-test. On an average, in post-test, caregivers are **gained** 26.7% knowledge after having **Video Teaching Modules**. Differences between pre-test and post-test score was analyzed using proportion with 95% CI and mean difference with 95% CI.

**Table 11: EFFECTIVENESS OF Video Teaching Modules**

Domains	Pretest knowledge	Posttest knowledge	% of knowledge gain
General health perception	56.6%	81.5%	<b>24.90%</b>
Physical resilience	57.0%	79.8%	<b>22.80%</b>
Psychological well being	56.3%	78.8%	<b>22.50%</b>
Social and Role playing	53.3%	80.9%	<b>27.60%</b>
Educational aspects	48.9%	84.7%	<b>35.80%</b>
OVERALL	54.4%	81.1%	<b>26.70%</b>

Table11 shows each domain wise knowledge gain.

In General health perception aspect they gained 24.9%% of knowledge.

In Physical resilience aspect they gained 22.8%% of knowledge.

In Psychological well being aspect they gained 22.5%% of knowledge.

In Social and Role playing aspect they gained 27.6%% of knowledge.

In Educational aspects aspect they gained 35.8%% of knowledge.

Overall they gained 26.7% knowledge when comparing pretest and posttest knowledge score.

This proves the effectiveness of Video Teaching Modules regarding attainment of quality of life.

**Table12: Association between knowledge gain and caregivers demographic variables.**

Demographic variables	Categories	Level of knowledge & attitude gain score				Total	Chi square test
		Below average(<66.8)		Above average(>66.8)			
		n	%	n	%		
Care givers	Mother	15	38.5%	24	61.5%	39	$\chi^2=7.08$ <b>P=0.04*</b>
	Father	12	66.7%	6	33.3%	18	
	Sister	3	100.0%	0	0.0%	3	
Age	< 20 years	3	75.0%	1	25.0%	4	$\chi^2=7.26$ P=0.07
	21 – 30 years	8	53.3%	7	46.7%	15	
	31 - 40 years	17	58.6%	12	41.4%	29	
	41 - 50 years	2	16.7%	10	83.3%	12	
Sex	Male	12	70.6%	5	29.4%	17	$\chi^2=4.02$ <b>P=0.03*</b>
	Female	18	41.9%	25	58.1%	43	
Religion	Hindu	23	47.9%	25	52.1%	48	$\chi^2=0.48$ P=0.78
	Muslim	1	50.0%	1	50.0%	2	
	Christian	6	60.0%	4	40.0%	10	
Educational standard	Primary	8	50.0%	8	50.0%	16	$\chi^2=0.00$ P=1.00
	Secondary	16	50.0%	16	50.0%	32	
	Non formal	6	50.0%	6	50.0%	12	
Job	Govt employee	1	100.0%			1	$\chi^2=3.16$ P=0.36
	Private employee	8	57.1%	6	42.9%	14	
	Labourer	14	41.2%	20	58.8%	34	
	Unemployed	7	63.6%	4	36.4%	11	
Monthly income	< Rs.3000	19	48.7%	20	51.3%	39	$\chi^2=0.60$ P=0.89
	Rs.3001 - 5000	9	56.3%	7	43.8%	16	
	Rs.5001 - 7000	1	33.3%	2	66.7%	3	
	>Rs.7000	1	50.0%	1	50.0%	2	
Family type	Nuclear family	12	70.6%	5	29.4%	17	$\chi^2=4.02$ <b>P=0.04*</b>
	Joint family	18	41.9%	25	58.1%	43	
Habitat	Rural	18	64.3%	10	35.7%	28	$\chi^2=4.57$ P=0.10
	Urban	6	33.3%	12	66.7%	18	
	Semi urban	6	42.9%	8	57.1%	14	

Knowledge gain = posttest score- pretest score Table no 13 shows the association between level of knowledge gain and their obstetric variables. Mother, female and joint family caregivers gained more Statistical significance which was calculated using chi square test. Here mother was statistically significant. When association between knowledge gain and caregivers demographic variables  $p=0.04$ ; When association between knowledge gain and caregivers of demographic variables females are statistically significant  $p=0.03$ ; and when the association between knowledge gain and caregivers demographic variables joint family is statistically significant  $p=0.04$ .

**SECTION-IX:** Association between caregivers knowledge gain and patients demographic variables. Table13: Association between caregivers knowledge gain and patients demographic variables.

Demographic variables		Differentiation				Total	Chi square test.
		Below average (<66.8)		Above average(>66.8)			
		n	%	n	%		
Patients Age	6 - 7 years	10	47.6%	11	52.4%	21	$\chi^2=2.30$ P=0.51
	8 - 9 years	10	62.5%	6	37.5%	16	
	10 - 11 years	5	55.6%	4	44.4%	9	
	11 - 12 years	5	35.7%	9	64.3%	14	
Sex	Male	16	50.0%	16	50.0%	32	$\chi^2=0.00$ P=1.00
	Female	14	50.0%	14	50.0%	28	
Religion	Hindu	23	47.9%	25	52.1%	48	$\chi^2=0.48$ P=0.78
	Muslim	1	50.0%	1	50.0%	2	
	Christian	6	60.0%	4	40.0%	10	
Educational standards	Kinder garden	7	63.6%	4	36.4%	11	$\chi^2=1.84$ P=0.39
	Primary education	17	51.5%	16	48.5%	33	
	Middle school	6	37.5%	10	62.5%	16	
Habitat	Rural	19	67.8%	9	32.2%	28	$\chi^2=7.82$ P=0.02*
	Urban	4	25.0%	12	75.0%	16	
	Semi urban	7	43.8%	9	56.3%	16	
Order of birth	First	19	47.5%	21	52.5%	40	$\chi^2=3.00$ P=0.58
	Second	11	55.0%	9	45.0%	20	

This table 13 shows association between caregiver's knowledge gain and patient's demographic variables. In this study patients age p value is 0.51, sex p value is 1.00, religion p value 0.78, educational standards p value 0.39, their habitat p value is 0.02 and order of birth value is 0.58. Knowledge gain = posttest score- pretest score. Urban patient caregivers gained more knowledge. Statistical significance was calculated using chi square test.

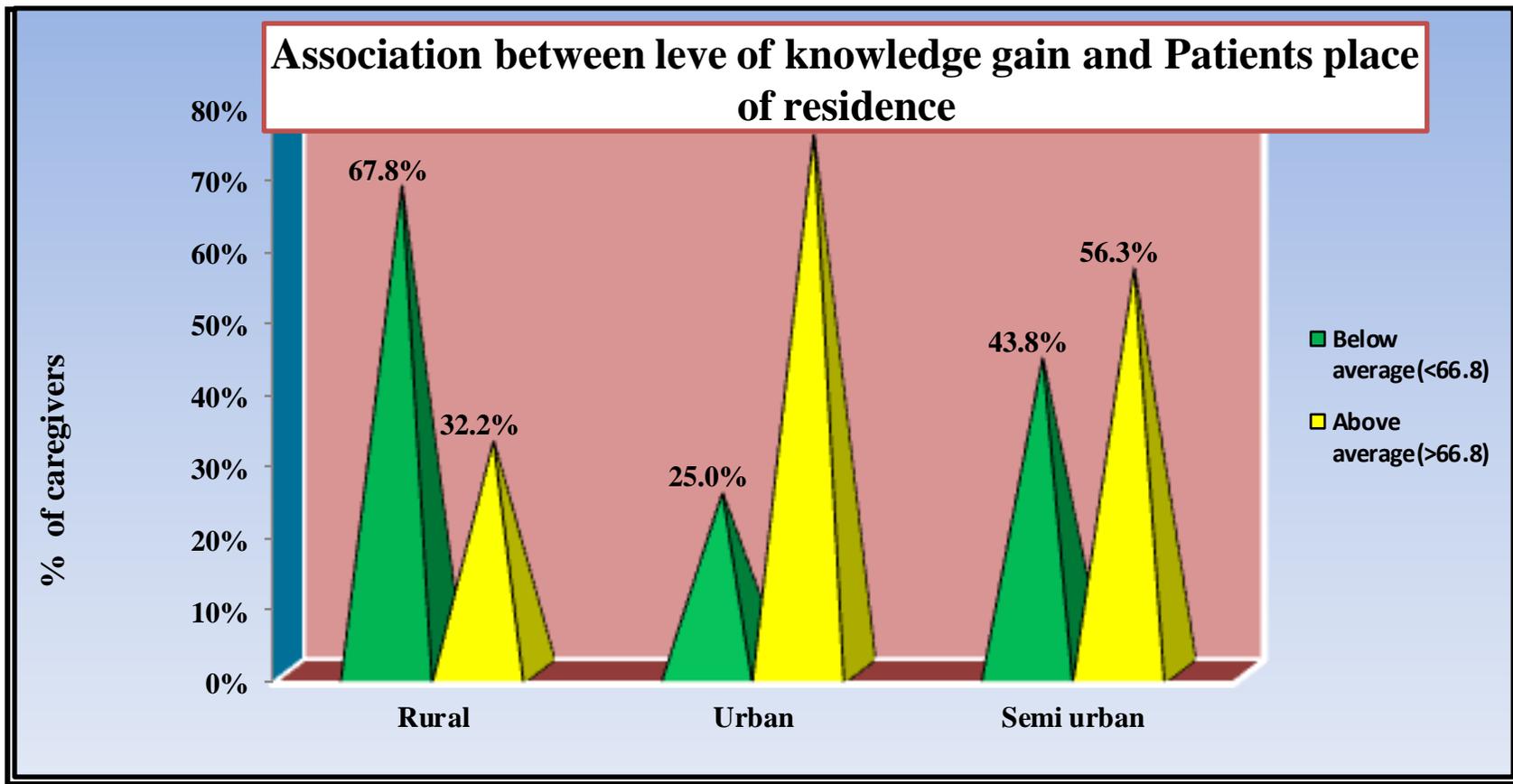


Fig-19. Association between level of knowledge gain and patient place of residence. The table shows association between level of knowledge gain and patient place of residence. There is the X-axis denoted as % of care givers from 0% - 100% and Y-axis denoted as habitat of patients. There is a diagram drawn against the below average level of knowledge that is <66.8 and above average is >66.8. Here urban patient caregivers gained more knowledge than other area in post-test.

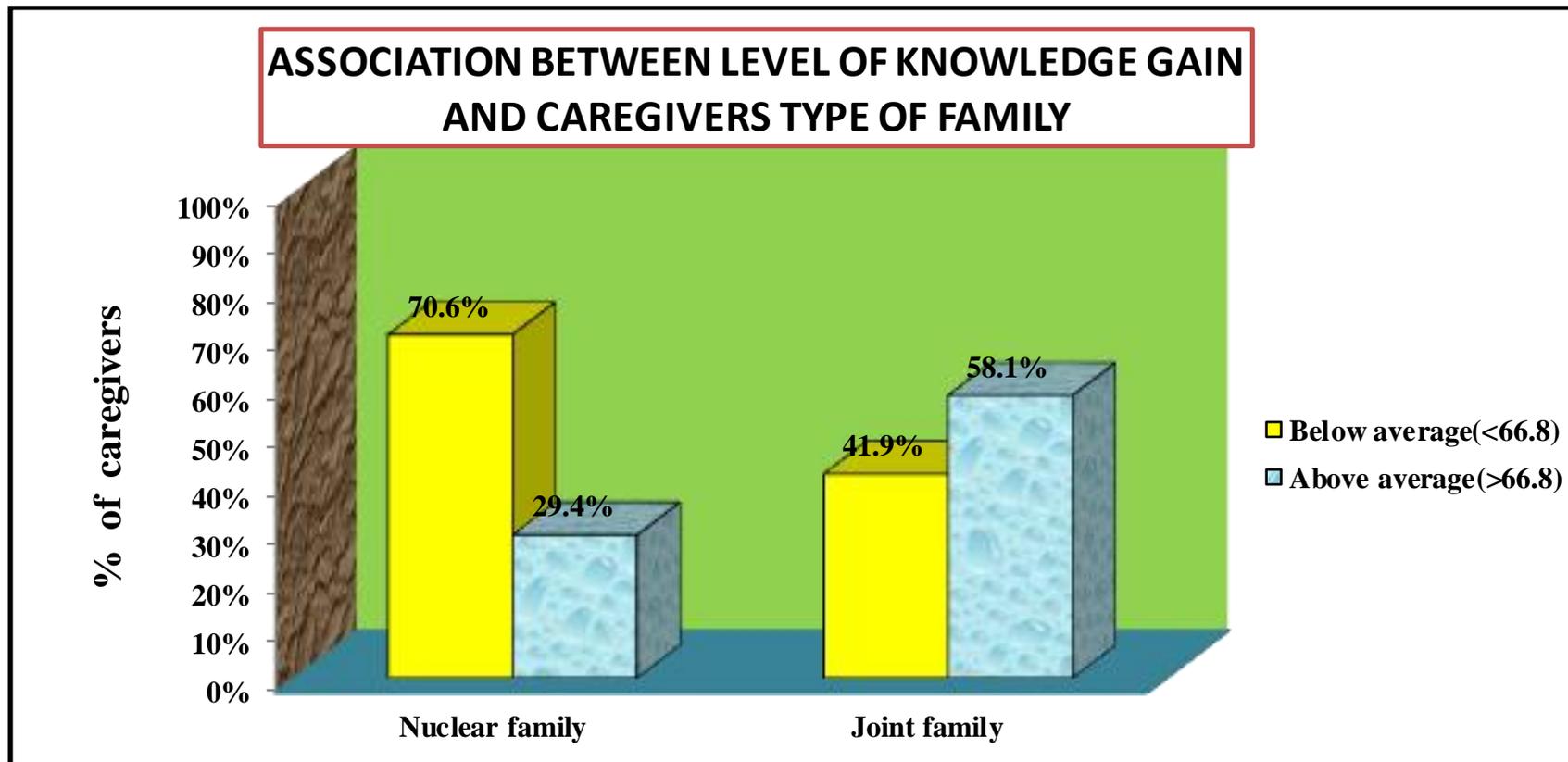


Fig-20. Association between the degree of knowledge gained and care givers type of family . The figure shows a connection between the degree of knowledge gained and care givers type of family. There is diagram drawn against the below average the level of knowledge that is <66.8 and above the average level of knowledge is >66.8. Here X-axis denoted as % of care givers and Y-axis denoted care givers type of family. After post-test the joint family gained more knowledge than nuclear family.

### ASSOCIATION BETWEEN LEVEL OF KNOWLEDGE GAIN AND CAREGIVERS GENDER

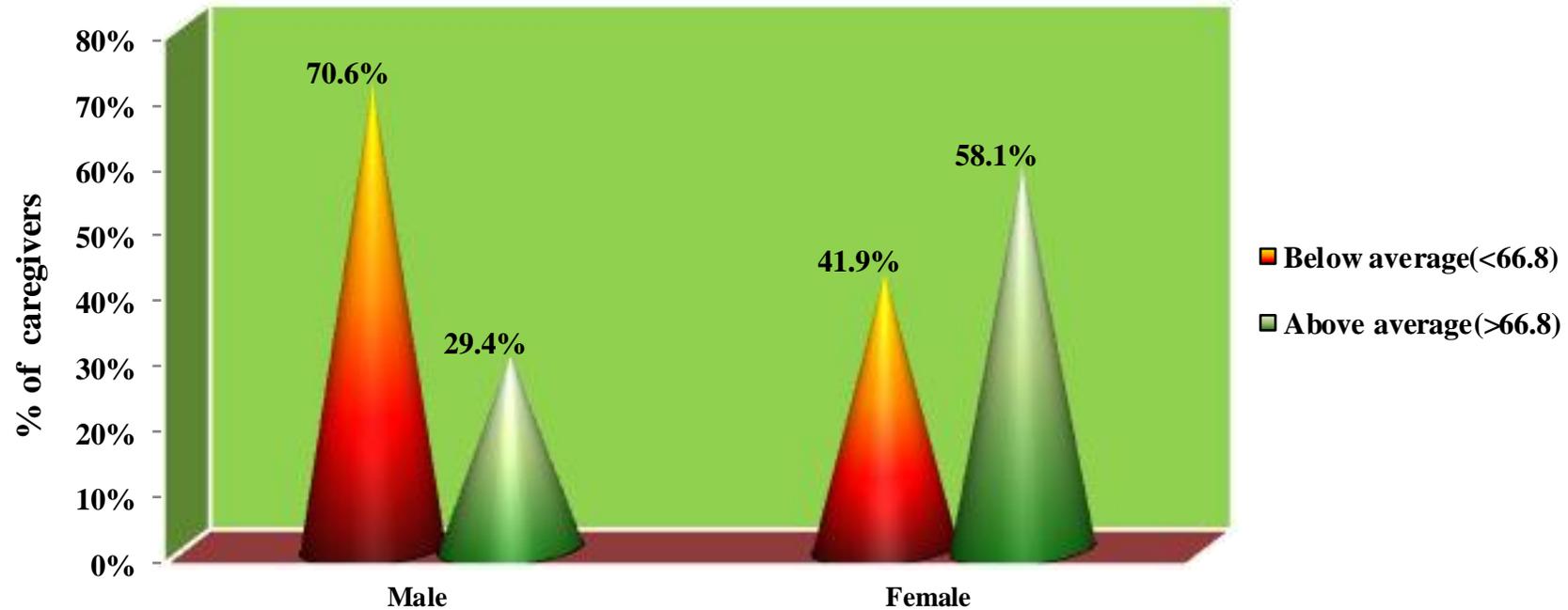


Fig-21. Association between level of knowledge gain and caregivers as gender wise. The figure shows association between level of knowledge gain and caregivers gender wise. There is X-axis denoted as % of caregivers and Y-axis denoted as sex ratio of care givers. Here below average (<66.8) gained male was 70.6% and female was 41.9%, above average (>66.8) gained male was 29.4% and female was 58.1%.

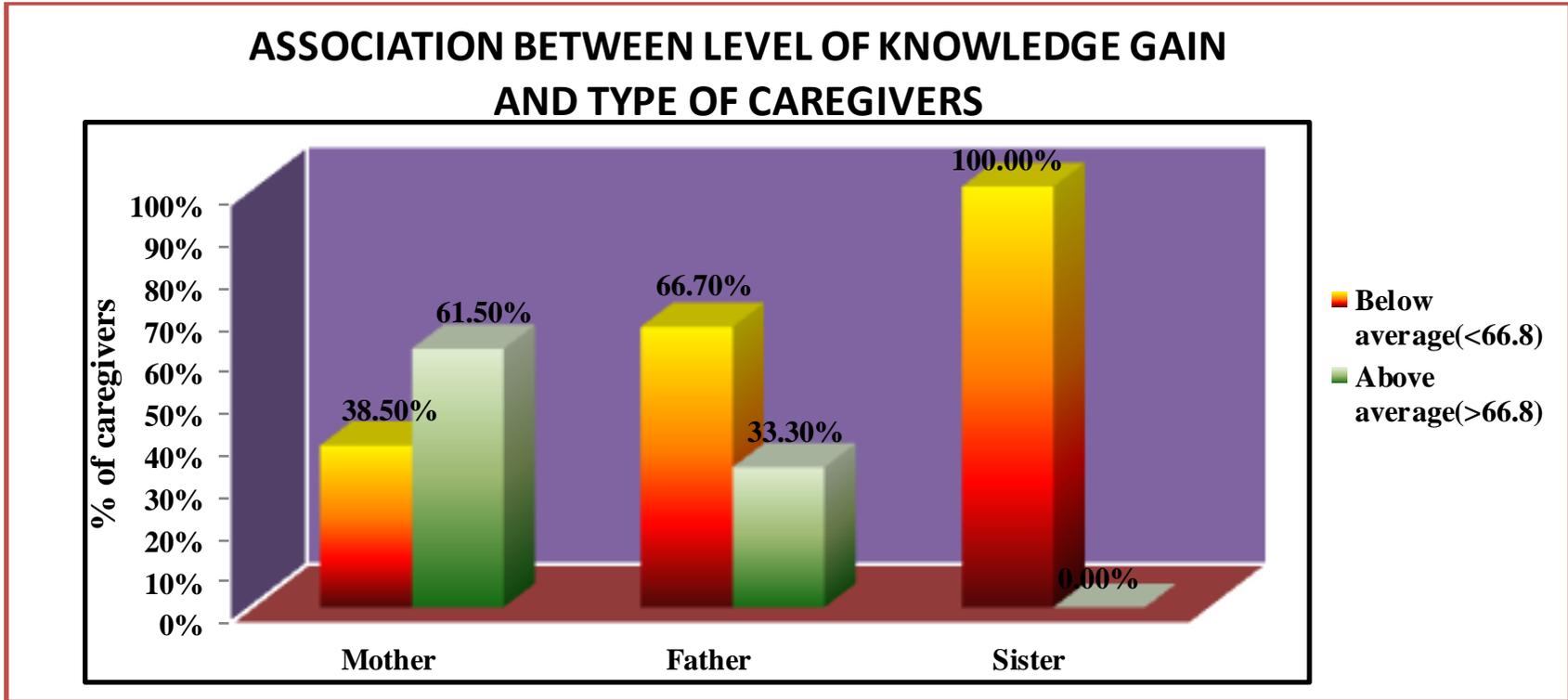


FIG-22. Figure shows association between level of knowledge gain and type of caregivers. For mothers, 38.5% of caregivers gained knowledge below the average (<66.8) and 61.5% gained above the average (>66.8). For fathers, 66.7% gained below the average and 33.3% gained above the average. For sisters, 100% of caregivers gained knowledge below the average and 0% gained above the average. Therefore, mothers gained more knowledge between the level of knowledge gain and type of caregivers. The X-axis is denoted as % of caregivers and the Y-axis is denoted as caregivers of CLHIV positive patients versus level of knowledge gained below average.

## **CHAPTER-V**

### **DISCUSSION**

**The decision is an exchange of knowledge;**

**Argument is an exchange of ignorance-Robert**

HIV / ADIS is major contagious / communicable diseases in global wise populations. I am the Health personnel, having major responsibility to prevent, through the comprehensive care and proper health education. In global area of population, 45% of children are living with **CLHIV**. We must concentrate on their health, because they are tomorrow's future generation and great leaders. Especially care given to CLHIV positive patients must be analyzed by the caregivers knowledge and attitude through the Video Teaching Modules towards their quality of life.

The present study was focuses to evaluate the effectiveness of video teaching modules regarding knowledge and attitudes of parents (caregivers) of **CLHIV** positive patients towards the quality of life. The study samples consist of 60 (60 in pre test and 60 in post test) parents (care givers) who attend the ART centre at ICH & Hospital, Egmore, Chennai. -08.

The investigator found that the caregivers (parents) of CLHIV were cooperative in the subject field. The investigator collected the demographic data from the care givers and CLHIV positive children.

In the present study majority of care givers of the mother was 65.0%, father was 30.0% and sister was 5.0% in pre-test and post test. The majority of the care givers age group was 20 to 50 years. Maximum 71.7% care givers of female and 28.3% are male care givers. Majority of caregivers are from Hindu Religion than other religion. The majority of care givers in pre-test and post-test had studied up to the Secondary Education level that was 53.3%, the Primary Education level was 26.7

and Non formal Education level was 20.0%. Maximum level of care giver job is daily laborers like mansion and cultivators.

The majority of the care givers of **CLHIV** positive patients is 65.0% in pre test and post-test group were in the lowest income group Rs.3000/- (Three Thousand) per month. The majority of the care givers is from (71.7%) Joint family in pre-test and post test. The majority of the care givers of **CLHIV** positive patients 48.7% were living in Rural Area, 30.0% were living with Urban Area and 14% care givers are living in Semi-Urban Area.

The discussion about the study finding is presented in this chapter to make a conclusion based on the objectives, the related literature and theory.

In the Present study Majority of the patient, male sex Ratio was 53% and Female Ratio was 48.7%. The majority of the Patient age group was 6-7 years in 35% majority of **the CLHIV positive patient group** more belong to Hindu. The majority of the **CLHIV** positive patients studying the elementary level of education. In my present study **CLHIV** positive patients living in rural area 46.7%, urban and semi-urban was 26.7% and 26.6% respectively. The majority of the **CLHIV** positive children's order of birth at first child was 66.7% and the second-child was 33.3% respectively.

#### **Findings based on the objectives:**

**The first objective studied was to assess (pre-test) the knowledge and attitude of parents (care givers) CL HIV positive children regarding attainment of quality of life.**

In assessing the pre-test knowledge and attitude of the selected parents (care givers) CL HIV +vet patients 60 Numbers (pre-test and post-test level) In this study has five domains (1) General Health

Perception, (2) Physical resilience, (3) Psychological well beings, (4) social and Role playing (5) educational aspects respectively. Each study related domains had 10 questions, its minimum score was 10 and maximum score was 50. In pretest caregivers level of knowledge and attitude in physical resilience the score was 57.0 % and a minimum score in Educational aspects of score is 48.9%. The Average overall score was 54.4%.

The majority of care givers had a lack of knowledge and attitude which may be due to cultural practice, lack of security, poor general Health practice, not well of psychological wellbeing, poor maintaining of social and Role playing and inadequate health educational aspects of prevention of illness, nutrition and other facilities, during their life periods. Television and Media including Medical drama, posters, short films, advertisements show that the awareness of HIV/ AIDS including prevention, promotion and rehabilitative measures. Even though all the influences of Health modifying behaviors of the PLHIV positive population, the overall pretest percentage of knowledge and attitude score was 54.4%. The overall score shows that insufficient knowledge and attitude of caregivers of **CLHIV** positive patients towards quality of life.

This study finding constructed of **MOHR.J (1999)** studied, a significant difference in QOL in all areas. In our work, the quality of life (QOL) is associated with study to assess the effectiveness of video teaching modules among knowledge and attitude of parents (caregiver) **CLHIV** positive children towards the QOL.

In the pre-test, caregivers level of knowledge and attitude was assessed. It was inadequate 33.3%, moderately adequate 66.7% and none of them had adequate knowledge and attitude towards attainment of QOL of **CLHIV** positive children. Therefore, pre-test indicates that lack of knowledge and attitude.

This work study by **LINDA STURLA FRANK, RN, PHD**, That is the lack of Health Education is heightening the general Health perception, physical Resilience, psychological well being, social role playing and educational aspects, There by lack / poor of knowledge and attitude among caregivers of **CLHIV** positive children towards **QOL**.

Thus the hypothesis which states that there will be a significant relationship of knowledge and attitude of caregivers.

**The second objective was to reassess the (post-test) the knowledge and attitude of parents having (caregivers) CLHIV positive patients towards QOL after the video teaching modules.**

The post test the care givers (parents) of **CLHIV** positive patients are gaining more knowledge in all domains respectively. The overall post test score was 81%, which is broadly higher than pre test score 54.4%. In post test, the general health perception score is 81.5%, physical resilience score is 79.8% psychological well-being score is 80.9% social and role playing is 80.9% and educational aspects score is 84.7% which is the highest score rate than pre-test in overall aspects.

The level of post test knowledge and attitude which showed that for higher rate in these caregivers of **CLHIV** positive patients. So video teaching modules were effective, the video teaching module made them aware of the entire caregivers of **CLHIV** positive patients. It shows that there is highly significant improvement in the level of knowledge and attitudes after the video teaching module.

The investigator assessed the Co-operation status of the caregivers (parents) of **CLHIV** positive patients in the community based care level. In post test overall score of percentage in knowledge and attitudes was 81.1%, It was only obtained from mothers which shows that the education programme on HIV/AIDS helps much improving the **QOL** of **CLHIV** positive patients.

The reasons for the finding may be that the care givers may acquire less knowledge while taking care of **CLHIV** positive patients during day to day life activities. They might not have provided adequate knowledge and attitude to improve **CLHIV** positive patient's QOL. The study revealed that all care givers who came with **CLHIV** positive at ART centre ICH&H Egmore, Chennai-08. Need educational aspect taking care of **CLHIV** positive patients.

The present survey findings are consistent with the study concluded by the researcher on the effect of Educational aspect and other mass media network during care will help to improve the knowledge and positive attitude regarding **CLHIV** positive patient QOL. The education programmes should be based on the need, for the active involvement during the total care **CLHIV** positive patient's life periods.

In the beginning based on the pre-test score, it was found that the care givers (parents) experienced a low level of knowledge and attitudes. The reason for this might be because they did not undergo any General Health Education measures and mass media due to Lack of educational standards, income and habitat after it was interesting to find that their knowledge and attitude level is increased from 54.4% to 81.4%.

The other reason could be that practical things are easy to learn and improve their knowledge and attitude while taking care of **CLHIV** positive patients during day to day life. Even after post test 81.4% of level of knowledge and attitude of the caregivers were evident. The student's paired 't' test for the pre and post test score on an aspect level of knowledge and attitude among parents (care givers) of the **CLHIV** positive patient towards QOL  $P=0.085$  highly significant. That finding revealed that the video assisted programme on QOL of **CLHIV** positive increases the awareness among the care givers of the **CLHIV** positive patient. In post-test there was a significant difference between pre and

post-test scores that is the level of knowledge and attitude on QOL of **CLHIV** positive patients.

In the post-test level of knowledge and attitude of parents having (care givers) **CLHIV** positive children regarding attainment of quality of life are none of the care givers gained inadequate knowledge and 81.7% of them gained adequate knowledge. Therefore the video teaching modules are very effective to parents (care givers) gained more knowledge than pre-test, because less knowledge and attitude of care givers due to improper functioning and effectiveness of mass media about HIV/AIDS comparing the mean knowledge and attitude of pre-test and post-test of the effectiveness of video teaching modules is very highly significant.

The other reason could be that practical things are easy to learn quickly when comprised to overall knowledge and attitude. The comparison of overall knowledge score between. pre-test and post-test quite considering.

In General health perception aspect they have gained 24.9% of knowledge.

In Physical resilience aspect they have gained 22.8% of .

In Psychological well being aspect they have gained 22.5% of knowledge.

In Social and Role playing aspect they have gained 27.6% of knowledge.

In Educational aspects they have gained 35.8% of knowledge.

Overall, they gained 26.7% knowledge when comparing pretest and posttest knowledge score.

This shows the effectiveness of Video Teaching Modules regarding attainment of quality of life.

**4<sup>th</sup> objective to associate the level of knowledge with selected demographic variables.**

On analyzing the outcome based on the age representation of the care givers demographic variables and knowledge gain level and association between care givers knowledge gain and patient demographic variables. It was found that mean knowledge score pre test was 136.03 + (or) - 17.42 and post test was 202.83 + (or) - 9.36. So, it is significant.

On the representation of the care givers of **CLHIV** positive children it was found that most of the care givers are mother next level of care givers is a father and the least level of care givers is a sister out of 60 (pre and post test) samples. It was found that mother gained more knowledge than others test is  $X^2=7.08$ ;  $p=0.04$ . The age group taken in this study was between 20-50 years.

On the representation of the care givers of **CLHIV** positive children, it was found that most of the care givers are mothers. The next level of care giver is the father and the least level of care giver is a sister out of 60 samples. It was found that mother highly gained the knowledge, when it was used CHI-Square test is  $x^2=7.08$ ;  $p=0.04$ . The age group taken in this study was held between 20-50 years Found that female caregivers of **CLHIV** positive children are associated between knowledge and attitude gain, When it was used by Chi-Square test is 4.02;  $p=0.03$ . More statistical value is substantial. A connection between knowledge gain and care givers demographic variables, Joint family caregivers are gaining more statistical significantly was calculated using Chi-Square test  $x^2=4.02$  and  $p=0.04$ .

These caregivers on educational standard ranged from primary level, secondary level and Non-formal education level. When was calculated using Chi-square test value is  $\chi^2=, 0.00$  and  $p=1. 00$  but on the whole education was found to be the leading factor is retaining the imparted program provided by the investigator.

At post- test it was found that the secondary education level is a significant degree of knowledge gained status. This reveals that when the education was higher the understanding capacity also becoming high.

Statistically, was found that the significant association between knowledge gain and caregivers demographic variable and type of caregivers, age, sex, religion, educational standard, job, monthly income. The family type and habitat after video teaching program regarding knowledge and attitude of caregivers of **CLHIV** positive children. There was a significant association between the post-test level of knowledge and attitude to selected demographic and obstetric variety of **CLHIV** positive children's caregivers. The hypothesis previously stated that was accepted into this study a significant association was found with the post test level of knowledge and attitude among mothers of **CLHIV** positive children wise type of caregivers at  $p=0. 04$ . The sex of caregivers at  $p=0. 03$  and referred to the type of family  $p=0. 04$  using the chi-square test.

And also considering the connection between caregivers knowledge gain and patient demographic variables of patient demographic variables of patients age, sex, educational standard, habitat and order of birth after video teaching module program regarding knowledge and attitude of caregivers of **CLHIV** positive. This had highly significant association between the post test status with respect to selected demographic variables and obstetric variables of patient age, sex, educational standard habitat and order of its birth. The hypothesis previously stated that was accepted into this study a significant

association was found that with the post test level of knowledge and attitude among caregivers of **CLHIV** positive children. The urban patients, caregivers gained more knowledge than rural and semi urban, statistically significance was calculated using chi-square test  $P=0.02$ .

This finding is consistent with a study done by **GRACE C. JOHN-STEWARTABC 2012** who found that the type of the caregivers was female, joint family also gained more knowledge and attitude with the help of education regarding the effectiveness of video teaching module. And that also it was found that the urban type of habitat to caregivers is more gained knowledge and attitude after video teaching modules.

In conclusion, it was considered that video teaching modules on assessments of knowledge and attitude among caregivers of **CLHIV** positive children plays an important role in promoting and attitude during the caregivers of **CLHIV** positive children at home level. So, it has to be over. Implemented during the visit at ART centre ICH&H for children, Egmore, Chennai-08 at regular intervals.

Thus the hypothesis which states that there wills the significant association between level of knowledge and attitude with selected demographic variables.

## CHAPTER VI

### SUMMARY, CONCLUSION, IMPLICATION AND RECOMMENDATION.

#### 6.1). SUMMARY

The study was conducted to ascertain the effectiveness of video teaching modules regarding knowledge and attitude of caregivers (parents) of **CLHIV** positive children towards QOL in ART Centre, ICH&H, Egmore, Chennai-08. This is to know about the knowledge and attitude level of caregivers regarding CLHIV positive children. It was quantitative approach with one group pre-test and post-test. It was suitable for this study.

In this study 60 patients (pre-test and post-test) were included in the study based on the inclusion criteria. Knowledge and attitude score of pre-post test were used the LIKERTS scale were used to determine the level of knowledge and attitude status of caregivers during the taking treatment in ART centre ICH Egmore, Chennai-08.

The review of literature provided the base to construct the tools to select the methodology. The conceptual frame work provided comprehensive frame work for evaluation through video teaching modules. A video teaching modules plan on QOL of **CLHIV** positive children was increased. All the tool was translated in Tamil language.

The content validity of tools was obtained from experts. The reliability was tested by post-test method and by conducting in ICH&H, egmore, chennai-8. The convenient sample technique was used and sample size of caregivers fulfill the inclusion criteria were finally included in the study and it was 6 samples (pre-test & post-test). Descriptive and inferential statistics were used in data analysis.

The finding analysis revealed that there was significant relationship between pre and post test. The pretest overall score domain was 51.5% among post test overall score of domain was 81.5%. The knowledge and attitude of caregivers in post test level score is significantly increased after video teaching module. It was statistically significant  $p=0.085$ . Hence the study accepts the first hypothesis in which and there is significant relationship of knowledge and attitude between pre and post test level of caregivers before and after video assisted module towards the **QOL** of **CLHIV** positive children.

Then the study reveals that there was no significant relationship between pre variables such as age, sex, occupation, religion, education standard, job, monthly income, family type and habitat of caregivers. There is no significant relationship between pre-test variables of **CLHIV** positive children demographic variables such as sex, age, religion, educational standards, habitat and order of birth. After video teaching module program regarding knowledge and attitude of caregivers of **CLHIV** positive children. There was significant relationship between the knowledge and attitude of caregivers of **CLHIV** positive children towards **QOL** with the respect of selected demographic variables such as age, sex, educational standard and family type.

In post test percentage of knowledge and attitude of caregivers of **CLHIV** positive children wise general health perception score is 81.5%, Physical health resilience 79.8%, Psychological score was 78.8%, Social and role playing score was 80.9%, Educational aspect score was 84.7% and overall score was 84.7% there is significant variation between pre tested and post knowledge and attitude of caregivers towards attainment of **QOL** of **CLHIV** positive children.

Statistically post-test level of knowledge and attitude of caregivers was none of them had inadequate knowledge and attitude 0.0%, 18.3% of them had moderately gained knowledge and attitude and 81.7% of them

had adequately gained knowledge and attitude towards the attainment of QOL. Therefore the video teaching module is very effective of caregivers gained the knowledge and attitude more.

Considering **General health perception** aspects, in the pretest, caregivers are having 28.28 score where as in protest they are having 40.75 scores, so the difference is 12.47. This difference between pretest and post-test is large and it is statistically significant.

Considering **Physical resilience** aspects, in the pre-test caregivers are having 28.50score where as in pre-test they are having 39.88 scores. so the difference is 11.38. This difference between pretest and post-test is large and it is statistically significant.

Considering **Psychological well being aspect**, in the pre-test ,caregivers are having 28.15 score where as in protest they are having 39.38 scores , so the difference is 11.23. This difference between pretest and post-test is large and it is statistically significant.

Considering **Social and Role playing aspects**, in the pre-test. caregivers are having 24.47 score where as in pre-test they are having 42.35 scores , so the difference is 13.83. This difference between pretest and post-test is large and it is statistically significant.

Considering **Educational aspects**, in the pre-test , caregivers are having 24.47 score where as in protest they are having 42.35 scores , so the difference is 17.88. This difference between pretest and post-test is large and it is statistically significant.

Statistical significance was calculated by using students paired 't' test.

The figure indicates that the majority of caregivers knowledge and attitude of pre-test inadequacy is 33.3% moderate is 66.6% and none of them has adequacy of knowledge and attitude, but post-test showed none of them has inadequacy of knowledge and attitude moderate is 18.3%

and adequately gained the knowledge and attitude is 81.7%. Therefore it shows the effectiveness of video teaching module.

The comparison of overall knowledge scores between pre-test and post-test. Considering **overall** pre-test, caregivers are having 136.03 score where as in post-test they are having 202.83 score , so the difference is 66.80. The difference between pretest and posttest knowledge score is large and it is statistically significant Differences between pretest and posttest knowledge was analyzed using paired t-test.

In the pretest and posttest knowledge & attitude score regarding attainment of quality of life among care givers having CLHIV positive children. Before **Video Teaching Modules**, 33.3% of the caregivers had inadequate knowledge,66.7% of them are had moderate knowledge and none of them are having adequate knowledge. After the **Video Teaching Modules**, none of the caregivers are had inadequate knowledge,18.3% of them had moderate knowledge and 81.7% of them had adequate knowledge. “**Chi square**” test was used to prove the statistical significance.

The comparison of overall knowledge score between pretest and posttest. On an average, in post-test, caregivers **gained** 26.7% of knowledge after having **Video Teaching Modules** Differences between pretest and posttest score was analyzed using proportion with 95% CI and mean difference with 95% CI.

In General health perception aspect they gained 24.9%% of knowledge .

In Physical resilience aspect they gained 22.8%% of knowledge.

In Psychological well being aspect they gained 22.5%% of knowledge.

In Social and Role playing aspect they gained 27.6%% of knowledge.

In Educational aspects aspect they gained 35.8%% of knowledge.

Overall they gained 26.7% knowledge when comparing pretest and posttest knowledge score.

This proves the effectiveness of Video Teaching Modules regarding attainment of quality of life.

Association between caregiver's knowledge gain and patient's demographic variables. In this study patients age wise score p value is 0.51, sex wise is p value is 1.00, religion wise is p value is 0.78, educational standards p value is 0.39, their habitat p value is 0.02 and order of birth value is 0.58. Knowledge gain = post-test score - pre-test score. Association between caregivers level of knowledge gained and patient demographic variables. Urban patient caregivers gained more knowledge. Statistical significance was calculated using chi square test.

Association between level of knowledge gain and caregivers gender wise versa. There is the X-axis denoted as % of care givers from 0% - and Y-axis denotes as a habitat of patients. There is a diagram draw against the below average level of knowledge that is <66.8 and above average is >66.8. The rural area Knowledge gained is lesser than the urban and semi-urban area.

This shows a connection between the degrees of knowledge gained and care givers type of family. There is diagram draw against the below average level of knowledge is <66.8 and above the average is >66.8.

Association between level of knowledge gain and caregivers as gender wise. Knowledge gain and caregivers ratio is below average is males in pre-test was 70.6% and pre-test females was 41.9%. Hence the knowledge gain and care giver ratio is above average is >66.8 males are pre-test is 29.4% and post-test females are 58.1%.

Association between the level of knowledge gain and type of care givers. The level of knowledge gained during the pre-test below averagically mother is 38.5% father is 66.7% and sister is 100.0%.

After construction of questionnaire for the study on “A Study To Assess The Effectiveness Of Video Teaching Modules Regarding Knowledge And Attitude Of parents (care givers) Of **CLHIV** (children living with Human Immunodeficiency Virus) Positive Children Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children Egmore. Chennai-8.” it was tested for its validity and reliability.

Validity of the tool was assessed using content validity. Content validity was determined by experts from Nursing and Medical. They suggested certain modifications in tool. After the modifications they agreed this tool for assessing assess the effectiveness of Video Teaching Modules Regarding Knowledge and Attitude Of parents (care givers) Of **CLHIV** positive Children Human Immunodeficiency Virus Positive Children towards the Quality Of Life in Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children.

After pilot study reliability of the tool was assessed by using split half method. Knowledge and attitude score reliability correlation coefficient value is 0.85. This correlation coefficient is very high and it is good tool to assess the effectiveness of Video Teaching Modules Regarding Knowledge And Attitude Of parents (care givers) Of Human Immunodeficiency Virus Positive Children Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children.

## 6.2. MAJOR FINDING OF THIS STUDY.

- ❖ The major finding of this study reveals that majority of the caregivers were mothers 39(65.0%) in pre and post test.
- ❖ It is clear that the caregivers are from Hindu society 48(80.0%).
- ❖ With regards to family type of caregivers it is on Joint family 43 (71.7%).
- ❖ Post-test knowledge and attitude of the majority of caregivers was higher than pretest level that is overall score was 81.1% and 54.4%.
- ❖ Association between knowledge gain caregivers (mothers) demographic variables are highly significant  $p=0.04$ .
- ❖ Association between knowledge gain caregivers (mothers) and demographic variables sex is  $p=0.03$ .
- ❖ Association between knowledge gain caregivers (mothers) demographic variables and such joint family gained more significant result  $p=0.04$ .
- ❖ Association between level of knowledge and attitude gain and patients place of residence from the urban people gained more knowledge than the other residence in post-test.
- ❖ It represents level of knowledge gained during the pre-test below averagically mother is 38.5%, father is 66.7% and sister is 100.0%.

## 6.3. MAJOR OBJECTIVES BROUGHT OUT THE FOLLOWING.

1. To assess (pre-test) the knowledge and attitude of **parents having (care givers) CLHIV** positive children regarding attainment of quality of life. In pre-test level of knowledge and attitude was inadequate is which is 33.3%, and at moderate level is 66.7% and none of them had adequate knowledge.
2. To Educate the **parents having (care givers) CLHIV** positive children regarding quality of life by using video teaching module .Here we are

conducting our video teaching module in the base of 5 domains as General health, Physical resilience, Psychological well being, Social and role playing and Educational aspects.

3. To Reassess (post-test) the knowledge and attitude of **parents having (care givers) CLHIV** positive children towards quality of life after the video teaching module. After video teaching module, the caregivers gained more knowledge and attitude, none of them gained inadequate knowledge, moderate adequate is 18.3% and adequate that gained the knowledge is 81.7%.
4. To correlate the results with selected demographic variables.  
When comparing the pre and post test result of Inadequate, moderate and adequate gained value was very highly significant at  $p=0.001$ .
5. Association between level of knowledge gain and caregivers gender below adequate, male was 70.6% and female was 41.9% and above average male was 29.4% and female was 58.1%.
6. Association between level of knowledge gain and type of care givers was below average ( $<66.8$ ) mother was 38.5%, father was 66.70% and sister was 100% and Above average ( $>66.8$ ) mother was 61.50% ,father was 33.30% and sister did not gained .
7. In association between level of knowledge gain and patients place of residence was below average ( $<66.8$ ) from rural was 67.8%,from urban was 25.0% and semi-urban was 43.8% and above average is from rural was 32.2%,from urban 75,0% and semi-urban was 56.3%.
8. In association between level of knowledge gain and caregivers type of family below average was ( $<66.8\%$ ) from nuclear family 70.6% and from joint family was 41.9% and above average was from nuclear family which was 26.4% and joint family was 58.1%.
9. In pre-test and post-test percentage of knowledge and practice of domains overall score was 54.4% and 81.1%.

10. In pre-test and post-test level of knowledge and attitude of caregivers was inadequate 33.3%, moderate 66.7% and adequate was 0.0% or none of them had adequate knowledge and post test level of knowledge, None of them had Inadequate knowledge, moderately gained was 18.3% and adequate of them gained 81.7%.

#### **6.4).NURSING IMPLICATIPON:**

##### **IMPLICATION FOR THE NURSING PRACTICE.**

The educational and awareness support given to the caregivers (parents) of the **CLHIV** positive children among QOL, during the care of children will increase the knowledge and attitude of caregivers. There by increasing awareness of care of **CLHIV** positive children and increase QOL of the **CLHIV**. Instead of education and educational module it is seems to be effective when it given along with video teaching module. Nurses who are interested in their desire to give awareness and educational support should collaborate with ART centre of ICH&H administrative staffs to develop the said system to meet the needs of all concerned. The most compelling reason for valuing professional support is that it has measurable benefits at the end of outcome of QOL of **CLHIV** positive children. The curriculum and educational standard of nurses and midwifery and community health needs and seeks to be strengthened to enable the nursing students to implement the said system among **CLHIV** positive children.

##### **IMPLICATION IN NURSING EDUCATION**

Students of midwifery also should be given opportunity to teach the caregivers of **CLHIV** positive children about the QOL process with help of video assisted teaching module with expert supervision. Based on this study the effectiveness of video assisted teaching module should be incorporated in curriculum of nursing students. It will be helpful for the students while formulating the nursing care plan in giving care to the

**CLHIV** positive children. Nursing educators should motivate the students to do many project and research based study on assessing the QOL of caregivers and to improve the knowledge and attitude. Nurses need to be given opportunity to participate in seminars, workshop, staff development programme, continues nursing education and conferences in this field which will improve the nursing personnel knowledge in care of children in various disease problem.

### **IMPLICATION IN NURSING ADMINISTRATION:**

Nurse administrators are challenged to provide quality care by effective organization and management. Nurse administrator should take part in the health policy making, developing procedure and standing orders related to patient care. The nurse already working in all area of institute of child health and hospital for children and other general and speciality area should be given in-service education to help them update their knowledge and cope with the demanding situation with the help of video assisted programme. More administrators should concentrate on proper selection, placement and utilization of nursing personnel in suitable area so that the mothers can be benefited by them. Government should be provide adequate funds that should mobilized for audio-visual aids and hand out to the mothers for reinforcing to promote knowledge and attitude and increase the QOL of **CLHIV** positive children in hospital and community area. Nursing administration shall organize continue nursing education and encourage nurse to use Video assisted Teaching programme as a strategy to educate the caregivers of **CLHIV** positive children. They need to supervise and monitor the practice of video teaching module assisted programme as a teaching method in ART centre ICH&H, Egmore, Chennai-8.

## **IMPLICATION IN NURSING RESEARCH:**

The essence of research is to build up a body of knowledge and attitude in nursing as an evolving procedure. Intervention that the same effect can be studied in order to give sound research based knowledge about nursing support during care of **CLHIV** children among the QOL. The effectiveness of video teaching module programme can be tested and implemented in various health care setting. These can be helpful in enhancing the child health nursing department.

## **6.5).RECOMMENDATIONS FOR FURTHER STUDY:**

On the basis of the present study, the following recommendations have been made for further study.

1. Similar studies can be conducted on larger samples.
2. Similar studies can be done in different settings.
3. Video teaching modules programme can assess the knowledge and attitude process can be compared with the other teaching.
4. Strategies as one of the goal during caregivers of **CLHIV** children among QOL and better outcome.
5. Similar study can be conducted for other department.
6. Similar study on comparing the QOL of diabetic children and Non – diabetic children.
7. Similar study can be conducted among caregivers of cardiac related QOL. Hospital and community situation.

## **6.6).LIMITATION**

1. The study is limited for only caregivers (parents) of **CLHIV**.
2. The study is limited to only HIV positive children.
3. The study is conducted only in ART centre at ICH Egmore, Chennai-8.
4. The time limit is delimited for a period of 4 weeks only.

## **6.7.CONCLUSION.**

Majority of the caregiver's knowledge and attitude regarding QOL of **CLHIV** positive children was inadequate. And also they don't know how to handle **CLHIV** positive children. Even though some caregivers had wrong belief and attitude of health practice about transmission, prevention, care, physical health resilience, social and role playing and especially health education aspects the care of **CLHIV** positive children, all these factors indicating the poor QOL of **CLHIV** positive children. Therefore assessing the knowledge and attitude among caregivers of **CLHIV** positive children towards QOL and it may be done through the video teaching module. The finding of the present study revealed that video teaching modules is effective for caregiver's knowledge and attitude among **CLHIV** positive children towards QOL. It is safe and easiest method of QOL for **CLHIV** positive children.

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**APPENDIX**

**QUESTIONNAIRE FOR STUDY.**

**SECTION A: -SOCIO DEMOGRAPHIC CHARACTERISTIC OF  
FAMILY MEMBERS.**

**STRUCTURED INTERVIEW**

**Sample No:**

**Date:**

**1. Care givers**

- a. Mother
- b. Father.
- c. Brother
- d. Sisters
- e. Guardians

**2. Age**

- a. <20 years
- b. 21-30 years.
- c. 31-40 years
- d. 41-50 years

**3. Sex**

- a. Male
- b. Female

**4. Religion**

- a. Hindu
- b. Muslim
- c. Christian
- d. Others

**5. Education**

- a. Primary
- b. Secondary
- c. Graduate
- d. Uneducated.

6. Occupation

- a. Govt. Employee
- b. Private
- c. Daily laborers
- d. Unemployed.

7. Monthly Income

- a. 2000-3000
- b. 4001-5000
- c. 6001-7000
- d. 8001-9000.

8. Type Of Family.

- a. Nuclear Family
- b. Joint Family
- c. Extended family

9. Habitat

- a. Rural
- b. Urban
- c. Semi-urban
- d. Tribal.

**SECTION-B**

**II. SOCIO –DEMOGRAPHIC CHARACTERISTICS OF DISEASED CHILDREN**

1. Sex

- a. Male
- b. Female

2. Age

- a. 6-7years
- b. 8-9 years
- c. 10-11years
- d. 11-12years

3. Religion

- a. Hindu
- b. Christian
- c. Muslim
- d. Others

4. Education

- a. Kindergarten
- b. Primary education
- c. Middle School
- d. Irregular

5. Place of birth

- a. Urban area.
- b. Ruralareaa.
- c. Tribal area.
- d. Semi-urban area.

6. Order of birth

- a) First Child.
- b) Second Child.
- c) Third Child.
- d) Above.

**SECTION –B THE STUDY COMPRISES FIVE DOMAINS.**

Domain I - General health perception-10 questions.

Domain II - Physical resilience-10 questions.

Domain III - Psychological well being. -10 questions.

Domain IV - Social and Role playing-10 questions

Domain V - Educational aspects-10 questions.

## DOMAIN-1

**Knowledge and attitude about general health performances.**

**It consist of 10 questionnaires.**

<b>S. no</b>	<b>Items</b>	<b>Strongly disagree-1</b>	<b>Disagree2</b>	<b>Uncertain3</b>	<b>Agree4</b>	<b>Strongly agree5</b>
1.	Do you think HIV/AIDS as a serious disease.					
2.	HIV/AIDS is caused by witchcraft/divine punished.					
3.	HIV/AIDS children always suffers in a dangerous situations.					
4.	HIV/AIDS children are to be kept apart.					
5.	HIV/AIDS children are untouchable					
6.	HIV/AIDS children are always depending on treatment.					
7.	HIV/AIDS always children have loss of energy/ fatigue					
8.	HIV/AIDS children have restricted condition.					
9.	HIV/AIDS children have decreased activity of daily living.					
10.	HIV/AIDS children have a good perceived working capacity.					

## DOMAIN-2

**Knowledge attitude for physical resilience.**

**It consist 10 questionnaires.**

<b>S.no</b>	<b>Items</b>	<b>Strongly disagree 1</b>	<b>Disagree 2</b>	<b>Uncertain 3</b>	<b>Agree 4</b>	<b>Strongly agree 5</b>
11.	HIV/AIDS children are suffering from pain and discomfort frequently.					
12.	HIV/AIDS children are often experiencing the loss of energy.					
13.	HIV/AIDS children's quality of life is poor.					
14.	HIV/AIDS children have diminished activity.					
15.	HIV/AIDS children have only poor appetite.					
16.	HIV/AIDS children are always declined of physical vitality.					
17.	HIV/AIDS children are not interested in daily work.					
18.	HIV/AIDS children are poor concentrated poorly in personal hygiene.					
19.	HIV/AIDS children are prone to common skin infection.					
20.	HIV/AIDS children are highly susceptible to infection.					

#### DOMAIN-4

**Knowledge and attitude for social relationship and environments.**

**It consist 10 questionnaires.**

<b>S. no</b>	<b>Items</b>	<b>Strongly disagree1</b>	<b>Disagree 2</b>	<b>Uncertain 3</b>	<b>Agree 4</b>	<b>Strongly agree5</b>
31.	HIV /AIDS children social comfort is good in condition.					
32.	HIV/AIDS children are easily transportable.					
33.	HIV/AIDS children are always having strong family and social support.					
34.	HIV /AIDS children move with others free association.					
35	HIV/AIDS children are always provided good quality of home environments.					
36.	HIV/AIDS children are having full rights of physical and social security.					
37.	HIV/AIDS children are healthy and social care is very important.					
38.	HIV/AIDS children allow them to sharing of utensils and stationary to others.					
39.	HIV/AIDS children affecting the societal level are mutual.					
40.	HIV/AIDS children is quality of life and accessible is very easy					

### DOMAIN-3

**Knowledge and attitude for psychological well being.**

**It consist 10 questionnaires.**

<b>S. no</b>	<b>Items</b>	<b>Strongly disagree 1</b>	<b>Disagree2</b>	<b>Uncertain3</b>	<b>Agree 4</b>	<b>Strongly agree 5</b>
21.	HIV /AIDS children 's are affection is diminished.					
22.	HIV/AIDS children are having both negative and positive comfort.					
23.	HIV/AIDS children have feeling of higher cognitive functioning.					
24.	HIV /AIDS children have feeling as being with the loss body image.					
25	HIV/AIDS children are well developed of spiritual well being.					
26.	HIV/AIDS children are constantly in a depressive mood.					
27.	HIV/AIDS children are responsible well motivated.					
28.	HIV/AIDS children are normally dependable character.					
29.	HIV/AIDS children are easily misusing.					
30.	HIV/AIDS children are making good relationship with others.					

## DOMAIN-5

### Knowledge and attitude for educational level.

It consist 10 questionnaires.

S.no	Items	Strongly disagree1	Disagree 2	Uncertain3	Agree 4	Strongly agree 5
41.	HIV/AIDS children is learning capacity is more.					
42.	HIV / AIDS children are perceive more knowledge.					
43.	HIV/AIDS children are motivated highly through the educational system.					
44.	Health education provided by health personnel and IEC is effective.					
45	HIV/AIDS awareness is increased by the level of health education.					
46.	HIV/AIDS children can have continuous learning with other normal children.					
47.	Health education is essential for HIV / AIDS children for maintaining their health.					
48.	HIV/AIDS children higher education is affected.					
49.	Health education is the standard tool for HIV / AIDS children.					
50.	HIV/AIDS children make good relationship with others.					

# **CERTIFICATE OF ENGLISH EDITING**

## **TO WHOMSOEVER IT MAY CONCERN**

This is to certify that the Dissertation Topic “**A study to assess the effectiveness of video teaching modules regarding knowledge and attitude of parents (Care givers) of CLHIV (Child living with Human Immunodeficiency Virus) towards the quality of life in Anti-Retro Viral Treatment Centre, Institute of Child Health and Hospital for Children, Egmore, Chennai-08**” done by Mr.R.Jayakumar, M.Sc (N), II Year, College of Nursing, Madras Medical College, Chennai – 03 has been edited for English Language appropriateness.

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**COLLEGE OF NURSING,  
MADRAS MEDICAL COLLEGE,  
CHENNAI-03.  
LESSON PLAN**

***“A Study To Assess The Effectiveness Of Video Teaching Modules Regarding Knowledge And Attitude Of Mothers Of Human Immunodeficiency Virus Positive Children Towards The Quality Of Life In Anti-Retro Viral Treatment Center. Institute Of Child Health And Hospital For Children Egmore. Chennai-08”.***

**NAME OF STUDENT  
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## INTRODUCTION

HIV infection continues to be a significant cause of disability and death worldwide, with an estimated 2.1 million children living with HIV in 2003 and dramatic decrease in rates of childhood deaths and morbidity are attributable to HIV/AIDS in the United States because of the availability of highly active antiretroviral therapy. Because children are now living with HIV as a chronic disease, our next challenge is to optimize the health of these children. The dissertation is one of the best methods of students and best education tool among the society in the aspect of prevention and promotion of quality of life for the human immunodeficiency positive children. Florence Nightingale insists on the art of family health nursing. Research and scientific method is important as sick paediatric nursing and sick children. Students have major responsibility for promoting general health of the patient. The research students are challenging the long standing problem experiences. Our responsibility of paediatric nurse is to develop adequate knowledge, positive attitude and healthy practice towards the optimum health through the dissertation research topic of HIV/AIDS positive related study.

## **CENTRAL OBJECTIVES:**

Make the care givers acquire knowledge and attitude regarding Quality Of Life of CLHIV positive Children.” A study to assess the effectiveness of video teaching modules regarding knowledge and attitude of mothers of HIV positive Children towards the Quality Of Life at Anti-Retro Viral Treatment Centre, Institute Of Child Health and Hospital For Children,” Egmore. Chennai-08. We develop positive attitudes while applying their day to day activity of child health care during my study and help them to lead near normal capacity of HIV/AIDS related study.

## **CONTRIBUTORY OBJECTIVES:**

After the end of this session the care givers of CLHIV Positive children will be able to

1. define the terms of HIV/AIDS.
2. state the various causes of HIV/AIDS.
3. brief the mode of transmission of HIV/AIDS.
4. enumerate the clinical features of HIV/AIDS.
5. explain about the prevention of HIV/AIDS.
6. list out complications of HIV/AIDS.
7. discuss various national programme for HIV/AIDS .
8. describe various components improving quality of life for HIV/AIDS positive children.

S.N O	TIME	CONTRIBUTORY OBJECTIVES	CONTENT	STUDENT'S ACTIVITY	CARE GIVER'S ACTIVITY	AUDIO VISUAL AIDS
1.	5mts	define the terms of HIV/AIDS.	<p align="center"><b>Human immunodeficiency virus:</b></p> <p>Human immunodeficiency virus; a retrovirus that causes AIDS by infecting helper t cells of the immune system. The most common stereotypic, HIV-1, is distributed worldwide, while HIV-2 is primarily confined to West Africa. Also called AIDS virus, human t-cell leukaemia virus type III, human t-cell lymphotropic virus type III, the lymphadenopathy-associated virus.</p> <p><b>Infection:</b> The invasion of the body of a human or an animal by a pathogen such as a bacterium, fungus, or virus. Infections can be localized, as in <b>pharyngitis</b>, or widespread as in <b>sepsis</b>, and are often accompanied by fever and an increased number of white blood cells. Individuals with <b>immunodeficiency</b> syndromes are predisposed to certain infections.</p>	Explaining.	Listening.	Chart.

S.No	Time	Contributory Objectives	Content	Student's Activity	Care Giver's activity	Audio Visual Aids
2.	5mts	State the Causes of HIV/AIDS.	<p><b>CAUSES OF HIV/AIDS.</b></p> <p>Human Immunodeficiency Virus.</p>	Explaining	Listening	Chart.

S.No	Time	Contributory Objectives	Content	Student's Activity	Care Giver's activity	Audio Visual Aids
3.	5mts	brief the mode of transmission of HIV/AIDS.	<p style="text-align: center;"><b>TRANSMISSION OF HIV/AIDS.</b></p> <ol style="list-style-type: none"> <li>1. Unsafe sexual contact.</li> <li>2. Unscreened blood transfusion.</li> <li>3. Needle stick injury.</li> <li>4. Placental transmission.</li> <li>5. Contact with body fluids and infected secreted.</li> <li>6. Breast feeding.</li> </ol>	Explaining.	Listening	Chart.

S.No	Time	Contributory Objectives	Content	Student's Activity	Care Giver's activity	Audio Visual Aids
4.	5mts	Enumerate the clinical features of HIV/AIDS	<p style="text-align: center;"><b>CLINICAL FEATURES OF HIV/AIDS POSITIVE CHILDREN.</b></p> <ol style="list-style-type: none"> <li>1. Lymphadenopathy,</li> <li>2. Hepatosplenomegaly,</li> <li>3. Failure to thrive,</li> <li>4. Chronic or recurrent diarrhoea,</li> <li>5. Interstitial pneumonia and oral thrush.</li> <li>6. Muscle wasting.</li> <li>7. Severe malnutrition,</li> <li>8. Recurrent bacterial infections,</li> <li>9. Chronic parotid swelling,</li> <li><b>10.</b>Lymphocytic interstitial pneumonia and neurological deterioration.</li> <li><b>11.</b>Kaposi's sarcoma.</li> </ol>	Explaining.	Listening.	Video module.

S.No	Time	Contributory Objectives	Content	Student's Activity	Care Giver's activity	Audio Visual Aids
5..	5mts	explain about the prevention of HIV/AIDS.	<p><b>PREVENTION OF HIV/AIDS TRANSMISSION</b></p> <ol style="list-style-type: none"> <li>1. Antiretroviral prophylaxis during pregnancy and labour and to the newborn period.</li> <li>2. Elective caesarean delivery prior to the onset of labour and rupture of membrane.</li> <li>3. Complete avoidance of breastfeeding.</li> <li>4. Avoidance of Unsafe sexual contact, Unscreened blood transfusion and contact with body fluids and secretion of infected secretion.</li> <li>5. Antiretroviral prophylaxis for needle stick injuries.</li> </ol>	Explaining.	Listening.	Chart.

S.No	Time	Contributory Objectives	Content	Student's Activity	Care Giver's activity	Audio Visual Aids
6.	5mts	list out complications of HIV/AIDS.	<p><b>COMPLICATIONS OF HIV/AIDS.</b></p> <ol style="list-style-type: none"> <li>1. Kaposi sarcoma.</li> <li>2. Failure to thrive.</li> <li>3. Malnutrition.</li> <li>4. Altered brain sensorium.</li> <li>5. Chronic diarrhea.</li> <li>6. Tuberculosis .</li> <li>7. Pneumonia.</li> </ol>	Explaining.	Listening.	Chart.

S.No	Time	Contributory Objectives	Content	Student's Activity	Care Giver's activity	Audio Visual Aids
7.	5mts	discuss various national programme for HIV/AIDS.	<p><b>NATIONAL PROGRAMME FOR HIV/AIDS.</b></p> <ol style="list-style-type: none"> <li>1. National AIDS Control Society.</li> <li>2. Tamilnadu State AIDS Control Society.</li> <li>3. Self help groups.</li> <li>4. Learning disability programme.</li> <li>5. Free bus/train pass.</li> <li>6. Free medical treatment.</li> <li>7. National AIDS programme.</li> </ol>	Explaining.	Listening.	Chart.

S.No	Time	Contributory Objectives	Content	Student's Activity	Care Giver's activity	Audio Visual Aids
8.	5mts	describe various components improving quality of life for HIV/AIDS positive children.	<p style="text-align: center;"><b>COMPONENTS OF IMPROVING QUALITY OF LIFE FOR HIV/AIDS POSITIVE CHILDREN.</b></p> <ol style="list-style-type: none"> <li>1. General health perception.</li> <li>2. Physical resilience.</li> <li>3. Psychological well being.</li> <li>4. Social and role playing.</li> <li>5. Health educational aspect.</li> </ol>	Explaining.	Listening.	Chart.

**CONCLUSION:** Therefore, from this lesson plan the caregivers of CLHIV positive children knowledge and attitude were improved through the video teaching module towards Quality of Life. The caregivers learned many events from this lesson plan, such as general health perception, physical resilience, Psychological wellbeing, Social role playing Health Education aspects etc.

## ஆய்வு தகவல் தாள்

எச்.ஐ.வி/எய்ட்ஸ் பாதித்த குழந்தைகளின் வாழ்க்கைத்தரம் பற்றிய ஆய்வில் நலம் பேணிகளின் (பெற்றோர்கள் மற்றும் பாதுகாவலர்கள்) பொது அரிவு மற்றும் செயலாக்கத்திறனை சின்னத்திரை ஒளி, ஒலி, கானொலி மூலம் எச்.ஐ.வி/ எய்ட்ஸ் எதிர்-சிகிச்சை மையம், அரசு குழந்தைகள் நல மருத்துவமனை, எழும்பூர், சென்னை-8ன் ஆய்வுக் கட்டுரையின் தமிழாக்கம்.

### முன்னுரை

எச்.ஐ.வி/ எய்ட்ஸ் என்ற மிகக் கொடிய உயிர்க்கொல்லி நோயின் தாக்கத்தால் உலகம் சுழன்று கொண்டிருக்கும் வேலையில், குழந்தைகள் இந்த நோயால் பாதிக்கப்பட்டு, அவர்களின் வாழ்க்கைத்தரம் பற்றிய ஆய்வில் பல்வேறு நிலைகளில் ஆய்வினை மேற்கொண்டு அதற்கான பிரத்தியேக ஆய்வின் சுறுக்கத்தினை இங்கே காணலாம்.

### வரையறு

எச்.ஐ.வி/ எய்ட்ஸ் என்பது மனித நோய் எதிர்ப்பு சக்தியை அழிக்கும், ரிட்ரோ வைரஸ் என்னும் குடும்ப வகை கொடிய நுண் கிருமியால் ஏற்படுவது ஆகும். எச்.ஐ.வி. நோய் கிருமிகளால் ஏற்படும் பல நோய் தொகுதிகளின் கூட்டுமச் சேர்க்கையே எய்ட்ஸ் எனப்படும்.

### இது கீழ்க்கண்ட வகைகளில் பாவுகிறது

- ❖ பாதுகாப்பற்ற உடலுறவு.
- ❖ சரியாக சுத்தப்படுத்தப்படாத மற்றும் பதப்படுத்தப்படாத இரத்த ஏற்ற முறை.
- ❖ மருத்துவ பணியாளர்கள், பணியில் நோய் தொற்றால் பாதிக்கப்பட்ட நபரின் சிகிச்சையின்போது சிறு ஊசிகளோ (அ) அறுவை சிகிச்சை உபகரணங்களோ இவர்கள் மீது காயம் ஏற்படுத்தி நோய் தொற்றை உண்டாக்குதல்.
- ❖ தாய்-சேய் தொற்று மூலம்.
- ❖ எய்ட்ஸால் பாதிக்கப்பட்ட நபரின் உடல் திரவங்கள் மூலம்.
- ❖ தாய்ப்பால் கொடுக்கும்போதும் கூட பரவலாம்.

### **எச்.ஐ.வி/ எய்ட்ஸின் அறிகுறிகள்**

- ❖ கழுத்து மற்றும் இடைப்பகுதிகளில் நாள சுரப்பிகள் வீக்கம்.
- ❖ வயிற்று உறுப்புகள் வீக்கம்.
- ❖ சராசரி வளர்ச்சி தடுக்கப்படுதல்.
- ❖ நிமோனியா காய்ச்சல் மற்றும் வாய் கொப்புலம்.
- ❖ மிக மோசமான சத்துக்குறைவு நோய்.
- ❖ திரும்ப திரும்ப தொற்றும் பாக்டீரியா நோய்.
- ❖ உமிழ்நீர் சுரப்பி நோய்.
- ❖ காய்ச்சல்/ பசியின்மை/ வயிற்றுப்போக்கு/ இருமல்/ உடல் மெலிந்து போதல்.

### **எச்.ஐ.வி/ எய்ட்ஸ் நோயை எவ்வாறு தடுக்க முடியும்**

- ❖ பாதுகாப்பான உடலுறவு முறை.
- ❖ தாய்ப்பாலை அறவே தரக்கூடாது. நிறுத்துதல்.
- ❖ சுத்தம் செய்து/ முறையான பாதுகாக்கப்பட்ட இரத்தம் செலுத்துதல்.
- ❖ அறுவை சிகிச்சையின் மூலம் குழந்தை பிறப்பை ஊக்குவித்தல்.
- ❖ ஆரோக்கியமான உணவு/ நலக்கல்வி மூலம்.

### **நலக்கல்வி கீழ்க்கண்ட பாகங்களால் பிரிக்கப்பட்டு**

#### **வழங்கப்பட்டது**

- ❖ பொது நல நிலை.
- ❖ உடல் நலத்தில் ஏற்படும் மாற்றம்.
- ❖ மன நலம் சாந்தம் சம்பந்தமாக.
- ❖ சமூக நலம் மற்றும் சமூக அங்கம்.
- ❖ பொது நலக்கல்வி அடிப்படையில் சின்னத்திரை குறும்பட நிகழ்வு மூலம் காண்பித்தல்.

### **தேசிய சமூக பாதுகாப்பு நிகழ்வு மற்றும் அரவணைப்பு**

- ❖ தேசிய எய்ட்ஸ் தடுப்பு மையம்.
- ❖ தமிழ்நாடு எய்ட்ஸ் தடுப்பு/ கட்டுப்பாட்டு மையம்.
- ❖ சுய உதவிக்குழுக்கள்.
- ❖ இலவச/ தொடர்வண்டி/ பேருந்து பயண உதவி.
- ❖ இலவச மருத்துவ வசதி.
- ❖ தேசிய எய்ட்ஸ் நிகழ்வுகள்

# ஆராய்ச்சியின் கேள்விகள் மற்றும் விடைகள்

பகுதி.அ. குடும்ப நபர்களின் சமூக பொருளாதார தகவல்

## வடிவமைக்கப்பட்ட படிவம்

பரிசோதனை எண்.:

தேதி :

1) உடல்நலம் பேணி காப்பவர்கள்

அ) தாய்

ஆ) தந்தை

இ) சகோதரர்

ஈ) சகோதரிகள்

2) வயது

அ) <20 வரை

ஆ) 21-30 வரை

இ) 31-40 வரை

ஈ) 41-50வரை

3) இனம்

அ) ஆண்

ஆ) பெண்

4) மதம்

அ) இந்து

ஆ) முஸ்லிம்

இ) கிறிஸ்துவர்

ஈ) மற்றவை

5) கல்வித்தரம்

அ) முதல் நிலைக்கல்வி

ஆ) இரண்டாம் நிலை பள்ளிக் கல்வி

இ) பட்டப்படிப்பு

ஈ) பள்ளி செல்லாதவர்

- 6) வேலை
- அ) அரசுவேலை
- ஆ) தனியார்துறை
- இ) தினக்கூலி
- ஈ) வேலை இல்லாதவர்
- 7) மாத வருமானம்
- அ) 2000 - 3000 வரை
- ஆ) 4001 - 5000 வரை
- இ) 6001 - 7000 வரை
- ஈ) 8001 - 9000 வரை
- 8) குடும்ப வகை
- அ) கூட்டுக்குடும்பம்
- ஆ) தனிக்குடும்பம்
- இ) விரிவுபடுத்தப்பட்ட குடும்பம்
- 9) வசிக்கும் நிலை
- அ) கிராமபுற வாழுநர்
- ஆ) நகர்புற வாழுநர்
- இ) மாநகர வாழுநர்
- இ) மலைபுற வாழுநர்

## நோயாளியின் சமூக பொருளாதார தகவல்

- 1) இனம்
- அ) ஆண்
- ஆ) பெண்
- 2) வயது
- அ) 06-07 வயது வரை
- ஆ) 08-09 வயது வரை
- இ) 10-11 வயது வரை
- ஈ) 11-12 வயது வரை
- 3) மதம்
- அ) இந்து
- ஆ) கிருஸ்துவம்
- இ) முஸ்லிம்
- ஈ) மற்றவர்
- 4) கல்வி நிலை
- அ) குழந்தைக் கல்வி நிலை
- ஆ) முதல்நிலைக் கல்வி
- இ) நடுநிலைக் கல்வி
- ஈ) பள்ளிக்கு செல்லாதவர்
- 5) பிறந்த இடம்
- அ) கிராமப்புற வாழுநர்
- ஆ) நகர்புற வாழுநர்
- இ) மாநகர வாழுநர்
- இ) மலைப்புற வாழுநர்
- 6) பிறப்பு நிலை
- அ) தலைக்குழந்தை
- ஆ) இரண்டாம் குழந்தை
- இ) மூன்றாம் குழந்தை
- ஈ) அதற்கும் மேல்

## பகுதி 2: ஆய்வு 5 களங்களைக் கொண்டது

- களம் 1 : பொது உடல்நலம் குறித்த ஆய்வு  
- 10 வினாக்களைக் கொண்டது
- களம் 2 : உடல்நீதியான செயல்பாடுகள் குறித்த ஆய்வு  
- 10 வினாக்களைக் கொண்டது
- களம் 3 : மனநிலை நீதியான ஆய்வு  
- 10 வினாக்களைக் கொண்டது
- களம் 4 : சமூக உறவு முறை மற்றும் சுற்றுப்புற ஆய்வு குறித்து  
- 10 வினாக்களைக் கொண்டது
- களம் 5 : நலக்கல்வி மற்றும் கருத்துக்கள் பற்றிய ஆய்வு  
- 10 வினாக்களைக் கொண்டது

## களம்-1

**பொதுவான உடல்நலம் குறித்து ஆய்வு  
இவை 10 எண்ணிக்கையிலான கேள்விகளைக் கொண்டது.**

வ. எண்	பொருள்கள்	நிச்சியமாக உடன்பாடில்லை	உடன் பாடில்லை	உறுதிபில்லை	ஒத்து போகிறேன்	நிச்சியமாக ஒத்து போகிறேன்
		1	2	3	4	5
1.	எச்.ஐ.வி/ எய்ட்ஸ் என்பது மிகக் கடுமையான நோய் என்பதாக கருதப்படுகிறது					
2.	எச்.ஐ.வி/எய்ட்ஸ் என்பது பில்லி சூனியம்/ கடவுளின் தண்டனையாக கருதப்படுகிறது					
3.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எப்பொழுதும் இக்கட்டான சூழ்நிலைகளில் நிலவுகிறார்கள்					
4.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் தனிமைப்படுத்தப்படுவார்கள்					
5.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் தொடக்காதவர்களாக காணப்படுகிறார்கள்					
6.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் அனைத்து தேவைகளுக்கும் அடுத்தவரையே சார்ந்திருக்கும் சூழ்நிலை உருவாகிறது					
7.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எப்பொழுதும் உடல் ரீதியாக பலவீனமாக இருப்பார்கள்					
8.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் அதிக உடல் கட்டுப்பாட்டுடன் இருக்கப்படவேண்டும்					
9.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் தினசரி செயல் பாடுகள் குறைக்கப்படுகிறது					
10.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் அதிக வேலைதிறனை ஏற்றுக் கொள்வார்கள்					

களம்-2

உடல்தீயான செயல்பாடுகள் குறித்த ஆய்வு  
இவை 10 எண்ணிக்கையிலான கேள்விகளைக் கொண்டது.

வ. எண்	பொருள்கள்	நிச்சியமாக உடன்பாடில்லை	உடன் பாடில்லை	உறுதியில்லை	ஒத்து போகிறேன்	நிச்சியமாக ஒத்து போகிறேன்
		1	2	3	4	5
11.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் வலி மற்றும் அசோகாரியமான சூழ்நிலையில் நிலவுவார்கள்					
12.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் உடல் சம்பந்தமான செயல்பாடுகளில் குறைந்தவர்களாக இருப்பார்கள்					
13.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் வாழ்க்கைத்தரம் குறைந்து காணப்படுகிறது					
14.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் மிக குறைந்த செயல்பாடுகள் உள்ளவர்கள்					
15.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எப்பொழுதும் பசி உள்ளவர்களாக இருப்பார்கள்					
16.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் உடல் எடையில் குறைந்த நிலையில் உள்ளவர்கள்					
17.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் தினசரி வேலைகளில் அதிக கவனம் செலுத்துவதில் விருப்பம் இல்லாதவர்கள்					
18.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் தினசரி தன் உடல் பராமரிப்புகளில் மிக குறைந்த அளவே பராமரிக்கப்படுகிறார்கள்					
19.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் அதிக தோல், வாந்தி, குடல் தொற்றுக்கு ஆளாக்கப்படுகிறார்கள்					
20.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எளிதாக மற்றத் தொற்றுக்களுக்கு ஆளாக்கப்படுகிறார்கள்.					

களம்-3

மனரீதியான செயல்பாடுகள் குறித்த ஆய்வு  
இவை 10 எண்ணிக்கையிலான கேள்விகளைக் கொண்டது.

வ. எண்	பொருள்கள்	நிச்சியமாக உடன்பாடில்லை	உடன் பாடில்லை	உறுதியில்லை	ஒத்து போகிறேன்	நிச்சியமாக ஒத்து போகிறேன்
		1	2	3	4	5
21.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகளின் மனசாந்தம் குறைக்கப்படுகிறது.					
22.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எதிர்மற்றும் நேர் மறை சவுகரியங்களை கொண்டவர்கள்					
23.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் அதிகமனத் திறன் கொண்டவர்களாக ஆக்கப்படுகிறார்கள்.					
24.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் உடலரீதியான பாதிப்பினை மனதளவில் உணருகிறார்கள்					
25.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் கடவுள் நம்பிக்கை அதிகம் கொண்டவர்களாக இருப்பார்கள்					
26.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எப்பொழுதும் மனஅழுத்தம் கொண்டவர்களாக இருப்பார்கள்					
27.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் உணக்கப்படுத்துதலுக்கு மிகவும் பொருத்தமாக இருப்பார்கள்					
28.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் இயல்பாகவே அடுத்தவர்களின் நம்பிக்கையை சார்ந்தவர்களாக இருப்பார்கள்					
29.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எளிதாக மற்ற விஷயங்களில் திசைதிருப்ப இயலும்					
30.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் அடுத்தவருடன் எளிதாக பழகுகூடியவர்கள்					

களம்-4

சமூக உறவுமுறை மற்றும் சுற்றுப்புறத்தை பற்றிய ஆய்வு  
இவை 10 எண்ணிக்கையிலான கேள்விகளைக் கொண்டது.

வ. எண்	பொருள்கள்	நிச்சியமாக உடன்பாடில்லை	உடன் பாடில்லை	உறுதியில்லை	ஒத்து போகிறேன்	நிச்சியமாக ஒத்து போகிறேன்
		1	2	3	4	5
31.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் சமூகத்தில் நல்ல நிலையில் இருக்கிறார்கள்.					
32.	எச்.ஐ.வி/எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகள் எளிதாக அணுகக்கூடியவர்கள்.					
33.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் எப்பொழுதும் வலுவான குடும்பம் மற்றும் சமூக பராமரிப்பை பெறுவார்கள்					
34.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் மற்றக் குழந்தைகளுடன் நன்றாக பழக வாய்ப்பு வழங்கப்படுகிறது.					
35.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகளுக்கு ஆரோக்கியமான குடும்ப சூழ்நிலை ஏற்படுகிறது.					
36.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் உடம்பு பாதுகாப்பு சம்பந்தமான அடிப்படை உரிமைகள் முறையாக வழங்கப்படுகிறது.					
37.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகளுக்கு பொதுநலம் மற்றும் சமூக நலம் மிகவும் அவசியமானது.					
38.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் பயன்படுத்திய பாத்திரங்கள்/எழுதுப்பொருட்கள் மற்றவர்கள் பயன்படுத்தலாம்					
39.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் சமூகத்தை பாதிக்கும் சூழ்நிலை பொதுவானது					
40.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் வாழ்க்கை தரம் மிகவும் எளிதானது.					

களம்-5

எய்ட்ஸ் நலக்கல்வி பற்றிய கருத்துக்கள் மற்றும் ஆய்வு  
இவை 10 எண்ணிக்கையிலான கேள்விகளைக் கொண்டது.

வ. எண்	பொருள்கள்	நிச்சியமாக உடன்பாடில்லை	உடன் பாடில்லை	உறுதியில்லை	ஒத்து போகிறேன்	நிச்சியமாக ஒத்து போகிறேன்
		1	2	3	4	5
41.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகளுக்கு நலக்கல்வி உடல்நல தாக்கத்தை ஏற்படுத்துகிறது.					
42.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகளை நலக்கல்விமூலம் உற்சாகம் ஊட்டமுடியும்					
43.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகளுக்கு களப்பணியாளர்கள் மூலம் வழங்கப்படும் நலக்கல்வி எய்ட்ஸ் பற்றிய விழிப்புணர்வு திறம்பட ஏற்படுத்துகிறது.					
44.	எச்.ஐ.வி/எய்ட்ஸ் விழிப்புணர்வு நலக்கல்வி மூலம் வாழ்க்கை தரம் தரமானதாக உருவாகப்படுகிறது.					
45.	எச்.ஐ.வி/எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகள் மற்ற குழந்தைகளுடன் சேர்ந்து பள்ளியில் படிக்கிறார்கள்.					
46.	எச்.ஐ.வி/எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகள் நலக்கல்வி மூலம் உடலை பராமரித்துக் கொள்ள பயன்படுகிறது.					
47.	எச்.ஐ.வி/எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகளின் மேல்படிப்பு பாதிக்காமல் பேணிபாதுகாக்கப் படுகிறது.					
48.	எச்.ஐ.வி/எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகளுக்கு நலக்கல்வி என்பது நிலையான அளவுகோலாகும்.					
49.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகள் மற்ற குழந்தைகளுடன் நல்ல ஆரோக்கியமான உறவுமுறைகள் ஏற்பட நலக்கல்வி உதவுகிறது.					
50.	எச்.ஐ.வி/எய்ட்ஸ் குழந்தைகளுக்கு பொதுக் கல்வி வழங்குவதன்மூலம் வாழ்க்கைதரம் மேம்படுகிறது.					



## EVALUATION CHECKLIST FOR THE VALIDATION OF TOOL

**Name of the expert:**

**Designation:**

**Name of the institution:**

Kindly go through the tool and give your valuable opinion on the criteria table. If the tool is not meeting the criteria, please give your valuable suggestions in the remarks column.

S.No	CRITERIA	MODIFICATIONS	SUGGESTIONS
1.	Proforma for socio-demographic data		
2.	PART II: Likert scale		

  
Signature of the expert .

## ஆராய்ச்சி ஒப்புதல் படிவம்

### ஆராய்ச்சியின் தலைப்பு

“எய்ட்ஸ் நோய் எதிர் மருந்தகத்தில் சிகிச்சைக்காக வரும் குழந்தை நோயாளிகளின் பெற்றோர்களிடம், எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகளின் வாழ்க்கைத் தரத்தினை ஊடுகதிர் ஒளி பெருக்கியின் துணை கொண்டு ஆராய்தல்”

பெயர் : தேதி :  
வயது : உள் நோயாளி எண் :  
பால் : ஆராய்ச்சி சேர்க்கை எண் :

இந்த ஆராய்ச்சியின் விவரங்களும் அதன் நோக்கமும் முழுமையாக எனக்கு தெளிவாக விளக்கப்பட்டது.

எனக்கு விளக்கப்பட்ட விஷயங்களை புரிந்துகொண்டு நான் எனது சம்மதத்தை தெரிவிக்கிறேன்.

இந்த ஆராய்ச்சியில் பிறரின் நிர்பந்தமின்றி என் சொந்த விருப்பத்தின்பேரில் நான் பங்கு பெறுகின்றேன். இந்த ஆராய்ச்சியில் இருந்து நான் எந்நேரமும் பின் வாங்கலாம் என்பதையும் அதனால் எந்த பாதிப்பும் ஏற்படாது என்பதையும் நான் புரிந்துகொண்டேன்.

இந்த ஆராய்ச்சியினால் ஏற்படும் நன்மைகளை பற்றி தெளிவாக ஆராய்ச்சியாளர் மூலம் தெரிந்துகொண்டேன்.

நான் என்னுடைய சுய நினைவுடனும் மற்றும் முழு சுதந்திரத்துடனும் இந்த மருத்துவ ஆராய்ச்சியில் நான் மற்றும் எனது குழந்தையை சேர்த்துக்கொள்ள சம்மதிக்கிறேன்.

ஆராய்ச்சியாளர் கையொப்பம்

பங்கேற்பாளர் கையொப்பம்/  
பெற்றோர் கையொப்பம்

நாள் :  
இடம் :

## ஆய்வு தகவல் தாள்

பங்கேற்பாளர் பெயர் :

ஆராய்ச்சியாளர் பெயர் : இரா.ஜெயக்குமார்

ஆராய்ச்சி தலைப்பு : எய்ட்ஸ் நோய் எதிர் மருந்தகத்தில் சிகிச்சைக்காக வரும் குழந்தை நோயாளிகளின் பெற்றோர்களிடம், எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகளின் வாழ்க்கைத் தரத்தினை ஊடுகதிர் ஒளி பெருக்கியின் துணை கொண்டு ஆராய்தல்

இந்த ஆய்வு சென்னை அரசு குழந்தைகள் நல மருத்துவமனையின் புறநோயாளிகள் மற்றும் உள்நோயாளிகள் பிரிவில் மேற்கொள்ளப்பட உள்ளது.

நீங்கள் இந்த ஆய்வில் பங்கேற்க அழைக்கிறோம். நீங்கள் இந்த ஆய்வில் பங்கேற்கலாமா அல்லது வேண்டாமா? என்பதை முடிவு செய்ய இந்த ஆவணத்தில் உள்ள தகவல் உதவியாக இருக்கும். உங்களுக்கு ஏதேனும் சந்தேகம் இருந்தால் நீங்கள் எங்களிடம் வெளிப்படையாக கேட்கலாம்.

எங்களுடைய அடிப்படை தகுதிகளில் நீங்கள் திருப்தியாக இருப்பதால் உங்களை இந்த ஆய்வில் பங்கேற்க அழைக்கிறோம்.

### ஆய்வின் நோக்கம் மற்றும் செயல்பாடு

எய்ட்ஸ் நோய் எதிர் மருந்தகத்தில் சிகிச்சைக்காக வரும் குழந்தை நோயாளிகளின் பெற்றோர்களிடம், எய்ட்ஸ் பாதிக்கப்பட்ட குழந்தைகளின் வாழ்க்கைத் தரத்தினை ஊடுகதிர் ஒளி பெருக்கியின் துணை கொண்டு ஆராய்தல்.

இந்த ஆய்வில் உங்கள் பெயர், வயது, ஆண்டு வருமானம், கல்வித்தகுதி பரிந்துரைக்கப்பட்ட மருந்துகளின் பெயர், சிகிச்சை கால அளவு ஆகிய தகவல்களை பெற்றுக்கொள்வோம்.

சில தகவல்கள் உங்களிடம் பெறப்படும்.

உங்களுக்கு உங்களுடைய மருத்துவத் தகவலை இரகசியமாக வைக்க உரிமை உண்டு. நீங்கள் இந்த ஆய்வில் கையொப்பமிடுவதால் நீங்கள் உங்களுடைய தகவலை ஆய்வுக்குழு மற்றும் நிறுவனத்திடம் காட்ட வேண்டும். இந்த ஆராய்ச்சியின் தகவல்கள் விஞ்ஞான இதழ்கள் மற்றும் விஞ்ஞான கூடத்தில் வெளியிடப்பட்டாலும் உங்களுடைய அடையாளங்கள் காட்டப்படமாட்டாது.

ஆராய்ச்சியாளர் கையொப்பம்

பங்கேற்பாளர் /பாதுகாவலர்/

பெற்றோர் கையொப்பம்/

தேதி:

தேதி:

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ATTITUDE OF PARENTS (CARE GIVERS) OF CLHIV(CHILD  
LIVING WITH HUMAN IMMUNO DEFICIENCY VIRUS)TOWARDS  
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CENTER, INSTITUTE OF CHILD HEALTH AND HOSPITAL FOR  
CHILDREN EGMORE. CHENNAI-08”.**

Approved by the Dissertation committee on \_\_\_\_\_

**RESEARCH GUIDE**

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Principal,  
College of Nursing,  
Madras Medical College, Chennai -03.

**CLINICAL SPECIALITY GUIDE**

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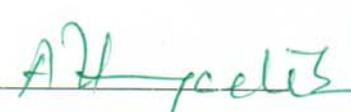
Senior Medical Officer,  
Pediatric centre of excellence.ARTCentre,  
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**STATISTICAL GUIDE**

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Lecturer in Statistics, Department of Statistics,  
Madras Medical College,  
Chennai -03.

  
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**Lecturer in Statistics**  
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**Chennai - 600 003.**

A Dissertation Submitted to  
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Chennai -32

In partial fulfillment of requirements for the degree of  
**MASTER OF SCIENCE IN NURSING**  
APRIL 2014

## CERTIFICATE OF CONTENT VALIDITY

This is to certify that a tool prepared by Mr. R.JAYAKUMAR, M.Sc. Nursing, II year of College of Nursing, Madras Medical College, undertaking a research study on, **Study To Assess The Effectiveness Of Video Teaching modules regarding knowledge And Attitude Of Mothers Of Human Immune Virus Positive Infected Children Towards The Quality Of Life In Anti- Retro Viral Treatment Center, Institute Of Child Health And Hospital For Children Egmore. Chennai-8**". Has been validated by me and is found to be valid and up to date and she can proceed with this tool to conduct the main study.

Signature :



Name :

ZEALOUS MARY. C

Designation :

READER

Date :

16.08.13

Place :

Seal :



**INSTITUTIONAL ETHICS COMMITTEE**  
**MADRAS MEDICAL COLLEGE, CHENNAI -3**

EC RegNo.ECR/270/Inst./TN/2013

Telephone No : 044 25305301

Fax : 044 25363970

**CERTIFICATE OF APPROVAL**

To

R.Jayakumar,

M.Sc.,(N) II year,

College of Nursing,

Madras Medical College, Chennai-3.

Dear Jayakumar

The Institutional Ethics committee of Madras Medical College, reviewed and discussed your application for approval of the proposal entitled "A study to assess the effectiveness of video-teaching module regarding knowledge and attitude of mothers of human immune deficiency virus positive infected children towards the quality of life in ART centre, at Institute of Child Health, Egmore, Chennai-8." No.10072013.

The following members of Ethics Committee were present in the meeting held on 06.07.2013 conducted at Madras Medical College, Chennai -3.

- |  |                     |
|--|---------------------|
| 1. Dr.G.SivaKumar, MS FICS FAIS  | --- Chairperson     |
| 2. Prof. R. Nandhini MD<br>Director, Instt. of Pharmacology ,MMC, Ch-3         | -- Member Secretary |
| 3. Prof. Shyamraj MD<br>Director i/c , Instt. of Biochemistry , MMC, Ch-3      | -- Member           |
| 4. Prof. P. Karkuzhali. MD<br>Prof., Instt. of Pathology, MMC, Ch-3            | -- Member           |
| 5. Prof. Kalai Selvi<br>Prof of Pharmacology, MMC, Ch-3                        | -- Member           |
| 6. Prof. Siva Subramanian,<br>Director, Instt. of Internal Medicine, MMC, Ch-3 | -- Member           |
| 7. Thiru. S. Govindsamy. BABL  | -- Lawyer           |
| 8. Tmt. Arnold Saulina MA MSW  | -- Social Scientist |

We approve the proposal to be conducted in its presented form.

Sd/ Chairman & Other Members

The Institutional Ethics Committee expects to be informed about the progress of the study, and SAE occurring in the course of the study, any changes in the protocol and patients information / informed consent and asks to be provided a copy of the final report.

*R Nandini*

Member Secretary, Ethics Committee





## TAMILNADU STATE AIDS CONTROL SOCIETY

417, Pantheon Road, Egmore, Chennai - 600 008.  
Ph : 044-2819 0467, 2819 0891 Fax No. : 91-044-2819 0465  
E-mail : tnsacs@gmail.com  
Website : www.tansacs.in; www.tansacsmis.org

Lr Ref.No. 008045/CST/2009 dated 29.08.2013

To,

✓ Thiru.R.Jayakumar,  
M.Sc(N) II year  
College of Nursing  
Madras Medical College  
Chennai - 600 003  
Dear Sir / Madam,

**Sub:** Permission to Conduct Research Work- Regarding  
**Ref:** Letter from Mr.R.Jayakumar , College of Nursing , MMC, Chennai - 3

### Greetings from TANSACS,

With reference to above cited letter, we wish to inform that you are permitted to conduct the research work on the topic entitled " **A Study to assess the effectiveness of video teaching module regarding knowledge and attitude of mothers of human immunodeficiency virus positive children towards the quality of life in ART Centre, at ICH, Egmore, Chennai.**" and to work in ART Centre, ICH, Egmore , Chennai with the following condition without any financial loss to the Government.

- 1) All the results of the study to be shared with TANSACS and it should not be published or shared with any other without prior permission of TANSACS.
- 2) This study should not affect the routine activities of the ART Centre.
- 3) Confidentiality of the patients to be maintained and the data collected is to be used only for study purpose and it should not disturb the study samples.
- 4) Participants for the study should be chosen based on his /mother willingness and only after getting informed consent from the study subjects/mothers.
- 5) Any harmful /invasive Procedure to the patient to be avoided.
- 6) Before data collection , the video teaching module has to be submitted to TANSACS
- 7) The TANSACS will not support financially to conduct the study.

BSK  
02/09/13  
For Project Director

Copy to,  
The Director,  
Regional Paediatric ART Centre, ICH & HC,  
Institute of Child Health and Govt.Hospital for Children,  
Halls Road, Egmore, Chennai - 600 008

The Nodal Officer & Medical officer,  
Regional Paediatric ART Centre, ICH & HC, Institute of Child Health and Govt.Hospital for  
Children, Halls Road,  
Egmore, Chennai - 600 008

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Signature :



Name :

**DR. E. SURESH, M.B.B.S. DCH.,  
SENIOR ART MEDICAL OFFICER,  
INSTITUTE OF CHILD HEALTH &  
HOSPITAL FOR CHILDREN**

Designation :

**EGMORE.**

Date :

Place :

Seal :

## EVALUATION CHECKLIST FOR THE VALIDATION OF TOOL

**None of the expert:**

**Designation:**

**Name of the institution:**

Kindly go through the tool and give your valuable opinion on the criteria table. If the tool is not meeting the criteria, please give your valuable suggestions in the remarks column.

S.No	CRITERIA	MODIFICATIONS	SUGGESTIONS
1.	Proforma for socio-demographic data		
2.	PART II: Lickert scale		



Signature of the expert

DR. E. SURESH, M.B.B.S., DCH.,  
SENIOR ART MEDICAL OFFICER,  
INSTITUTE OF CHILD HEALTH &  
HOSPITAL FOR CHILDREN  
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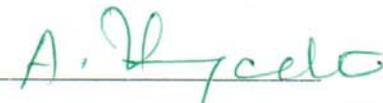
**STATISTICAL GUIDE**

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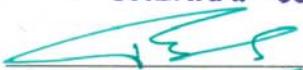
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