RESEARCH ARTICLE

EVALUATE THE EFFECTIVENESS OF STRUCTURED INSTRUCTIONAL MODULE ON KNOWLEDGE REGARDING FIRST AID MANAGEMENT OF SELECTED EMERGENCIES AMONG ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHES) IN SELECTED RURAL AREAS OF PHC, BIDADI."

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Manuscript Info

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Abstract

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First aid management of selected emergencies is a discipline with a broad scope involving many specialized fields in its most general sense**.**According to the Biomedical report, unintentional injury caused 648 000 deaths (7% of all deaths; 58/100 000 population). SinceFirst aid personnel is persons on the spot, generally, peripheral health workers who are familiar with the specific conditions of work and who might not be medically qualified but must be trained and prepared to perform particular tasks. Hence creating awareness in the prevention of emergencies is very important. First aid personnel should be selected carefully, taking into account attributes such as reliability, motivation, and the ability to cope with people and availability in a crisis situation.[5] Present study attempts to evaluate the effectiveness of structured instructional module on Knowledge regarding first aid management of selected emergencies among Accredited social health activists(ASHAs) at selected rural areas of PHC, Bidadi.

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Introduction:-
The Goal Of First Aid Is To Save Life, Prevent An Injury Or Illness From Worsening Or To Help Speedy Recovery. Without Any Delay As a First Aid Save Persons Life So It Is Always Better As It Is Said That Preparedness Is a Key Element Of First Aid.

"Timelyfirstaidsavesmorelivesthanheroicsurgeries."

Injuries are very common now a day and can occur at any point of timein our day to day life.[1] First aid is the immediate care given to a person who has beeninjured or suddenly fallen ill. It includes self-help and home care if medical assistanceis not available or is delayed. It also includes well-selected words of encouragement,evidence of willingness to help, and promotion of confidence by demonstration ofcompetence.

First aid is not only just about helping crash victims at the roadside.Butalsocalminganinjuredpersonorasprofoundassavingalife.Certainselflimitingillnessesorminorinjuriesmaynot requirefurthermedicalcareimmediatelyif first aid is given. It aims to preserve and protect life, prevent further injury ordeterioration of illness and help to promote recovery. The internationally acceptedsymbol for first aid is the white cross on a green background, **St John Ambulance2008.**

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TheNationalFirstaidScienceAdvisoryBoarddefinedFirstaidas" assessments and interventions that can be performed by a bystander (or by thepatient/victim) with minimal or no medical equipment. The board defined First aid providers"someonewithformaltraininginfirstaid,emergencycare,(or)medicinewhoprovidesfirst aid.

First aid personnel are persons on the spot, generally health workerswhoarefamiliarwiththespecificconditionsofwork,andwhomightnotbe medically qualified but must be trained and prepared to perform very specific tasks.Not every worker is suitable to be trained for providing first aid. First aid personnelshouldbeselectedcarefully,takingintoaccountattributessuchasreliability,motivationandthe abilitytocope with peopleandavailability inacrisissituation.

Firstaidtrainingnotonlyprovideswithknowledgeandskilltogivelife support and other emergency care but also helps you to develop safety awarenessand habits that promote safety at home, at work, during recreation, and on the streetsand highways. In the promotion of safety awareness, it is important to closely relatethree terms: cause,effect, andprevention.

The goal of first aid is to save life, prevent an injury or illness fromworsening or to help speedy recovery. Without any delay as a first aid save personslifesoitisalwaysbetter asitissaidthatPreparednessisa keyelementoffirst aid.

T. K. Indianian said that in most of the cases, the complications of theinjuries and fractures can be reduced by proper application of the first aid in propertime. Lacking of the first aid management at the accidental scene leads to majorcomplications, disability or even death. By considering the importance of first aid it isimperative that every person should be capable of rendering first aid to sick andinjuredpersontillthepatientreaches inthe safe handsofspecificmedicalpersonal.

First aid is the initial care that is given to the victim arise at a healthcare centre, before medically trained personnel arrived or before the victim arrives ata health care center. It is estimated that 50% of death occurs within the 1st hour ofaccident, 30% between 1hr. anda week.And20%occurafter1stweek.The"golden hour" and platinum hour highlight the importance early trauma care Important factorresponsible for increasing secondary injuries and complication are non   available offirstaid.Delayintransferfrominjurysidetoahospital,lackofdefinitivetreatmentinfirstaidcontact.Hospitals,absence oftriage andexternalmedicolegal problem.

It'stheknownfactthatCommunityHealthWorkers(CHWs)provide a critical and essential link with health systems and are a powerful force forpromoting healthy behaviors in resource-constrained settings. During the past decade,there has been an explosion of evidence and interest concerning community healthworkers and their potential for improving the health of populations where healthworkforce resources are limited. Given the massive shortage of training the healthworkersin AfricaandAsia– recentlyestimated.

As such it is the newer concept that Government of India trainingASHAswhoarethemajorlinkbetweentheruralpeopleandhealthservices.ASHAis a resident woman of the village with formal education at least up to the 8th standard.She is selected by the Gramasabha and is accountable to village Panchayath, thegeneral norm of selection is one ASHA per 1000 population. ASHA will be helpingout rural peoplein their health matters. They provide serviceat the point of care,oftenin thepatient's homeandattheplaceofemergenciesinthe community.Training them in the first aid could really help to save many lives in emergencycondition.

Needfor Study.
Most of us don't think about the value of first aid until we need it.Many of its basic skills can be mastered without attending a formal training course.Medical emergencies are bound to happen, the best thing we can do is to be preparedandknowabouthowto givefirst aid.

Our environment is full of accidents, emergency illnesses and otherhealth problems that have different level of severity and magnitude. The problems canbe generally classified into two. These are accidents (deliberate and incidental) andemergency illnesses. The consequences of these health problems could end up inphysicaldisabilityanddeath.However,thephysicaldisabilityordeathcanbesignificantly reduced and/or prevented by first-aid treatment using locally availablematerials.

In healthcare, we know that properly administered first aid could saves person's life, which makes the importance of learning first aid and to choose the correct and authorized first aid training.The main aim to give first aid is to save life,to prevent deterioration of the condition and further injury, to prevent conditions thatmight increase the original injury, to make the victims as comfortable as possible, toarrange for transportation to the hospital. To preserve the valuable life of victim'sundergoneemergencysituations,theblossomsoffutureshouldhaveproperawarenessregarding thefirst aid management.

In response to the Health and Safety (First Aid) Regulations 1981,guidancefromtheHealthandSafetyExecutiveintheApprovedCodeofPractice 'First Aid at Work', amended 1997 and advice from the Department for Education andSkills, the Department has issued a detailed policy and guidance to all establishments.It is recognized that there is a need in educational establishments to provide facilitiesand arrangements for first aid when an accident occurs.First aid is a vital part ofeveryestablishment'sprovisionforhealthandsafety.TheaimistoclarifytheDepartment's policy on the standard and level of first aid provision in schools and to provide guidance for managers to assist them when assessing their needs. It is notpossible in most cases to determine precise requirements for first aid provision due tothewidenatureofestablishment types andactivity.

The Health and Safety Executive strongly recommends that it is goodpractice for first aides to undergo annual 'refresher' courses. It is important thatemployers make sure qualified first aides attend these courses to help maintain theirbasicskillsand keep up todatewithany changes to firstaid procedures.

AccordingtoOpenAccessArticle;Bio-med-central,reports that unintentional injury caused 648 000 deaths (7% of all deaths; 58/100 000 population).Unintentional injury mortality rates were higher among males than females, and inruralversusurbanareas.Roadtrafficinjuries(185000deaths;29%ofallunintentional injury deaths), falls (160 000 deaths, 25%) and drowning (73 000 deaths,11%) were the three leading causes of unintentional injury mortality, with fire-relatedinjury causing 5% of these deaths. The highest unintentional mortality rates were inthoseaged70yearsorolder(410/100000).

According to ministry of Road transport and highways New Delhi,AllIndiaaccidentaldeathratewas30%whereasinKarnatakaitis39%.Unnatural accident rate in India was 36.3% whereas in Karnataka it is 43.2%.The unnaturalaccidentsincluderoadandrailaccidents,poisoning,drowning,fire,falls,andelectrocution etc.

WHO (2004) reported that the global injury mortality rate is estimatedto be 98/100,000 population, with male and female rates of 128/100,000 (38 lakhdeaths) and 67/100,000 (19 lakh deaths), respectively. Five of the top ten causes ofdeathgloballyareduetoinjuries.Amongthetotal disability-adjusted-life-years(DALYs), 13% were due to injuries. Unintentional and intentional injuries contributed to three-fourth and one-fourth of total DALYs, respectively. Among unintentional injuries, road traffic injuries (RTIs), falls and burns resulted in, respectively, 29%,12%and 9%oftotal DALYs.

According to **National Crime Record Bureau NCRB (2007)** in India injuries were the leading cause of death in the age group of 15–24 years (13,309;35%), second leading cause of death in 5–14 years (3003; 16.2%). Like any other health problem, injuries also have a definitive causative pattern and mechanism intermarriage(product/vehicle),host(human beings)and environmental(roads,homes, play grounds, workplaces) factors along with system-related issues. Every year, injuries contribute to a significant number of deaths, hospitalizations (for shorthand long periods), emergency care, disabilities (physical, social and psychological),amputations,disfigure-ment,pain,sufferingandagony.Manychildren become orphans,women become destituteandthe elderly grieveinsolation.
According to National Crime Record Bureau NCRB (2007)12inKarnataka, (2007) there were about 516 deaths and 13% had injuries. In the same oneyear period, 4,986 persons were brought to the hospitals in a ratio of 1: 25 for fatal tonon-fatal injuries. 10% of deaths and 20% of injuries occurred among children (< 15years), contributed for 6% deathsand 7%of injuries. Among children falls on roadandplay sites resultedin nonfatal injury.Morethan80%of fatalandnon-fatalinjuries occurred at home while playing in balconies, staircases, compounds and at theentrance of home. More than 50% of the fatal and the non-fatal cases had received some sort of first aid. Only 1%patients had been given first aid at the site of injury whereas majority of them were administered for first aid inthehospital.

A study was conducted on 'effect on training program regarding first aid management among residents' at Nepal .The objective of the study was to trainthem regarding first aid management of common problems requiring first aid

andevaluate the effectiveness of the program. The sample consists of 696 respondents where 60.5% males and 39.5% females. The result showed that the training program conducted was very effective. Majority of the subjects (87.2%) reported thatthetrainingprogramconductedwasveryuseful and12.8%reporteduseful**.**

The Survey conducted by G Gururaj on injuries and violence in India,facts and figures, NIMHANS Bangalore shows that in Bangalore 209 children below the age of 18 years died and 5,505 children brought to the hospital with injury.Majority of the children belonged to average socio economic house hold and were studying in schools. Nearly one fourth of the total death in children was due to roadtrafficaccidents.Thesewerefollowedbyburnswith17%andfallswith 13%.Drowning and poisoning accounts for 6% and 5% respectively. It is estimatedthat Bangalore witnesses an average of nearly 10,000 hospitalizations every year.Road traffic accidents were the leading cause of injury (40%).Falls are the secondcause with 19% of injuries. Animal bites, Poisoning, Burns and Assault accounts for11%,10%, 9%,and 6%respectively.

A study was conducted to evaluate the effect of previous training onfirst aid knowledge and skills of urban and rural Australians .30.4% of respondentshadcompletedaseniorfirstaidtraining.Trainedpersonsperformedbetterthanuntrained . But both trained and untrained demonstrated poor skills in performing firstaid . The study concludes that overall knowledge and skills by community is poor,butcanbeimproved by first aidtrainingcourses.

A descriptive study was conducted to estimate the incidence of minor injuries and to study the wound care practices of school children. A fortnightly followup of urban and rural high school children was done in Chandigarh and rural Haryana.Initialpointprevalencesurveywasfollowedbyfortnightlyfollowupsurveyinvolving interview for assessing incidence and wound care practices among students.The setting was government high schools of Chandigarh and rural Ambala. It wasfound that in average episodes of minor injuries per year, point prevalence was higher in urban area. First aid training of teachers or the students were lacking in both the areas. Many of the injuries occurred during the school time. Rural students were moretolerant to minor injuries. Itwas concluded that incidence of minor injuries washigherinruralareaascomparedtourbanarea.Trainingonwoundcareisrecommended.
ASHAwillbethefirstportofcallforanyhealthrelateddemandsofthe village people in general and deprived section of the population especially womenandchildrenin particularwhofind itdifficult access healthservices.

Since ASHA is the one who is selected from their own community shewill be available for the community at the crucial time. Thus its highly essential toimprovetheknowledgeofASHAregardingfirstaidmanagementofselectedemergencies . They will be acting like the first respondent for the life saving situation.So the investigator feel that it is necessary to impart knowledge to ASHA regardingselected first aid measures with the help of structured instructional module which helpthemtotakeappropriatefirstaid measuresinemergencies.

Objectives:-
This chapter deals with the statement of the research problem,objectives ofthe study,hypotheses, research variables made in the study,operational definitionsandconceptualframework.Objectivesaretheguidingforcesforaresearcherthroughout his or her study. Explicit descriptions of objectives are essential to come outwith themean meaningful search.

Thestatementof theproblemand theobjectivesfor thecurrentstudyare asfollows.

Statementoftheproblem:
"Evaluate The Effectiveness Of Structured Instructionalmodule On Knowledge Regarding First Aid Management Ofselectedemergenciesamongaccreditedsocialhealthactivists(Ashas)Inselectedruralareasofphc,Bidadi."

Objectivesofthestudy:-
1. To assess the existing knowledge ofAccredited Social Health Activists(ASHAs) regarding first aid managementofselectedemergencies .
2. To evaluate the effectiveness of structured instructional module on knowledge ofAccredited Social Health Activists(ASHAs)regarding first aid management ofselectedemergencies.
3. To find an association between post test level in knowledge of AccreditedSocialHealthActivists(ASHAs)regardingfirstaidmanagementofselectedemergencieswiththeir selectedsociodemographicvariables.

Hypotheses.
H1: TherewillbeasignificantdifferencebetweenthemeanpreandposttestknowledgescoresofASHAsregardingfirstaidmanagementofselectedemergencies..

H2: There will be a significant association between the post test level of knowledgescoresofASHAsregardingfirstaidmanagementofselectedemergenciesandselectedsocio-demographicvariables.

Researchvariables.
1. **Independentvariable:**Structuredinstructional module on first aid   management of selectedemergencies..
2. **Dependentvariable:** Knowledge   of ASHAs   on first   aid managementofselectedemergencies.
3. **Socio-demographicvariables   :** Age, Education, Family   income, Religion, Type of family, Marital status,workingexperience,sourceofinformation.

Operationaldefinitions.
Effectiveness:
ItreferstosignificantgaininknowledgeasdeterminedbythedifferenceinpreandpostknowledgescoresofASHAsregardingfirstaidmanagementofselected emergencies.

Structured instructional module:
It refers to systematically organized instructionalmoduleprepared by the investigator for ASHAs regarding first aid management ofselectedemergencies.

Knowledge:
It refers to correct responses of ASHAs to items included in structuredknowledge questionnaire regarding first aid management of selected emergencies asexpressedin terms ofscores.

Firstaid:
InthepresentstudyFirstaidrefersto, theimmediateandtemporarytreatment given to victim of sudden illness or injuries before the main treatment isstarted.

Selectedemergencies:
Inthepresentstudyselectedemergenciesincludesaccidents ,poisoning ,drowning ,burns, snake bite in selected rural areas of PHC,Bidadi.

Management :
In this study it refers to the first level care of selected emergencies byASHAsin theselectedruralareas ofPHC ,Bidadi.

ASHA:
A trained female community health activist under NRHM who is selectedfrom the same village and is accountable to it and work as the inter phase betweencommunityandpublichealth system.

Conceptualframework
Conceptual   framework   act   as   a   building   block   for   the   research   study. Theoverallpurposeofframeworkistomakescientificfindingsmeaningfulandgeneralized.Itprovidesacertainframeworkofreferenceforclinicalpractice,education and research. Frame work can guidethe researcher's undertaking of notonly 'What' of natural phenomena but also 'Why' of their occurrence. They also givedirectionforrelevantquestionto practicalproblem.

The   present   study   was   designed   to   evaluate   the   effectiveness   of   the StructuredInstructionalModuleonknowledgeregardingfirstaidmanagementofselectedemergenciesamong Accreditedsocialheathactivists(ASHAs).

TheconceptualframeworkselectedforthisstudywasbasedonmodifiedStufflebeam`s(1973)ContextInput Product Process (CIPP)model.Itisafourstepmodel   ofprogrammeevaluationdevelopedforobtaining   usefulinformation fortakingdecisions.Itinvolvesfourtypesofdecisions,namelyplanningdecisions,Structuringdecisions,   implementing

decisions   and   recycling   decisions.   It   provides acomprehensive, systematic, continuous and ongoing framework for the programme

Context evaluation:
In the present study, context evaluation refers to the planning decision by needassessment of knowledge regarding first aid management of selected emergenciesamong Accredited social heath activists(ASHAs) by reviewing related literature andusingstateand national statistics

Input evaluation:
Inthe present study,inputevaluationreferstostructuringdecisionsbydevelopment of structured knowledge questionnaire to collect data from samples andestablishing validity and reliability of the tool and developing Structured InstructionalModuleregarding first aid management of selected emergencies.

Process evaluation:
In the present study, it refers to implementation of decision by pre testing theknowledge of ASHAs regarding first aid management   by   using   structured knowledgequestionnaireandadministeringstructuredInstructionalModuletothem.Theenvironmentsetting wasselectedrural areasofPHC,Bidadi

Productevaluation:
Inthe   presentstudy,it   refers   to   recycling   the   decision   by   assessing   the posttestknowledgeofAccreditedsocialheathactivists(ASHAs)regardingfirstaidmanagementof selected emergencies by using structuredknowledgequestionnaireand administering Structured Instructional Module to them. The environment settingwasselected ruralareaofPHC,Bidadi.

If the Structured instructional module is ineffective, the decision needs to berecycled to make changes in response to the outcome of the programme. The contextevaluation needs to be retained based on changes. This area is not included in thestudy.

IncludedintheStudyNotincludedinthestudy

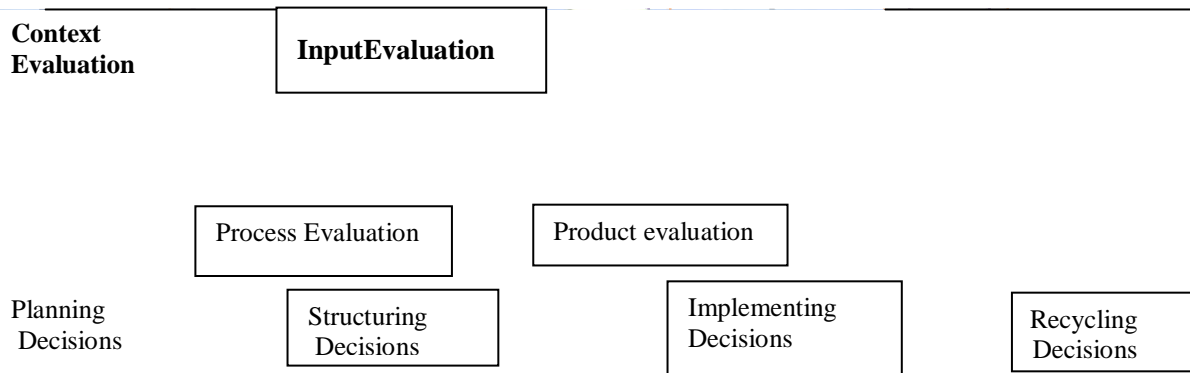|			
Context Evaluation	**InputEvaluation**		

	Process Evaluation	Product evaluation	
Planning Decisions	Structuring Decisions	Implementing Decisions	Recycling Decisions

Fig1:- ConceptualframeworkbasedonmodifiedStufflebeam'sCIPPModel (1973).

Methodology:-
A research methodology involves the systematic procedure by the researcherwhich starts from the initial identification of programme to its final conclusion. Thischapter deals with the type of research approach used, setting of the study, population,samplingtechnique,sampleselection,theinclusionandexclusioncriteria,development of the tool, collection of data, pilot study, procedure of data collectionandtheplan fordataanalysis.

ResearchApproach
The approach to research is the umbrella that covers the basic procedure forconducting research.The research approach helps the investigator to determine howto collect the data and analyze the data. In view to the nature of the problem selectedforthestudyandtheobjectivestobeaccomplished,evaluativeapproachwasconsideredas appropriate researchapproachforthe presentstudy.

### ResearchDesign
A researchers overall plan for obtaining answers to the research questions or fortesting the research hypotheses is the research design. The research design spells outthe basic strategies that the researcher adopts to develop information that is accurateand interpret-able.

For the present study, Pre-experimentalone group pre-test post-test designwas adopted. In this one group pre-test post-test design **(O1   X   O2)** the investigatorintroducedabasemeasurebeforeandafteraplannedexposurewhichisdepictedas**O1**and**O2**respectively.Inthepre

sentstudy,themeasurewastheknowledgeofAccredited social health activists(ASHAs) and independent variable is the StructuredInstructionalModule depicted as**X**.

The research design selected for the present study is Pre-experimental onegrouppre-test-post-testdesign,inwhichpre-testisconductedfollowedbyAdministration of Structured Instructional Module and then conducting post-test forthesamegroupafter7 days.
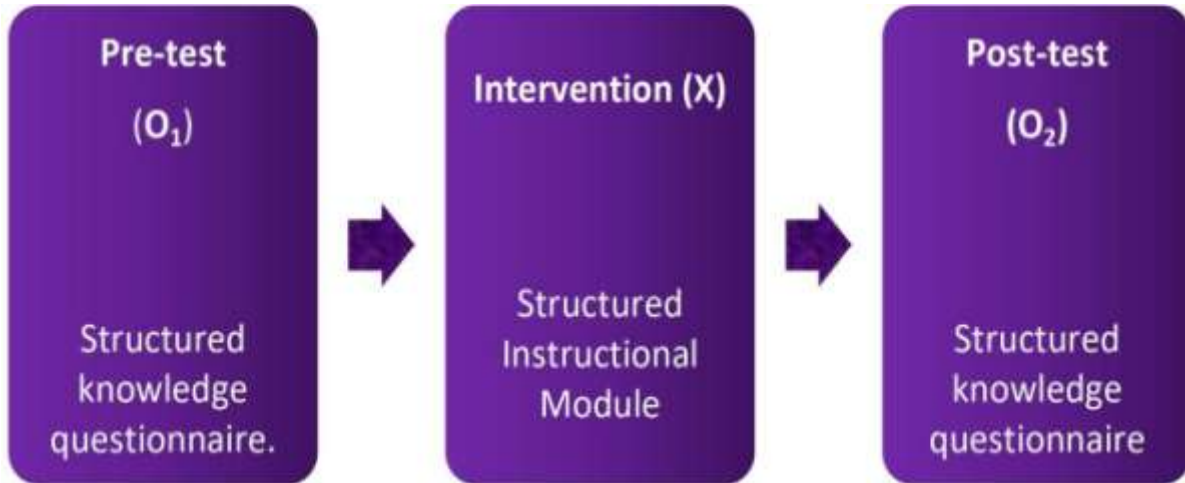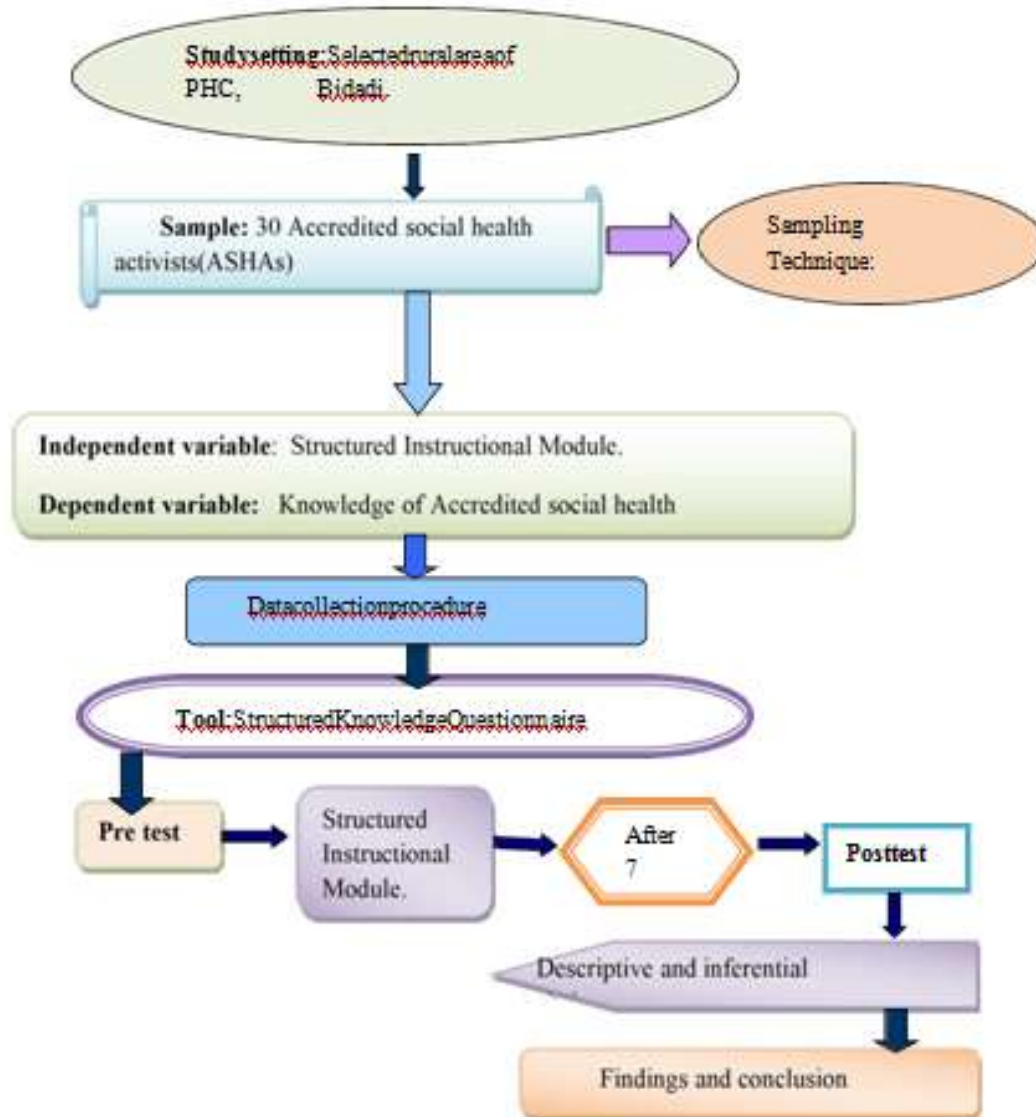
Figure3:- Schematicrepresentationofresearchplan.

Variablesunderstudy:
Variablesarequalities,properties,orcharacteristicsofperson,thingsorsituation that change or vary andtake on different quantitative values.[54] Three typesof variables were identified in this study. They are independent, dependent and Socio-demographic variables.

1. **IndependentVariable:**
Theindependentvariableisthevariablethatstandsaloneandnotdependenton any other. Itis the cause of action. In this study the Structured InstructionalModulewas thandependent variable.

2. **Dependent Variable:**
Dependent   variable   is   the   effect   of   the   action   of   independent   variable andcannotexistbyitself.KnowledgeofAccreditedsocialhealthactivists(ASHAs)regarding First aid management of selected emergencieswas the dependent variableinthis study.

3. **Socio-demographicVariables:**
The researchers make the attempt to study the sample characteristics and present themin research findings.These characteristics of the studysubjectsareconsideredassocio demographic variables. The Socio-demographic variables in this study wereAge, Education, Family income, Religion, Type of family, Marital status, workingexperience,sourceofinformation .

Settingofthestudy:
"Setting" refers to the area where the study is conducted. It is the physicallocation and condition in which data collection takes place in a study. This study was conducted at Rural areas of PHC , Bidadi (rural areas such as hejjala, byramangala,bidadigramantara, shanmangala.)

TargetPopulation
Populationisagroupwhosememberpossessesspecificattributesthataresearcherisinterestedtostudy.[61]Targetpopulationfor thepresentstudywereAccreditedsocialhealthactivists(ASHAs) ofselectedruralareasofPHC,Bidadi.

Sample
Sample refers to a sub set of population, selected to participate in theresearchstudy.ThesampleofthisstudywasAccreditedsocialhealthactivists(ASHAs)ofselectedruralareas ofPHC, Bidadi.

SampleSize:
The sample size was 30 Accredited social health activists(ASHAs) of selected ruralareasofPHC , Bidadi.

Sampling Technique:
Sampling refers to the process of selecting a portion of population to represent theentire population.[55] In this study Purposive sampling technique was used to select thesamplesfromtheaccessiblepopulation.Purposivesamplingtechniqueisatypeof nonprobabilitysamplingtechniqueinwhichsubjectsare chosen tobepartofthesamplewith aspecificpurposeinmind.

CriteriaforSelectionofSample
Inclusioncriteria   :   ASHAsthose whoare
Presentatthetimeofdata collection
Willingtoparticipate.
Workingtheselectedareas

Exclusioncriteria
SelectionandDevelopmentofTool
To meet the objectives of the study the tool was developed by the investigator.The tool used for the study comprised of a Structured Knowledge questionnaireandStructuredInstructionModuleonFirst aidmanagementamong ASHAs.

Selectionofthe Tool
TocollecttheaccuratedatafromthesamplesStructuredKnowledgequestionnairewas selected through literature search and in consultation with theresearch guide to assess the knowledge of ASHAs regarding First aid management ofselectedemergencies.

DevelopmentofTool
A Structured Knowledge questionnaire was developed by the investigator based on the research problem; review of related literature and with suggestions andguidancefromresearchguideand11expertsinthefieldofCommunityHealthNursing.   ASHASwhoare   : 1.Sickatthetime ofdata collection

Descriptionofthetool
TheStructured Knowledge questionnaireconsistsoftwosections.

Section I: It consists of items on Socio-demographic data which are 08 in numbersuch as Age, Education, Family income, Religion, Type of family, Marital status,workingexperience,sourceofinformation

Section II: It consists of 42 items, which has the structured knowledge questionnairewasdevelopedon 07 areassuch as;

PART A : Consists of 6 items regarding General information on First aid managementPARTB :Consistsof7items regarding First aid management ofBurns

PART C : Consists of 7 items regarding First aid management of PoisoningPART D : Consists of 5 items regarding First aid management of Snake bite.PART E: Consists of 7 items regarding First aid management of Drowning.PART F : Consists of 8 items regarding First aid management of RTA.PARTG: Consists of02questionsregardingFirst aid kit.

ScoringInterpretation:
Section IIhas a total of 42 questions, score of (one) 1 will be given for every correctresponse and score of zero (0) will be given for every wrong . The resulting score willbeinterpreted as follows
Adequately knowledge score: above 34(75-100 %)Moderately knowledge score: 22-33 (51-74 %)Inadequateknowledgescore   : below 21 (below 50 %)Minimum score   :00 MaximumScore   42

DevelopmentofSIM
TheSIMwasdevelopedonthebasisofresearchstudy,reviewofLiteratureandconsultingwithexperts.The   step followedtodevelopSIMwasas follows:
1. PreparationoffirstdraftofSIM
2. DevelopmentofcriteriachecklisttoevaluatetheSIM
3. ContentvalidityofSIM
4. PreparationoffinaldraftofSIMinKannadaandEnglishLanguages

Preparationof firstdraftofSIM
SIMwaspreparedonthebasisofresearchproblem,reviewofliterature,whichwaspertainingto   thefirstaid managementamong ASHAs.

DevelopmentofCriteriaChecklisttoevaluatetheSIM:

SelectionoftheContent
1. ThecontentofSIMonfirstaidmanagementwasselectedthroughliteraturesearchandinconsultationwiththeresearchguide. Thecontentwasanalyzed intosubtopics OrganizationoftheContent
2. Thecontent selected wasorganizedunderfollowingmainheadings.
3. Introduction
4. Goalofthemodule
5. DefinitionofFirstaid.
6. Aimsandprinciplesoffirstaid.
7. Stepsoffirstaid
8. Chapter1:Firstaidmanagementof Burns
9. Chapter2:Firstaidmanagementof Poisoning
10. Chapter3:Firstaidmanagementof snakebite
11. Chapter4:FirstaidmanagementofDrowning
12. Chapter5:FirstaidmanagementofRTA
13. ExplainsaboutFirstaidkit.

Conclusion:-
ContentValidityofSIM
The SIM was given to 11 experts in the field of Community Health Nursingalongwith thetool.Thesuggestionswerein corporate intheSIM.

Preparationof FinalDraftofSIMinKannadaandEnglishlanguages
The draft of SIM consisted of introduction, content and summary. Finally SIMwaspreparedandtitledas"StructuredInstructionalModuleregardingFirstaidmanagementofselectedemergenciesamongASHAs".ThentheSIMwastranslatedto Kannada language to administer for the samples those were not able to understandEnglish.

Validityofthetool
It refers to "the degree to which the instrument measures what it is intended tomeasure." The prepared tool along with   SIM   on   First   aid   management   was

submittedto11expertswhoareinthefieldofCommunityHealthNursing.Theexpertssuggestionswereincorporatedeffectively andpreparedthefinaltoolwiththedirectionofresearchguide

Reliabilityofthe Tool

Reliability of the research instruments is defined as the extent to which theinstrument yields the same results in repeated measures. It is then concerned withconsistency, accuracy, precision, stability, equivalence and homogeneity. The toolafter the validation was subjected to test for its reliability. The structured knowledgequestionnairewasadministeredto05samples.Thereliabilityofthetoolwascomputedbysplithalf KarlPearson'scorrelationformula.(Raw scoremethod).

The reliability of the tool is computed by using split half technique with rawscore method. The reliability coefficient of structured knowledge questionnaire foundtobe0.91revealingthetoolisfeasibleforadministrationforthemainstudy.Validity co efficient worked to be 0.95 (r=2r / 1+r) Brawn's prophecy formula wasused.Thetoolwasfound tobereliableand feasible.

Pilot Study:

After having obtained formal administrative approval from the Medicalofficer of PHC,Bidadi (Annexure – B) Participants were informed about the purposeofthestudyandconsentwastakenfromthem.Thepilotstudywasconductedfromthe02-09-2014 to 09-09-2014 at PHC,Bidadi. Data was collected from 5 samples.TheknowledgeoftheparticipantsonfirstaidmanagementwasassessedonSeptember02[nd] byusingstructuredknowl edgequestionnairefollowedbySIMwas administered on the same day, later the post test was conducted on 09th September toassess the improvement in the knowledge of the ASHAs. The samples chosen weresimilarincharacteristicstothepopulationunderstudy.Itwasfound that each respondent took 40 to 45 minutes to complete the structured knowledge questionnaireandit was foundthattheitemsweresimpleand comprehend.

The results of pilot study shows that the Pre Test mean percentage was47.61% andthe Post Test the mean percentagewas 64.28%with enhancement of16.67%and

Thestatisticalpaired't'impliesthatthe differenceinthepretestand posttestknowledge scorefound statisticallysignificant at 5% level.

Thepurposeofthepilotstudywasto:
1. Findoutthefeasibilityof conductingthefinalstudy.
2. Determinethemethodofstatisticalanalysis.
3. Torefinetheinstrument.
4. Toknowtimerequiredforadministeringtooland tocollectdata.

ProcedureforDataCollection

A formal written permission was obtained from concerned authority [Medicalofficer of CHC , Bidadi] {Annexure - B} to conduct main study. The data wascollected by using structured knowledge questionnaire from 25[th]September to 27[th]October2014.AtselectedruralareasofPHCs,BidadiandByramanga.Theinvestigator personally visited ASHAs and explained the purpose of the study andcollecteddatafromsubjectswhowereinterestedandwillingtoparticipateinthe study. They were assured of anonymity and confidentiality. Pre-test was conducted byusing structuredknowledge questionnaire to assessthe pre testknowledge followedby administration of SIM regarding First aid management , after 7 days post-test wasconducted with the same structured knowledge questionnaire to assess the post testknowledge. The study was conducted according to the convenience and choice ofASHAs.

PlanforDataAnalysis

Thedataobtainedwasanalyzedintermsofobjectivesofthestudyusingdescriptiveandinferential statistics.
1. Organizeddatainmaster sheet
2. Frequenciesandpercentagefortheanalysisofdemographicdata
3. Meanandstandarddeviationforthetool
4. Paired't test was used to find the effectiveness of structured instructional module andChi-square test was used to determine the association between post test knowledgescoreswithselected socio-demographicvariables
5. Thefindingswerepresentedintablesandgraphs

Thischapterdealtwithresearchmaterialsandmethods,setting,population,development of tool, development of SIM, sampling methods and concludes with datacollectionprocedure,andplan fordata analysis

Results:-

This chapter deals with the analysis and interpretation of data collected toevaluatetheeffectivenessofStructuredInstructionalModuleregardingFirstaidmanagement of selected emergencies among ASHAs at selected rural areas of PHCs ,Bidadi.

Thepurposeofthisanalysisistoreduce thedatatoa manageable andinterpretable form so that the research problems can be studied and tested. Analysisand interpretation of research study data is done on the basis of following objectivesandtheresultswerecomputed byusingdescriptive andinferentialstatistics.

Objectivesofthestudy:-

1. To assess the existing knowledge ofAccredited Social Health Activists(ASHAs)regardingfirst aid managementofselectedemergencies .
2. To evaluate the effectiveness of structured instructional module on knowledge ofAccredited Social Health Activists(ASHAs)regarding first aid management ofselectedemergencies.
3. To find an association between post test level in knowledge of AccreditedSocialHealthActivists(ASHAs)regardingfirstaidmanagementofselectedemergencieswiththeir selectedsociodemographicvariables.

PresentationoftheData:

To begin with, the data was entered in a master sheet, for tabulation andstatistical processing. In order to find the relationship the data was tabulated, analyzedand interpreted by using descriptive and inferential statistics. The data is presentedunderthefollowingheadings.

Section1:Sociodemographiccharacteristicsofrespondents   understudy.Section2:Overallandaspectwiseknowledge scoresofrespondents.

Section 3: Analysisof association betweenSocio demographicvariables& post testKnowledge scores.

Section1

Analysisofsociodemogrphiccharacteristicsofashas

Table 1:- DistributionofRespondentsbyAge N= 30.

SI.No.	AgeinYears	Frequency	Percentage
1	25-30years	13	43.3
2	31-35years	13	43.3
3	36-40years	4	13.4
4	41-45years	-	-
	Total	**30**	**100**

Table 1 & Fig. 4 shows that 43.33% (13) of the respondents were in the age group of25– 30yearsfollowedby43.33%(13) oftherespondentswereinthe age groupof 31 –35years,13.4%(4) oftherespondentswere intheagegroupof36– 40years
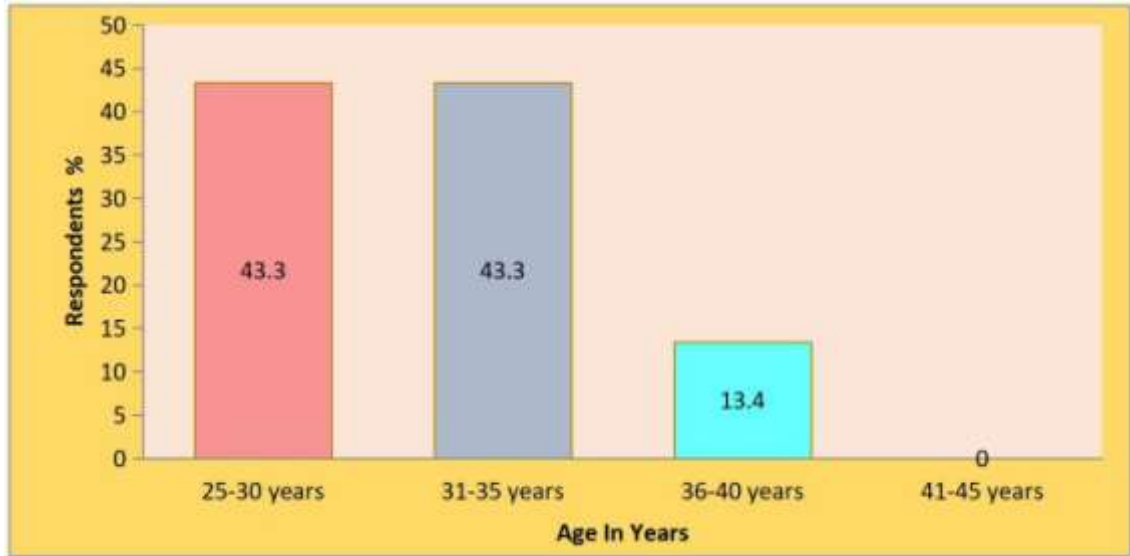
Figure4:- BardiagramrepresentingpercentagedistributionofRespondents.

by Age

Table 2:- DistributionofRespondentsby Educational statusN= 30.

SI.No.	EducationalStatus	Frequency	Percentage
1	Primaryeducation	-	-
2	High school	23	76.7
3	P.U.C	7	23.3
	Total	**30**	**100**

The Data from Table 2 & Fig. 5 shows that majority 76.7% (23) of the respondentswere completed High school education, 23.3% (07) were completed Pre-Universityeducationandnoneofthem falls in categoryprimary education.

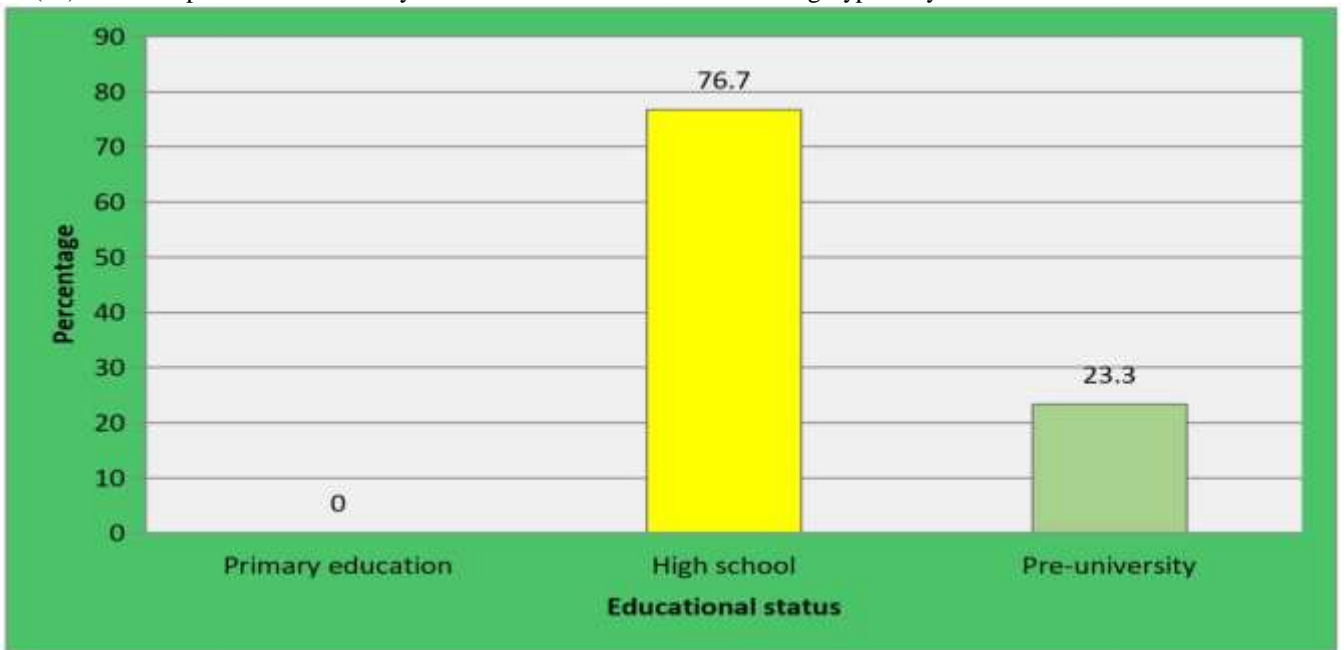**Figure 5:-** Cylinder diagram representing percentage distribution of RespondentsbyEducationalstatus.

Table 3:- DistributionofRespondentsbyMarital Status **N= 30.**

SI.No.	MaritalStatus	Frequency	Percentage
1	Married	27	90.0
2	Widow	3	10.0
3	Divorced	-	-
	Total	**30**	**100**

TheDatafromTable3&Fig.6showsthatmajority90%(27)oftherespondentswere Married , followedby10%(03)werewidows.
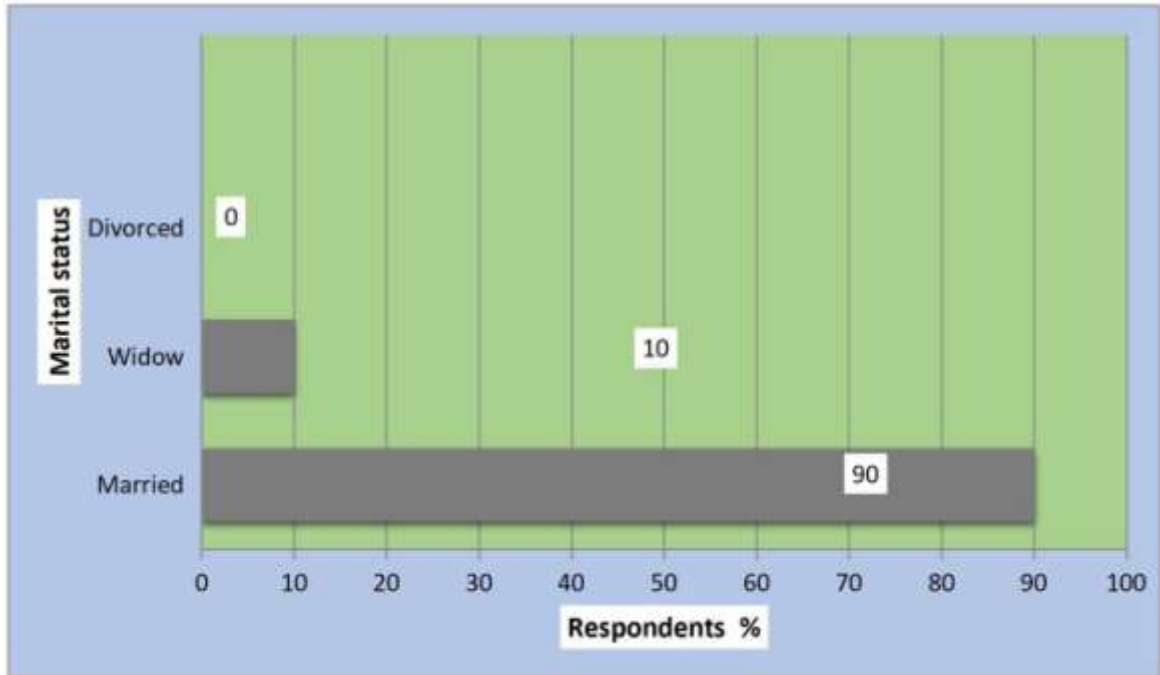
Figure 6:- Horizontal cylinder diagram represents percentage distribution ofRespondentsby Marital Status.

Table 4:- DistributionofRespondentsbyTypeofFamily **N= 30.**

SI.No.	TypeofFamily	Frequency	Percentage
1	Nuclear	27	90
2	Joint	3	10
3	Extended	00	
	Total	**30**	**100**

The Data from Table 4 & Fig. 7 Shows that majority 90% (27) of the respondentswere belong to Nuclear family and remaining 10% (3) respondents were belongs toJointfamily andnonebelong to extendedfamily.
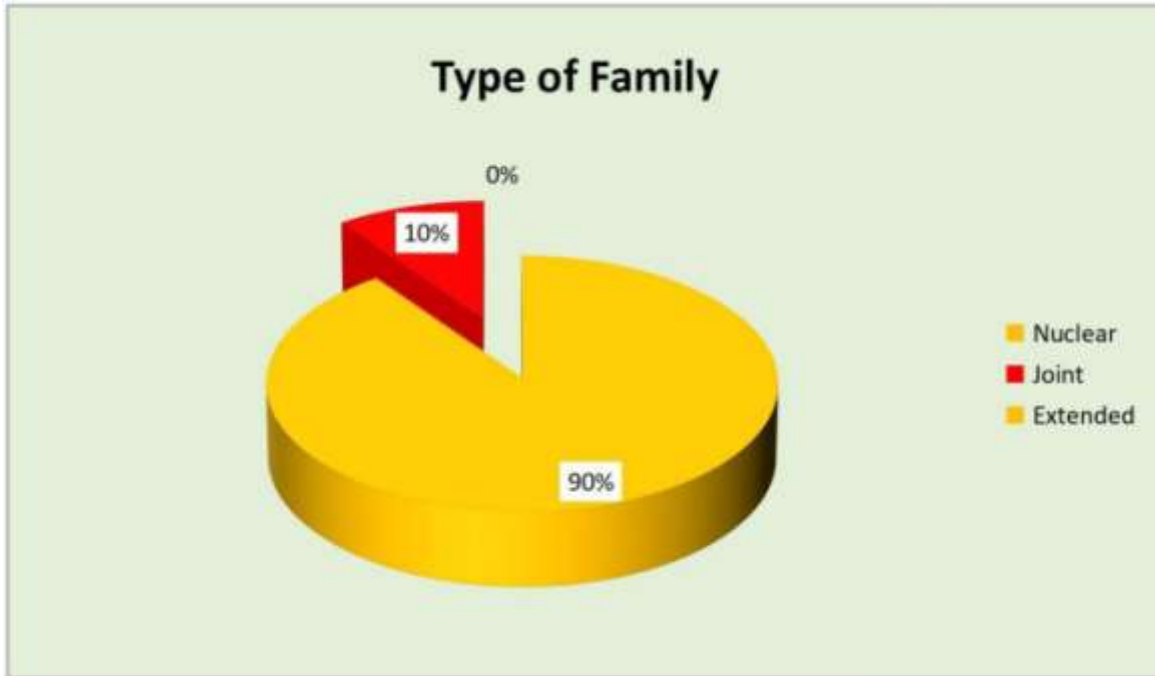
Figure 7:- Pie diagram representing percentage distribution of Respondents byTypeofFamily.

Table 5:- DistributionofRespondentsbyReligion N= 30.

SI.No.	Religion	Frequency	Percentage
1	Hindu	30	100.0
2	Muslim	-	-
3	Christian	-	-
4	Anyother	-	-
	Total	**30**	**100**

The Data from Table 5 & Fig. 8 Shows that all the respondents 100 % (30) werebelongs to Hindu religion None of them belongs to Muslim , Christian and other religion.

Figure 8:- Cone diagram representing percentage distribution of Respondents by Religion.

Table 6:- DistributionofRespondentsbyYears ofWorkingExperienceN= 30

SI.No.	YearsofExperience	Frequency	Percentage
1	0-1yearr	-	-
2	1-3years	6	20.0
3	4-7years	20	66.7
4	8-9years	4	13.3
	Total	**30**	**100**

Table 6 & Fig. 9 shows that majority 66.7% (20) of the respondents had 4-7years of-experience,20% (6) of the respondents had 1 – 3 years of experience, 13.3% (4) oftherespondentshad 8 – 9 years of experience .
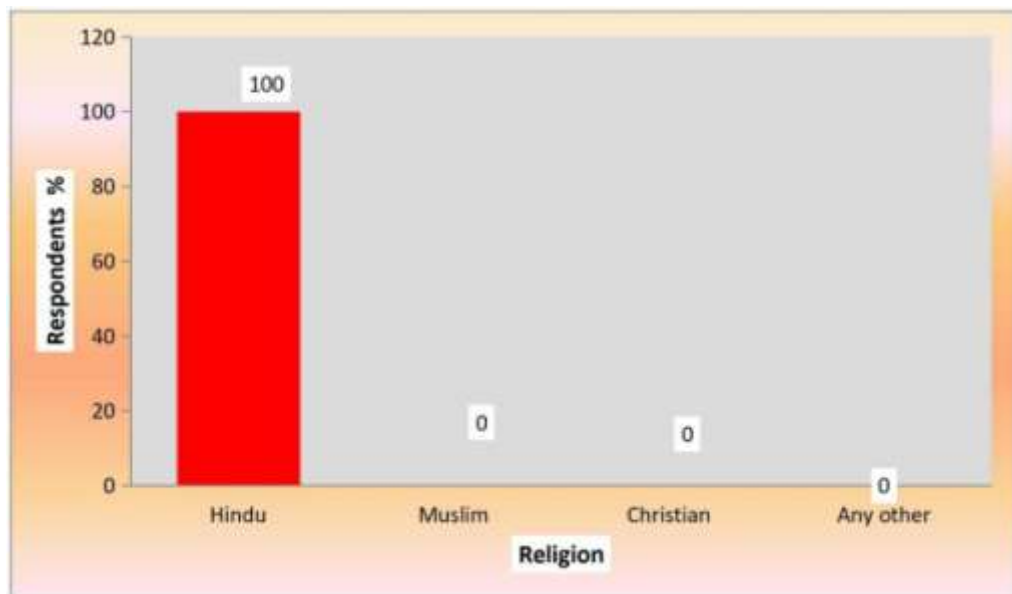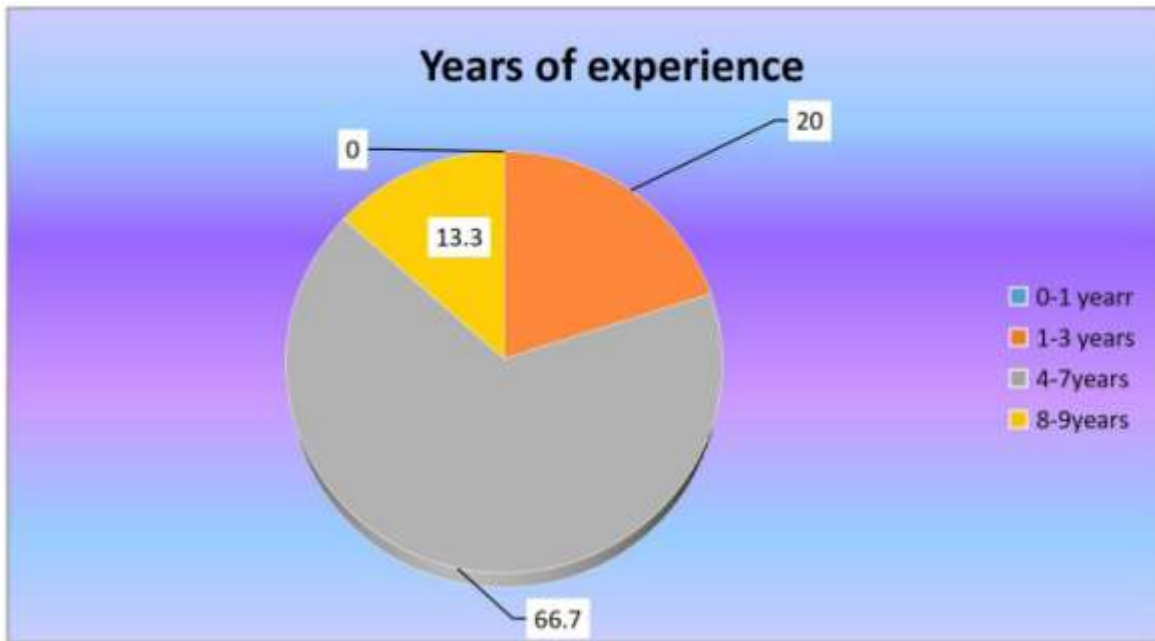

Figure 9:- Pie diagram representing percentage distribution of Respondents byYearsofExperience.

Table-7:- DistributionofRespondentsbyMonthlyfamilyincome.N= 30

SI.No.	Monthly family income inRupees	Frequency	Percentage
1	<10000	21	70.0
2	10001-15000	9	30.0
3	15001-20000	-	-
4	>20000	-	-
	Total	**30**	**100**

The Data from Table 7 & Fig. 10 shows that majority 70 % (21) of respondents hadmonthly family income ofRs. Less than 10,000, 30% (9) of respondents had monthlyfamily income between Rs. 10001-15000 and no such family was their which had theincomeofeither15001-20000 ormorethan 20000.
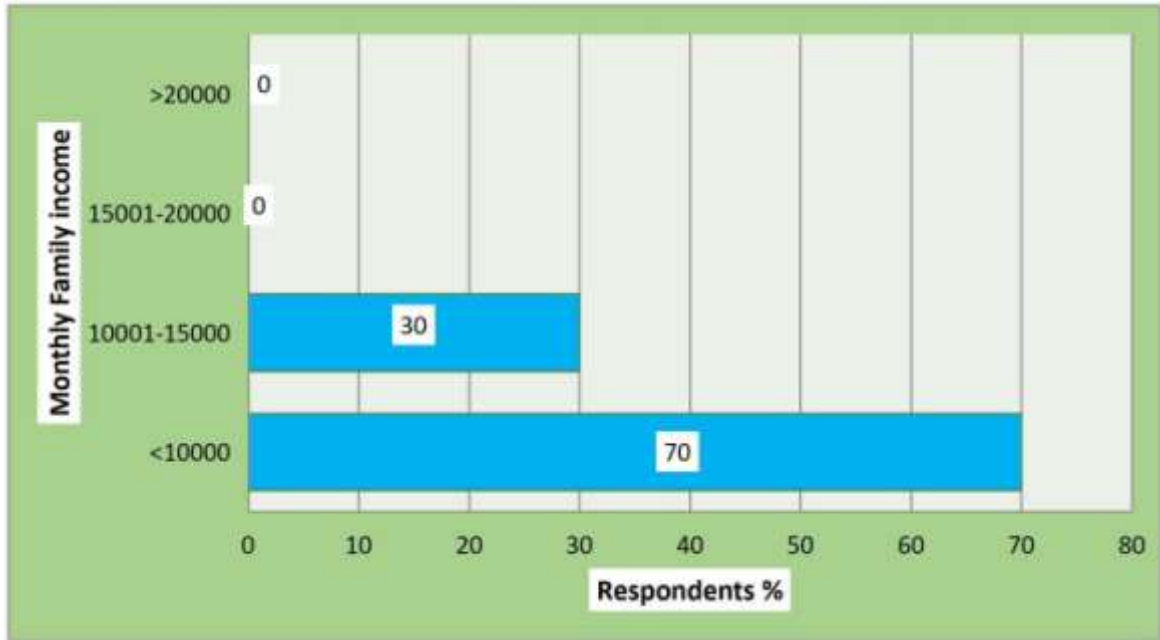
Figure 10:- Bar diagram representing percentage distribution of Respondents byMonthlyfamily income.

Table-8:- DistributionofRespondentsbySourceofinformation **N**= 3**0.**

SI.No.	Sourceofinformation	Frequency	Percentage
1	In-service education/Training	12	40.0
2	Books/Magazines/Journal	04	13.3
3	Massmedia	06	20.0
4	Healthpersonnel	08	26.7
5	Workshop/conference	00	00
	Total	**30**	**100**

Table 8 & Fig. 11 shows that majority of 40.0% (12) respondents were receiving information from In service education/training, 26.7% (8) respondents were receiving information from health personnel, 20.0% (6) respondents were receiving informationfrom mass media,13.3% (4) respondents were receiving information from Books/Magazines/Journalandnorespondenthadattendedanyworkshoporconference.

Figure 11:- Pie diagram representing percentage distribution of Respondents bySourceofinformation.

Section 2: Overall And Aspect Wise Knowledge Scores Ofrespondentsonfirstaid Management.

Table– 9:- Distributionofrespondentsonpretestknowledgescores on firstaidmanagement   N= 30

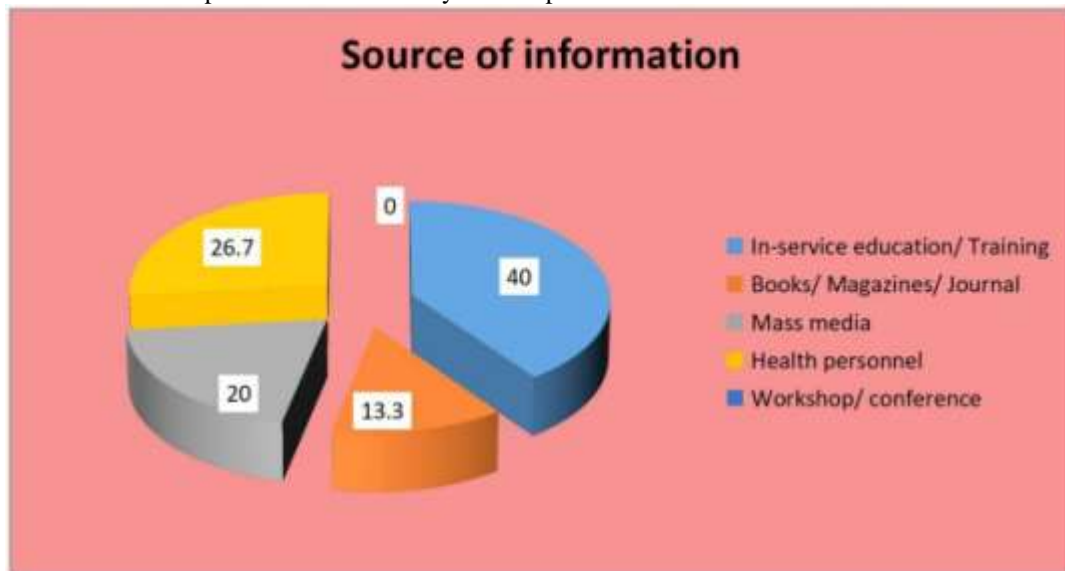| KnowledgeLevel	Category	Respondents	
		Number	Percent
Inadequate	<50%Score	21	70.0
Moderate	50– 75%Score	9	30.0
Adequate	>75% Score	-	-
Total		**30**	**100**

The   DatafromTable   9&   Fig.12showsthat70%   (21)   of   the respondentshadinadequateknowledge**(<50%)**andremaining30%(9)oftherespondentshadmoderate   knowledge   **(51-75%)** regarding occupational safety. None of respondentshadadequateknowledge.
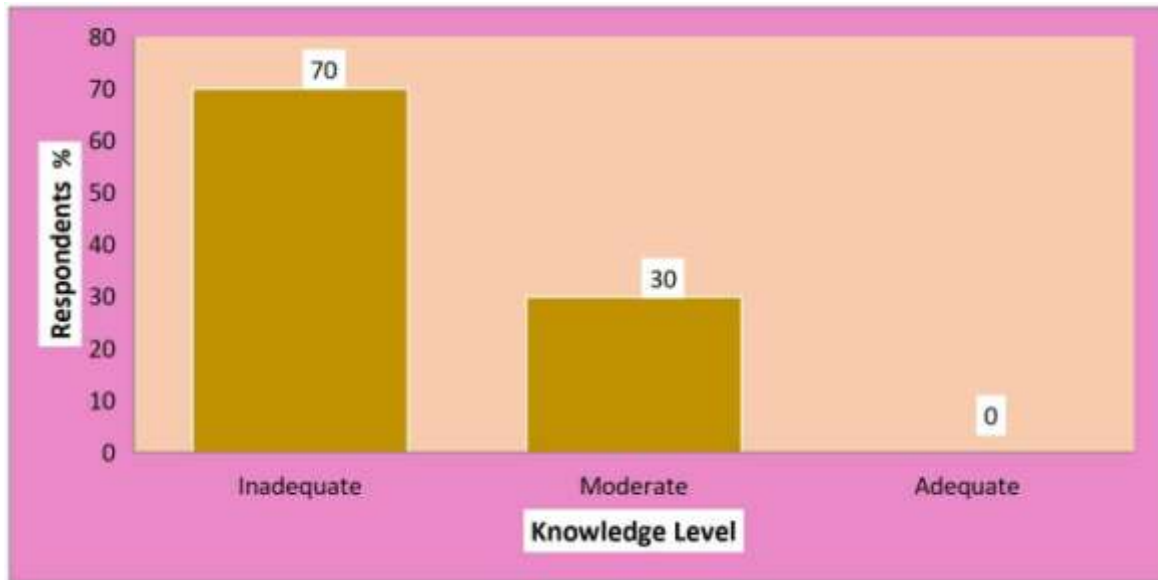

G.   **Figure 12:-** Bar diagram representing percentage distribution of respondents onpretestknowledgescoresonfirstaid management.

Table– 10:- Aspect wise Pre test Mean knowledge scores of Respondents on first aidmanagement N= 30.

No.	Knowledge Aspects	Statements	Max.Score	Respondents Knowledge			
				Mean	SD	Mean (%)	SD(%)
A	Generalinformation	6	6	2.77	1.35	46.1	6.83
B	Related toBurns	7	7	2.87	1.33	41.0	13.42
C	Relatedtopoisoning	7	7	2.60	1.03	37.1	6.57
D	Related tosnake bite	5	5	2.03	0.76	40.6	15.2
E	Relatedtodrowning	7	7	2.63	0.92	37.5	13.14
F	Relatedtoroadtrafficaccidents	8	8	3.27	1.23	40.8	15.37
G	Relatedtofirstaidkit	2	2	1.17	0.53	58.8	26.5
	Combined	42	42	17.33	4.98	41.2	**11.85**

TheDatafromtheaboveTable10revealsthattheaspectwisepre-
testmeanknowledgeofrespondentsregardingFirstaidmanagement.Thehighestmeanknowledge percentage was seen in the aspect of first aid kit 58.8 % followed byGeneral information 46.1%,Related toBurns41.0%,Relatedto road traffic accidents 40.8 %, Related to snake bite 40.6 % Related to drowning 37.5% and the lowest meanpercentage was seenintheaspectRelatedto poisoning37.1 %.

Table– 11:- Distributionofrespondentsonposttestknowledgescoreson first aidmanagement N= 30

Knowledge Level	Category	Respondents	
		Number	Percent

Inadequate	<50%Score	00	00
Moderate	50– 75%Score	10	33.3
Adequate	>75% Score	20	66.7
Total		**30**	**100**

The Data from Table 11 & Fig. 13 shows that 66.7% (20) of the respondents hadadequate knowledge **(> 75 %)** and remaining 33.3% (10) of the respondents hadmoderate knowledge **(50-75%)** regarding occupational safety. None of respondentshadinadequateknowledge.
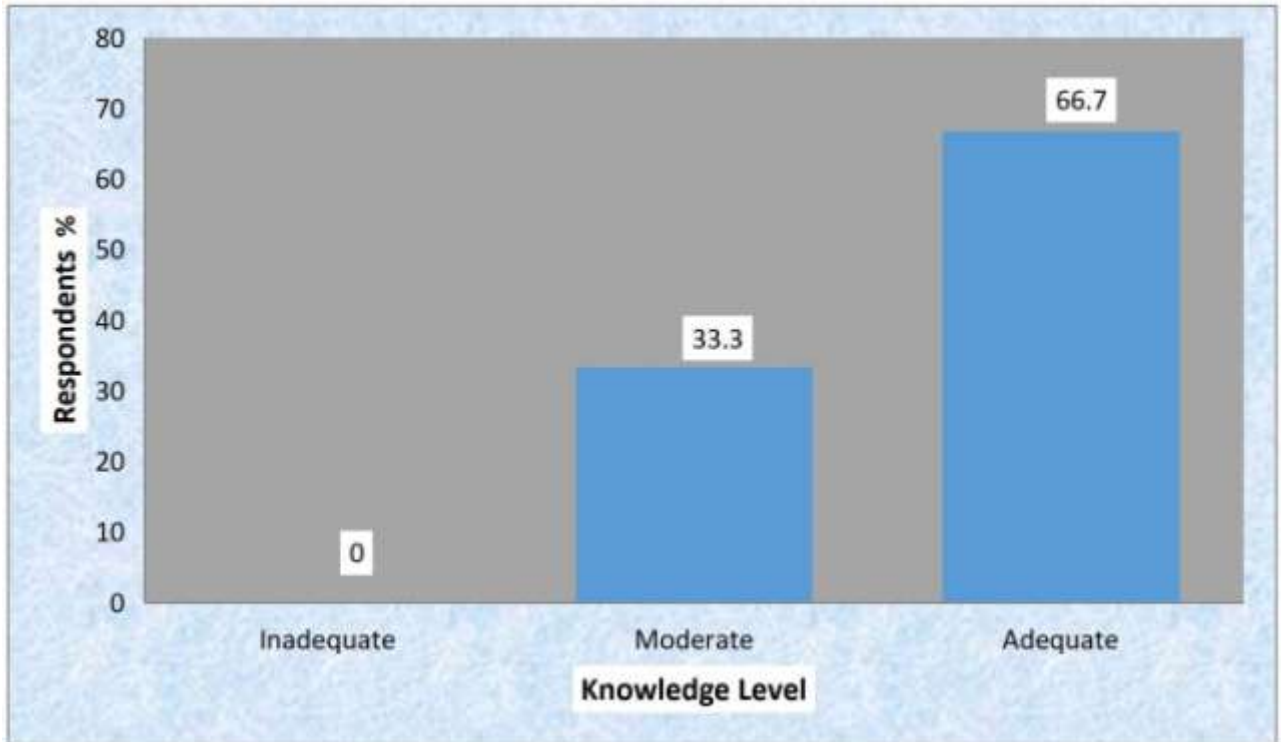

Figure 13:- Bar diagram representing percentage distribution of respondents onposttestknowledgescoresonfirstaidmanagement.

Table– 12:- AspectwisePosttestMeanknowledgescoresofRespondentsonfirstaidmanagement   N= 30

No.	Knowledge Aspects	Statements	Max.Score	Respondents Knowledge			
				Mean	SD	Mean (%)	SD(%)
A	Generalinformation	6	6	4.03	0.41	67.1	22.5
B	RelatedtoBurns	7	7	5.73	.0.94	81.9	19
C	Relatedtopoisoning	7	7	5.70	0.46	81.5	14.71
D	Relatedtosnake bite	5	5	3.53	1.19	70.6	23.8
E	Relatedtodrowning	7	7	5.60	1.16	80.0	16.52
F	Relatedtoroad traffic accidents	8	8	5.93	1.70	74.1	21.25
G	Relatedtofirstaidkit	2	2	1.53	0.68	76.6	34
	Combined	42	42	**32.07**	**5.44**	**76.3**	**12.95**

The Data from the above Table 12 reveals that the aspect wise post - test meanknowledgeofrespondentsregardingFirstaidmanagement.Thehighestmeanknowledge percentage was seen in the aspect of Related to Burns 81.9 % followed byRelatedtopoisoning81.5%,Relatedtodrowning80%,Relatedtofirstaidkit 76.6 % , Related to road traffic accidents 74.1 % Related to snake bite 70.6 % and thelowestmeanpercentage wasseeninthe aspect Generalinformation67.1%.

Table– 13:- OverallDistributionofrespondentsonknowledgelevelonfirstaidmanagement N= 30.

Knowledgelevel	Category	Classificationof respondents			
		Pretest		Posttest	
		Number	Percent	Number	Percent
Inadequate	<50%Score	21	70.0	00	00
Moderate	50– 75%Score	9	30.0	10	33.3
Adequate	>75% Score	00	00	20	66.7
Total		**30**	**100**	**30**	**100**

*Significantat5%level,

Table -13& Fig.14depictsthatin pre test70% (21) of respondentshadinadequate knowledge **(< 50 %)**, 30% (09) of respondents had moderate knowledge**(50-75 %)** and none of them had adequate knowledge **(> 75 %)**. In post test, none ofrespondentshadinadequateknowledge**(<50%)**,33.3%(10)respondentshadmoderate knowledge **(50-75 %)** and remaining 66.7% (20) respondents had adequateknowledge**(>75%)**regardingfirstaidmanagement.Howeverχ^2 indicatesthesignificantdifferenceintheknowledge levelofASHAsonfirstaidmanagement.
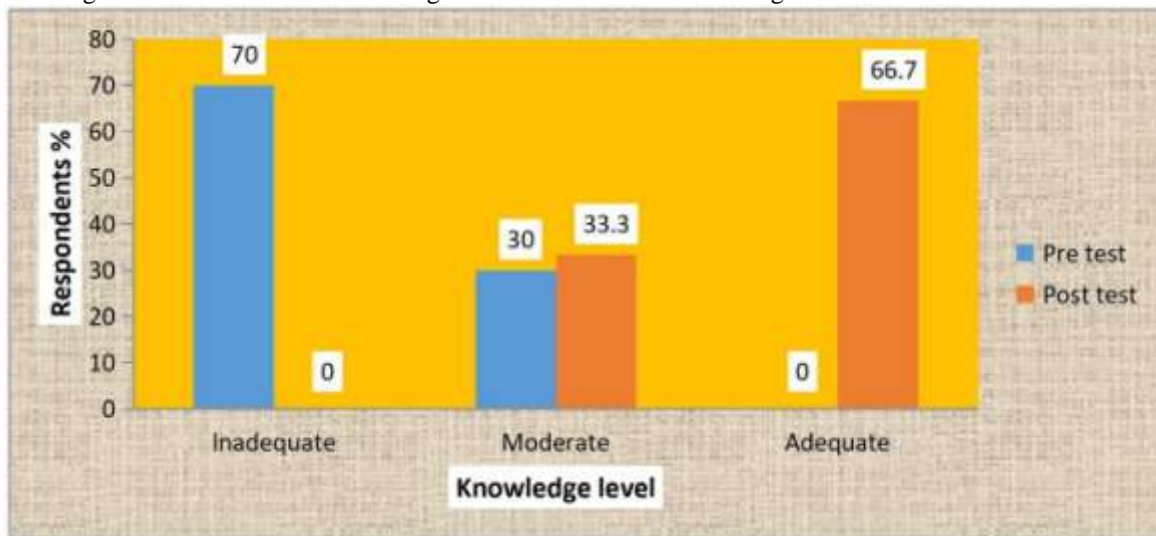
Figure 14:- Cylinder diagram representing over all percentage distribution ofrespondentson knowledgelevelon firstaidmanagement.

Table– 14:- OverallPretestandPosttestMeanknowledgeonfirst aidmanagement N=30.

Aspects	Max.Score	RespondentsKnowledge				Paired 't'Test
		Mean	SD	Mean (%)	SD(%)	
Pretest	42	17.33	4.98	41.2	11.85	23.85*
Posttest	42	32.07	5.44	76.3	12.95	
Enhancement		**14.74**	**0.46**	**35.1**	**1.1**	

 *Significantat5%level   t (0.05, 29df) =

 1.96Table14&figure.15:depictsthatpretestmeanpercentagewas41.2%andposttest mean percentage was 76.3%, with enhancement of 35.1%, calculated "t" test value of23.85* is greater than table value [t (0.05, 29df) = 1.96] hence study found to besignificantat 5%level.
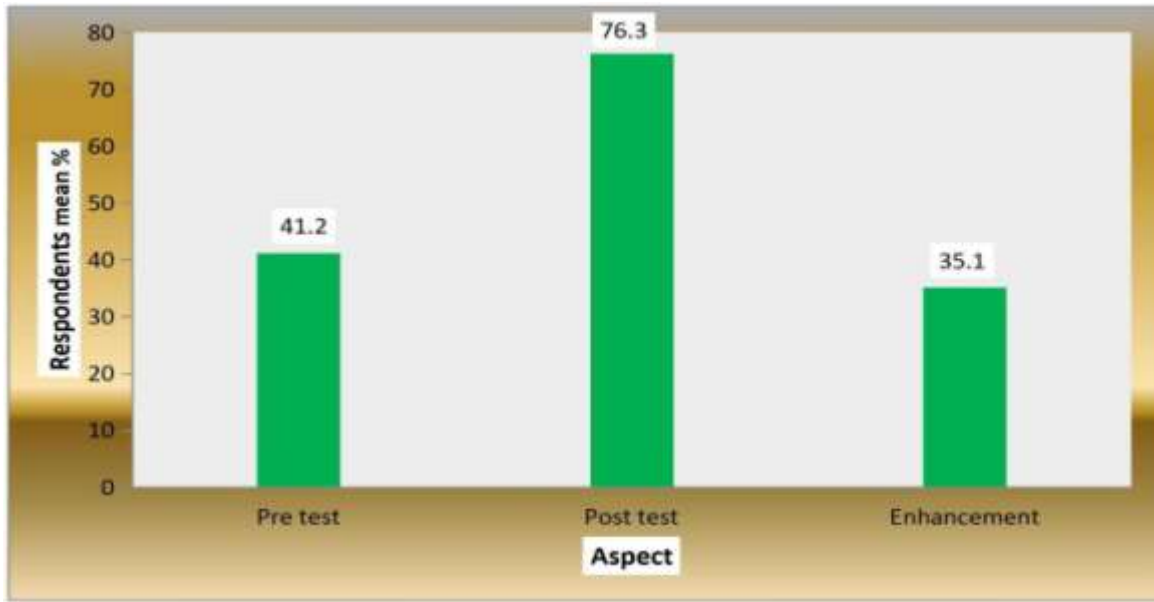
Figure 15:- Bar diagram representing Mean percentage distribution of overallPre testandPosttestknowledgeon firstaidmanagement.

Table 15:- Aspect wise Mean percentage of pre test and post test knowledge on first aid managementN= 30.

No.	Knowledge aspect	Respondents'knowledge(%)						Paired't'test
		Pretest		Posttest		Enhancement		
		Mean	SD	Mean	SD	Mean	SD	
A	Generalinformation	46.1	6.83	67.1	22.5	21.0	15.67	4.47*
B	Related to Burns	41.0	13.42	81.9	19	40.8	5.58	12.82*
C	Relatedtopoisoning	37.1	6.57	81.5	14.71	44.3	8.14	17.06*
D	Related tosnake bite	40.6	15.2	70.6	23.8	30.0	8.6	7.42*
E	Related todrowning	37.5	13.14	80.0	16.52	42.3	3.38	15.72*
F	Related to road traffic accidents	40.8	15.37	74.1	21.25	38.0	5.88	10.63*
G	Related tofirstaidkit	58.8	26.5	76.6	34	18.0	7.5	2.62*
H	Overall	**41.2**	11.85	**76.3**	12.95	**35.0**	1.1	**23.85***

*Significantat5%level

Table-15&Fig.16:revealsthattheaspectwisemeanpreandposttestandknowledge enhancement score on first aid management. The pre test mean knowledgescore regarding General information was 46.1% and the post test score is 67.1%. Theenhancement of the knowledge is found to be 21.0%. Related to Burns the pre testscore was found to be 41.0% and post test score of 81.9% with the enhancement of40.8%.ThepretestscorerelatedtoPoisoningwasfoundtobe37.1%andposttest score of 81.5% with the enhancement of 44.3% . Related to snake bite pre test scorewas 40.6% and the post test score of 70.6% with the enhancement of 30.0%. Relatedto Drowning pre test score was 37.5% and the post test score of 80.0% with theenhancement of 42.3%. Related to Road traffic accident pre test score was 40.8% and the post test scoreof 74.1% with the enhancement of 38.0%.Related to first aid kitpre test score was 58.8% and the post test score of 76.6% with the enhancement of18.0%.

The overall mean score in the pre test was 41.2% and 76.3 % in the post testwithanenhancementof35.0%.Thestatisticalpaired't'testindicatestheenhancementinthemeanknowledgescoreswasfoundtobesignificantat5%levelforall theaspect underthestudy.
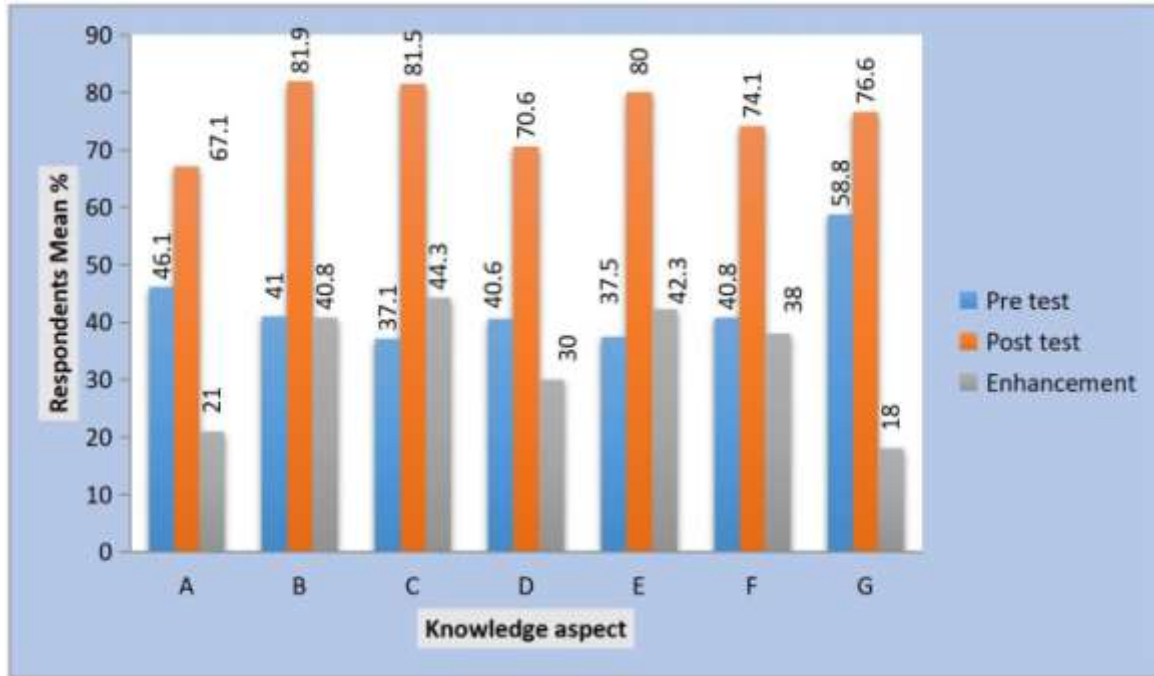
Figure 16:- Bar diagram representing aspect wise Mean percentage of pre testand post test knowledge and its enhancement on knowledge of first aidmanagement.

Section 3: Analysis Of Association Between Sociodemographicvariablesandposttestknowledgescores.

Table– 16:- AssociationbetweenAgeandPosttestKnowledgelevel onFirstaidmanagement. N=30

Personal Variable	Category	Sample	Respondents Knowledge				χ^2Value	P Value
			Moderate		Adequate			
			N	%	N	%		
Agegroupinyears	25-30	13	8	66.7	5	27.8		
	31-35	13	3	25.0	10	55.6	3, df$_=$2,S	**p<0.05**
	36-40	4	1	8.3	3	16.7		
	41-45	-	-	-	-	-		
Combined		30	16		34			

S:Significantat5% χ^2(0.05,2df)= 5.98

Table 16:- The above table shows that the obtained value (χ^2= 5.99) is more than tablevalue (χ^2= 5.98). This implies their significant association between the knowledgescoresand age.Hence research hypothesis is accepted.

Table 17:- Association between Educational status and Post test Knowledge level on firstaidmanagement. N=30

Personal Variable	Category	Sample	RespondentsKnowledge				χ^2 Value	P Value
			Moderate		Adequate			
			N	%	N	%		
EducationalStatus	Primary education	-	-	-	-	-	2.134, df$_=$1,NS	p>0.05
	Highschool	23	9	75.0	14	77.8		
	Pre-university	7	3	25.0	4	22.2		
Combined		30	16		34			

NS:Non-Significance χ^2(0.05,1df)=3.84

Table 17:- The above table shows that the obtained value (χ^2= 2.134) is less than tablevalue (χ^2= 3.84). This implies no significant association between the knowledgescoresandeducational status.Henceresearchhypothesis isrejected.

Personal Variable	Category	Sample	RespondentsKnowledge		χ^2Value	P Value
			Moderate	Adequate		

			N	%	N	%		
Maritalstatus	Married	27	9	75.0	18	100	, df=1,S	
	Widow	3	3	25.0	0	0		p<0.05
	Divorced	-	-	-	-	-		
Combined		30	16		34			

Table– 18:- Association between Marital status and Post test Knowledge level on first aid management .N=30

Personal Variable	Category	Sample	Respondents Knowledge				χ^2Value	P Value
			Moderate		Adequate			
			N	%	N	%		
Typeof family	Nuclear	27	10	83.3	17	94.4	52, df=1,NS	
	Joint	3	2	16.7	1	5.6		p>0.05
	Extended	-	-	-	-	-		
Combined		30	16		34			

    S:Significantat5% χ^2(0.05, 1df)=3.84

Table 18 : The above table shows that the obtained value (χ^2= 4.89) is more than tablevalue (χ^2 = 3.84). This implies significant association between the knowledge scoresandmarital status. Hence researchhypothesis isaccepted.

Table– 19:- Association between Type of family and Post test Knowledge level on first aid management.
N=30

Personal Variable	Category	Sample	Respondents Knowledge				χ^2 Value	P Value
			Moderate		Adequate			
			N	%	N	%		
Years of experience	0-1yearr	-	-	-	-	-	2.476, df=2,NS	p>0.05
	1-3years	6	2	16.7	4	22.2		
	4-7years	20	8	66.7	12	66.7		
	8-9years	4	2	16.7	2	11.1		
Combined		30	16		34			

    NS:Non-Significance χ^2(0.05, 1df) = 3.84

Table 19 : The above table shows that the obtained value (χ^2= 2.452) is less than table value (χ^2= 3.84). This implies no significant association between the knowledge scoresandtypeof family.Henceresearchhypothesis isrejected.

Table– 20:- Association between Years of working experience and Post test Knowledge levelonfirstaid management.
    N=30
    NS-NonSignificant χ^2 (0.05, 2df)=5.98

Table 20 : The above table shows that the obtained value (χ^2= 2.476) is less than tablevalue (χ^2 = 5.98). So there isno significant association between the knowledge scoresandtheyearsofexperience.Henceresearchhypothesis is rejected.

Table– 21:- Association between Monthly family income and Post test Knowledge level onfirstaidmanagement.
N=30.

Personal Variable	Category	Sample	Respondents Knowledge				χ^2 Value	P Value
			Moderate		Adequate			
			N	%	N	%		
Monthlyfamilyincome	<10000	21	7	58.3	14	77.8	1.678, df=1,NS	p>0.05
	10001-15000	9	5	41.7	4	22.2		
	15001-20000	-						
	>20000	-						
Combined		30	16		34			

    NS:Non-Significance χ^2(0.05, 1df) = 3.84

Table 21 : The above table shows that the obtained value (χ^2= 1.678) is less than tablevalue (χ^2= 3.84). This implies no significant association between the knowledgescoresandmonthlyfamilyincome.Henceresearchhypothesis isrejected.

Table 22:- Association between Source of information and Post test Knowledge level onFirstaidmanagement. N=30

Personal Variable	Category	Sample	Respondents Knowledge				χ^2 Value	P Value
			Moderate		Adequate			
			N	%	N	%		
Source of information	In-serviceeducation	12	4	33.3	8	44.4	**11.67, If=3,S**	**P<0.05**
	Books/magazine/Journal	4	4	33.3	0	0		
	Massmedia	6	2	16.7	4	8.3		
	Healthpersonnel	8	2	16.7	6	33.3		
	Workshop/conference	-	-	-	-	-		
Combined		30	16		26			

Significantat5%Level χ^2 (0.05, 3df) =
7.82Table22:Theabovetableshowsthattheobtainedvalue(χ^2=11.67) ismorethantable

value($\chi^2$9.49).Sothereissignificantassociationbetweentheknowledgescoresandthesourceofinformation .Henceresearchhypothesisisaccepted.

Note: The demographic variables not having frequency for at least one row andcolumn(Socio demographic variable - Religion) is being omitted since it is invalid toperformChi-squareanalysis.

Discussion:-

This chapter deals with the discussion of the study with appropriate literaturereview, statistical analysis and findings of the study based on objectives of the study.A report of findings is never sufficient to convey their significance. The meaning thatresearchers give to the results plays a rightful and important role in the report. Thediscussion section is devoted to a thoughtful and insightful analysis of the findings,leadingto adiscussion oftheirclinical andtheoreticalutility.

The present study is focused on to "evaluate the effectiveness of structuredinstructional module on knowledge of regarding first aid management of selectedemergenciesamongASHAs at selectedruralareas of PHC, Bidadi.

A pre experimental one group pretest and post test design was used to conductthe study. Research approach was an evaluative approach. The target population forthe study was ASHAs working at selected rural areas of PHC , Bidadi. Samples wereselectedbypurposivesamplingtechniquefromaccessiblepopulation.Thetotalsamples under the study were 30 ASHAs working in different areas of PHCs, Bidadi.Structuredknowledgequestionnaire was used tocollectdata.

Thefollowingcomponentswereusedtoconductthisstudy.

Section I: Socio-DemographicvariablesofASHAs
SectionII:Structured knowledgequestionnaireaboutfirstaidmanagement.

Thefindingsof thestudyarediscussedunder thefollowingheadings:
1. Sociodemographic characteristics.
2. AssessmentofexistingknowledgeregardingfirstaidmanagementamongASHAs.
3. Evaluatingtheeffectivenessofstructuredinstructionalmoduleregardingfirstaidmanagement among ASHAs.
4. Association between   post   test   knowledge   scores   with   selected   Sociodemographicvariables.
5. Testingofthehypotheses.

Sociodemographiccharacteristics:
ThissectiondealtwiththeanalysisofselectedSociodemographicvariablesbasedonfrequencyand percentagedistributionofthesamples.

Themajorfindingof thestudywassummarizedasfollows.

1. Majority 43.3% (13) of the respondents were in the age group of 25 – 30 yearsfollowed by 43.3% (13) of the respondents were in the age group of 31 – 35years, 13.3% (4) of the respondents were in the age group of 36 – 40 years andnonein theagegroup of41 – 45 years.
2. Majority 76.7% (23) of the respondents were completed high school education,23.3%(7)werecompletedPreuniversity education.
3. Most of 90% (27) of the respondents were married and remaining 10% (3)respondentswerewidowers.
4. Majority 90% (27) of the respondents were belong to Nuclear family andremaining10%(3)respondentswerebelongsto Jointfamily.
5. Allthe 100%ofrespondentswere Hindu.
6. Majority 66.7% (20) of the respondents had 4 – 7 years of experience, 20% (6)oftherespondentshad1–3yearsofexperience,13.3%(4)oftherespondentshad8 – 9 yearsofexperience.
7. Majority 70 % (21) of respondents had monthly family income Rs. Less than10,000, 30% (9) of respondents had monthly family income Rs. 10,001 –15,000
8. Majorityof40.0%(12)respondentswerereceivinginformationfromInservice education/training, 26.7% (8) respondents were receiving informationfromhealthpersonnel,20.0%(6)respondentswerereceivinginformationfrommassmedia,13.3%(4)respondentswerereceivinginformationfromBooks/ Magazines/ Journal and no respondent had attended any workshop orconference.

Assessmentofexistingknowledgeof ASHAsregardingfirstaidmanagement ofselectedemergencies.

Knowledge of ASHAs was assessed through conducting the pre test by usingstructured knowledge questionnaire as a tool. The present study confirms that the overall mean knowledge scores in pre-test is 41.2%.This shows that there is lack ofinformationamongASHAsregardingfirstaidmanagement.Although30%ofASHAs had moderate knowledge, and majority of them had inadequate knowledge(70%) regarding first aid management . Hence it is necessary to provide education in order to enhance knowledge on first aid management . So, structured instructionalmodulewas providedtotheASHAs.

A cross sectional worldwide study in knowledge on injuries , emergencies andtheir prevention in Singapore. The samples are collected with a two stage stratifiedrandom sampling This study revealed that samples are having poor knowledge (nearly82%) on first aid practices. He conclude the study with needed frequent educationaland training programme.[62]

Evaluating the effectiveness of structured instructional module regarding firstaidmanagement.

The present study confirmed that there was a considerable improvement ofknowledgeaftertheadministrationofstructuredinstructionmoduleonfirstaidmanagement of selectedemergencies andis statistically established as significant.Theoverallpretestmeanknowledgepercentagewas41.2% andposttestmeanpercentage was 76.3% with mean knowledge enhancement of35.1%.

A study was conducted in Italy with an objective to evaluate the benefit of teaching emergency first aid procedures for 469 samples. The result showed that theirwasabetterknowledgegaininposttestthanpretestafterateachingprogramme.Thisproposedandconcludedthatteachingemergencyfirstaidcouldbesuccessful.

Association between post test knowledge scores with selected sociodemographicvariables.

The findings of the study revealed that there is significant association betweenposttestknowledgescoresandsociodemographicvariablessuchasAge($5.99*^S$), Marital status ($4.89*^S$)and Source of information ($11.67*^S$)at0.05%level.

A descriptive study was conducted on first aid among community workers to determine the knowledge of first aid practices. It includes management of stings and bites,burns,scald,nosebleed,seizure,eye injuries,fracture,sprain,fever,skin wounds drowning , poisoning and etc. Knowledge of specific guidelines ranged from21-90%.Subjectsespeciallylackedknowledgeregardingtherapidremovalofallstingers and in animal bite situation .

only 36%have sting awareness , 23% poisoning awareness and 46% burn awareness. Knowledge is affected by age and unaffected by gender and education. Further education is needed to the younger one and unmarriedtoimprovetheknowledgeoffirst aid practices.

The study findings also reveals that there was no significant associationbetweeneducationalstatus(2.134^{NS}),typeoffamily(2.452^{NS}),monthlyfamilyincome(1.678^{NS}), workingexperience (2.476^{NS})andthepost test knowledge scores.

Testingthehypotheses:
H$_1$: Therewillbe   a   significantdifference   betweenthe   meanpreandpost testknowledgescoresofASHAsregardingfirstaidmanagementofselectedemergencies .

In this study the overall pre test mean knowledge score was 41.2 % and posttestscore was 76.3%.with mean knowledge enhancement 35.1%. The **H$_1$**stated inthe study is accepted since there was significant change found between the pre-testand post-test knowledge scores regarding first aid managementat level (0.05%)P<0.05. Hence, there was a significant improvement in knowledge scores of ASHAsafteradministrationofSIM regardingfirstaidmanagementofselected emergencies.

H$_2$: There will be a significant association between the post test level ofknowledgeonfirstaidmanagementofselectedemergenciesandselectedsocio-demographic variables.

The investigator accepts the **H$_2$**for significantassociation between Age(5.99*^{S}), Marital status (4.89*^{S}), Source of information (11.67*^{S}) and post test knowledge scores.

TheinvestigatorrejectsthehypothesesH$_2$fornosignificantassociationbetween socio demographic variables such as educational status(2.134^{NS}), type offamily (2.452^{NS}), monthly family income (1.678^{NS}), working experience (2.476^{NS}) and thepost testknowledgescores.

Conclusion:-
Thischapterpresentstheconclusionsdrawn, implicationsandrecommendations.Thefocusofthestudywasto"evaluatetheeffectivenessofstructured   instructional module on knowledge of regarding first aid management ofselectedemergenciesamongASHAsat selectedruralareasof PHC,Bidadi

Apre-experimentalonegrouppretestposttestdesignandevaluativeapproach was used in the study. The data was collected from 30 ASHAs throughpurposivesampling technique.

The SIM contains Goal of module, Introduction to first aid management, firstaid management of burns, poisoning, drowning, snake bite, RTA ,   information onfirstaid kit andconclusion.

Thefollowingconclusionsweredrawnonthebasisofthefindingsofthe study:
1. Thepre-testknowledgescoreamongmajorityofASHAswasinadequateandpost-testknowledge score wasfoundtobe adequate.
2. There was significant enhancement in knowledge of ASHAs after administrationofstructuredinstructionalmoduleregarding firstaidmanagement.
3. There was significant association between Post test knowledge scores andsocio demographic variables such as age(5.99) , marital status (4.89) ,Sourceofinformation (11.67)at 0.05 level.
4. The findings of the study revealed that there is no significant associationbetween personal variables such as educational status (2.134^{NS}),type offamily (2.452^{NS}), monthly family income (1.678^{NS}), working experience(2.476^{NS})andthepost test knowledgescores.At 0.05level.

Nursing Implications:
The main aim of the present study was to educate the ASHAs regarding firstaid management. The study revealed that there was gap in knowledge of ASHAsregarding first aid management .It is indicated that concentrated efforts should betaken by health professionals in educating the ASHAs regarding first aid managementtoimpartknowledgeandtocreateawarenessaboutimportanceoffirstaidmanagement in community level . The findings of this study have implications in thefield of Nursing education, Nursing practice, Nursing administration and Nursing research. The dissemination of the knowledge takes place when the research findingsare madeuseofin thefollowing fields.

Nursing Practice:-
Nursing profession has been developing faster in recent years in a unique way.Themajorchangethathasoccurredintheprofessionisexpansionintheroleof nurses.Oneofthemajorrolesthatnurseplayiseducatingtheperiperallevelcommunity health workers regarding various health related facts and its managementat community level . Updating the knowledge of ASHAs is a very important taskwhich will help them to aware about the various emergencies at the community leveland lack of knowledge about their first aid management . Therefore the communityhealth nurses should take active involvement in educating the ASHAs regarding firstaid management so that the mortality and morbidity rates due to unavailability ofthefirstaid managementduring anemergencysituationcanbereduced.

Nursing Education:
1. The study can be extended for educating the different levels of communityhealthworkersregardingfirstaidmanagement.
2. Nurseeducatorscanusethefindingsofthisstudytounderstandwhatdifferent strategies can be adapted for educatingASHAs regarding first aidmanagement.
3. As a community health nurse there are abundant opportunities for nursingprofessionalstoeducatetheASHAsofdifferentareasofPHC andvillages
4. Nurseeducatorscanuseinnovativeteachingmethodlikestructuredinstructional module to increase the knowledge and awareness about variousemergenciesanditsfirstaidmanagement.

Nursing Administration:
1. Thenurseadministratorshouldarrangecontinuingeducationprogrammefornursingpersonnelregardingfirstaid management
2. This will help the nurse administrator to prepare adequate learning materials forgivinghealthinformationregarding firstaidmanagementin anysetting.
3. Nursing personnel should be prepared to take leadership role in educating the ASHAsindifferentsettings suchas variousareas,PHCs, villages.
4. The nurse administrator should explore their potentials and encourage innovativeideas in preparation of teaching material. She/he should organize to see that sufficientmanpower,money andmaterialfordisseminatinghealthinformation.

Nursing research:
1. Thestudywillmotivatethebeginningresearcherstoconductsamestudywithdifferentvariableson a large scale.
2. Various studies conducted showed that awareness on first aid management should becreatedamongcitizens.Thereisneedforextensiveresearchonfirstaidmanagement
3. Research must focus on improvement in knowledge, attitude and practice of ASHAsregardingfirstaidmanagement.Researchmustbedoneinonnewmethodsofteachingtoenable ASHAstoimprove knowledge.

Limitationsofthestudy:
1. ThestudyislimitedonlytoASHAs workingatselectedruralareasofPHC,Bidadi
2. Thestudydidnotusecontrolgroup.
3. Onlyasingledomainthatisknowledgeisconsideredinthepresentstudy.
4. Thesample sizeforthestudy waslimitedto 30ASHAs.

Recommendations:-
Onthebasisofthefindingsofthestudyfollowingrecommendationshavebeenmade:

Areplicationof present study canbeconductedwith alarger populationtogeneralizethefindings.
Asimilarstudycanbeconductedondifferentsamplessuchasanganwadiworkers,healthassistants, lady healthvisitorswitha controlgroup.
Adescriptivestudycanbeconductedtoassesstheknowledge,attitudeandpracticeofASHAs regardingfirstaidmanagementwithlargersample.
AcomparativestudycanbeconductedbeweenladyhealthvisitorsandASHAs.
Manualsandinformationbookletsmaybedevelopedtoenhanceknowledgeregardingfirstaid management.
Acomparativestudycanbedonebetweentheeffectivenessofstructuredinstructionalmoduleversesstructureteaching programme.

Summary:
This chapter deals with the summary of the study and its major findings alongwithimplications.Thestudywas conducted"evaluatetheeffectivenessofstructuredinstructionalmoduleonknowledgeregardingfirstaidmanagementofselec ted emergencies among Accredited social health activists (ASHAs) at selectedruralareas ofPHC , Bidadi".

Objectives ofthestudy:-
1. To assess the existing knowledge ofAccredited Social Health Activists(ASHAs)regardingfirst aid managementofselectedemergencies .
2. To evaluate the effectiveness of structured instructional module on knowledge of Accredited Social Health Activists(ASHAs)regarding first aid management ofselectedemergencies.
3. To find an association between post test level in knowledge of AccreditedSocialHealthActivists(ASHAs)regardingfirstaidmanagementofselectedemergencieswiththeir selectedsociodemographicvariables.

Hypotheses.
H1: TherewillbeasignificantdifferencebetweenthemeanpreandposttestknowledgescoresofASHAsregardingfirstaidmana gementofselectedemergencies .
H2: Therewill be a significantassociation between the post test level ofknowledge on first aid management of selected emergencies and selected socio-demographicvariables.

TheconductedstudyaimsatdevelopingandevaluatingeffectivenessofstructuredinstructionalmoduleonknowledgeofASH AsregardingfirstaidmanagementofselectedemergenciesatselectedruralareasofPHC,Bidadi".

Reviewofliteratureofrelatedstudiesenabledtheinvestigatortocollectrelated and relevant information to support the study, design the methodology, todeveloptheconceptualframe work andinthedevelopment of tool.

The conceptualframeworkselected forthis study was basedon modifiedStufflebeam,s (1973) Context Input Product Process (CIPP) model. It is a four stepmodel of programme evaluation developed for obtaining useful information for takingdecisions. It involves four types of decisions, namely planning decisions, Structuringdecisions,implementingdecisionsandrecyclingdecisions.Itprovidesacomprehensive,systematic,continuousa ndongoing frameworkfortheprogramme.

The research design selected for the study was Pre-experimental one group pretestandposttestdesign.Theindependentvariablewasstructuredinstructional module regarding first aid management and the dependent variable was post testknowledgescoresofASHAsregardingfirstaidmanagementofselectedemergencies.

The sample of this study comprised of 30 ASHAs working at different areas ofPHCs, Bidadi . Purposive sampling technique was used to select the sample. The tooldeveloped and used for the data collection was Structured knowledge questionnaire .11 experts validated the content of the tool and the tool was found to be reliable andfeasible. The structured instructional module consisted of various aspects on first aidmanagement. The StructuredInstructionalModule wasprepared with a view toenhancetheknowledgeofASHAs.

After obtaining formal written permission from concerned authority[Medical officer of Bidadi CHC and Byramangala PHC] {Annexure - B}. Pilot studywas conductedat Bidadi gramantara PHC area from 02.09.2014 to 09.09.2014 as apart of the major study, tool proved to be comprehensible, feasible and acceptable.Data collection procedure for main study began from 25.09.2014 to 27.10.2014. Theinvestigator personally visited ASHAs and explained the

purpose of the study andcollected data from subjects who were interested and willing to participate in the study. They were assured of anonymity and confidentiality. Pre-test was conducted byusing structuredknowledge questionnaire to assessthe pre testknowledge followedby administration of SIM regarding First aid management , after 7 days post-test wasconductedwiththesamestructuredinterviewscheduletoassesstheposttestknowledge.   The study was conducted according to the convenience and choice ofASHAs.

Thedatagathered wereanalyzed andinterpretedaccordingtoobjectives.

Descriptive statistics mean and standard deviation were used. And inferential statistics like paired 't' test and chi-square were included to test the hypothesis at differentlevelsofsignificanceandthedataobtainedare presentedinthegraphicalform.

Majorfindingsofthestudy:
Findingsrelatedtosociodemographiccharacteristics ofthesubjects:
1. Majority 43.3% (13) of the respondents were in the age group of 25 – 30 yearsfollowed by 43.3% (13) of the respondents were in the age group of 31 – 35 years,13.3% (4) of the respondents were in the age group of 36 – 40 years and none in theagegroup of41– 45 years.
2. Majority76.7%(23)oftherespondentswerecompletedhighschooleducation,23.3%(7)werecompleted   Preuniversity education.
3. Majority90%(27)oftherespondentsweremarriedandremaining10%(3)respondentswere widowers.
4. Majority 90% (27) of the respondents were belong to Nuclear family and remaining10%(3)respondentswerebelongs toJointfamily.
5. Allthe100%ofrespondentswereHindu.
6. Majority 66.7% (20) of the respondents had 4 – 7 years of experience, 20% (6) of therespondents had1 – 3 years of experience, 13.3% (4) of the respondents had 8 – 9yearsofexperience.
7. Majority 70 % (21) of respondents had monthly family income Rs. Less than 10,000,30%(9)of respondentshadmonthlyfamilyincome Rs. 10,001– 15,000.
8. Majorityof40.0%(12)respondentswerereceivinginformationfromInserviceeducation/training,26.7%(8)respondents werereceivinginformationfromhealth
    personnel,20.0%(6)respondentswerereceivinginformationfrommassmedia,13.3% (4) respondents were receiving information from Books/ Magazines/Journal and norespondenthadattendedanyworkshoporconference.
9. Findingsrelatedtoknowledgeregardingfirstaidmanagementamong

ASHAs
1. The overall pre test mean knowledge score was found to be 41.2%.The highestmeanknowledgepercentagewasseenintheaspectoffirstaidkit58.8%followed by Generalinformation46.1%, Related toBurns41.0 %,Relatedtoroad traffic accidents 40.8 %, Related to snake bite 40.6 % Related to drowning37.5%andthelowestmeanpercentagewasseenintheaspectRelatedtopoisoning37.1%.
2. The overall post test mean knowledge score was found to be 76.3% . The highestmean knowledge percentage was seen in the aspect of Related to Burns 81.9 %followed by Related to poisoning 81.5 %, Related to drowning 80 % , Related tofirstaidkit76.6%,Relatedtoroadtrafficaccidents74.1%Relatedtosnakebite 70.6 % and the lowest mean percentage was seen in the aspect Generalinformation67.1% .
3. The overall pre test mean knowledge score was 41.2% and post test value was76.3% with enhancement of 35.1 %. Calculated "t" test value of 23.85* is greaterthan table value [t (0.05, 49df) = 1.96] hence study found to be significant at 5%level.

FindingsrelatedtoassociationbetweenPosttestknowledgescoresandSociodemographicvariables:
1. The association between post test knowledge score and socio demographicvariableswerecomputed byusingchi-squaretest.
2. There was significant association between Age(5.99^S) , Marital status(4.89^S) ,Sourceofinformation(11.67^S)andpost-testknowledge scores.
3. There was no significant association betweeneducational status(2.134^{NS}),typeoffamily(2.452^{NS}),monthlyfamilyincome(1.678^{NS}),workingexperience(2.476^{NS})and theposttestknowledgescores.

References:-

1. Facts about injuries to children at school. Available from:http://ukhealthcare.uky.edu/uploadedfiles/school.facts.pdf
2. Parker G Thomas. Introduction to first aid. Available from:http://www.healthguidance.org/entry/8941/1/introduction_to_first_aid.html
3. EngelJayce,(1993),"MOBY'sPOCKETGUIDESERIESPEDIATRIC
4. ASSESSMENT,"3rdedition,MosbyPublishers,Newyork,page no;3-37,109.
5. The national first aid science advisory board. Availablefrom:
6. http://circ.ahajournal.org/content/112/22;suppl/III;115.full.
7. Dajer J Antonio. First aid. Available from:http://www.ilo.org/safework_bookshelf/english?content&nd=857170142
8. Firstaidfor theinjured.StJohnAmbulance association,2008;123-124
9. T.K.Indirani,Firstaidfornurses,1stedition,NewDelhi,Jaypeepublishers,2003.
10. Mrs.Kazi Fauzia Jawed, Effectiveness Of Planned Teaching Programme OnFirst – Aid For Selected Accidents & Emergencies For School Children InSelectedHighSchools Of UdupiDistrict NNT2007Dec;30-32
11. WHO.Theglobalshortageofhealthworkers,theirtraininganditsimpact.WHOfactsheet302.Geneval:WHO2006.
12. TheASHAintheNRHMasparahealthworker,Availablefrom:http://essaybank.degree-essays.com/health/the-asha-in-the-nrhm-as-para-health-worker
13. Ababa Addis. First Aid extension package. Federal Democratic Republic ofEthopia,Ministryofhealth.2003Sep.Availablefrom:http://cnhde.ei.columbia.edu/training/documents/First_Aid.pdf
14. Researchshowschildrenlackfirstaidskills.BritishRedCross.[Cited2010May4].http://www.redcross.org.uk/standard.aspid=88738.
15. Healthandsafetyteam.GuidanceforHeadteachersandmanagersonfirst aid.
16. EastSussexcountycouncil,FlinderUniversity. 2011
17. Jagnoor,Wilsonsuraweera,Lisakeay,RebeccaQIvers,JSThakur,PrabhathJha and Million death study collaborators,BMC Public health2012,12:487 doi:10.1186/1471-2458-12-487.Available from:http://www.biomedcentral.com
18. MotorTransportStatisticsofIndia,TransportResearchWing,MinistryofRoad,Transportand Highway,NewDelhi.
19. World Health Organization. Handbook for the documentation of interpersonalviolencepreventionprogrammes.Geneva:WHO;2004availablefrom:http://www.nimhans.kar.nic.in/epidemiology/bisp/fs8.pdf)
20. National Crime Record Bureau NCRB accidental death and suicides in Indiaministry of home affairs New DelhiGovtof India 2007 availablefrom:http://www.nimhans.kar.nic.in/epidemiology/bisp/fs8.pdf
21. Melita. R. S, Sharma. S. S, Pandel. R. K.effect on training program regardingfirst aid management among high school students. Journal of Nepal HealthResearchCouncil.2005;3(1):17-20
22. GGururaj,injuriesandviolenceinIndia,factsandfigures,NIMHANS,publicationno.82,Bengaluru.Availablefrom:www.nimhans.kar.nic.in/epidemiology/bisp/ivipdfS 2011
23. AustNZJPublichealth2006Apr;30(2):147-50.Communityfirstaidtraining
24. in western Australia . Discipline of Emergency medicine , Aboriginal andruralhealth care university ofwesternAustralia
25. Singh AJ, Kaur A. Minor injuries in ninth class school children of ChandigarhandruralHaryana.Indian Pediatr.1996 Jan;33(1):25-30.
26. PolitD,HungerHP.Nursingresearchprinciplesandmethods.5thed. Philadelphia:Lippinkott;1999.p156-58,76
27. J Pak Med Assoc. 2012 Mar;62(3):218-21 Knowledge, attitude and practicesofreliefworkersregardingfirstaidmeasures.FatemezahraInfertilityandReproductiveHealthResearchCenter,DepartmentofMidwifery,BabolUniversityofMedicalSciences,Babol
28. TeachingwildernessfirstaidinaremoteFirstNationscommunity:thestoryoftheSachigoLakeWildernessEmergencyResponseEducationInitiative. Institute of Health Policy & Management, Faculty of Medicine, University ofToronto,Toronto,ON,Canada.PMCID:PMC3482695PMID:23110258[PubMed-indexed forMEDLINE]
29. Khan A, Sheikh S. Knowledge attitude and practice of undergraduate studentsregarding first aid measures. Journal of Pakistan Medical association. [Cited2010May6].http://:www.jpma.org.pk/editorialboard.php.
30. George Bolling, Hans Alvin Wahl, Training of community health workersregarding first aid measures, volume 80 , Issue 6 , June 2009 , Pages 689 -692
31. Nafissi N,Saghafinia M, Balochi K. Improving trauma care inElam the

ruralIranbytrainingexistingtreatmentchains.2008Oct–
December.[cited2010May1].8(4):P.881.http://:www.rrh.org.au/publishedarticles/ari.

32. BaserM,CobanS,TasciS,Sungur,BayatM.,Evaluatingfirst–aidknowledge and attitudes of a Turkish primary school teachers. J Emerg Nurs.2007Oct:33(5):428-32

33. King L, Thomas M, Gatenby K, Georgiou A, Hera M. First aid for scaldcampaign:reachingSydne's,Chinese,Victanamese,andArabicspeakingcommunities.BMJ2006;12:427-429.

34. ALikarEB,EssienAA,Childhoodepilepsy:knowledgeandattitudeofprimaryschoolteachersinPortHarcourt,Nigeria, NigerJed.2005Jul-Sep;14(3):299-303.

35. Singur AJ, Thode HC, Cronin KA. Paediatric first aid knowledge. JCN 2004Dec;20(12):808-11.

36. Uray T,Lunzer A, Ochsenhofer A, Thanikkel L, Zingerle R, Lillie P, Brandl E,SterzDepartmentOfEmergencyMedicine,UniversityofVienna,Austria;"feasibility of Life supporting First aid training as a mandatory subject inprimaryschools; Resuscitation,2003 November,59(2);211-220

37. Aly SA Ahmed NI, Department of community health nursing, higher instituteof nursing, Zagazig university, J Egypt Public health association. 2003:68(1 -2):101 –118.33

38. Engeland A, Roysamb E, Smedslund G, Sogaurd A .J. Effects of first-aidtraininginJuniorhighschools,InjControlSafPrompt.2002Jun;9(2):99-106

39. Goniewicz M, Chemperek E et al , " Attitude of students of high school inLublin towards the problem of first aid " . Wiad Lek 2002 ; 55 Suppl 1 , Pages679 – 685

40. Gagliardi M, Neighbors M, Spears C, Byrd S, Snarr J. Emergencies in theschoolsetting:arepublicschoolteachersadequatelytrainedtorespond.PrehospitalDisasterMed.1994Oct-Dec;9(4):222-5.

41. PrabhjotSaini,RanadiveP,MahalR.StudyofKnowledgeofFirstAidManagement and Emergency Care in Burn Patients . TNAI journel .2009;c(7):1-4.

42. Sani P, RanadeveP, Mahal R. Study of knowledgeof first aid managementandemergencycareinburnpatients.2009;[3screens].Availableat:http://www.tnainonline.org.Accessed November15,2009.

43. Brain O Neil.(2000).First aid forschool children. At gosford Hospital ,JonesandBartlell publishers.(3rdedi).45-46

44. PrabhakaraG.N,Textbookofcommunityhealthfornurses1stedition,PeepeePubhlishers,NewDelhi.(2005).pageno 205

45. JulieConsidine ,BelindaMitchell .Chemical, biological and radiologicalincidents: preparedness and perceptions of emergency nurses [internet] 2008Nov3[cited2009Oct23];33(482-97).Availablefrom:http://onlinelibrary.wiley.com/ doi/10.1111/j. 1467-

46. 7717.2008.01084.x/abstract

47. Ann E Hiott, M D, Sara A Quandt, Julie early et. al. Review of pesticideeducation materials for health care providers providing care to agriculturalworkersNationalruralhealthassociation[Internet].2006Availablefrom:

48. www.factic.org/pdf/mig_review/20of/20pesticide/20materials.pdf

49. Jors M D. Acute pesticide poisonings among small- scale farmers in la PazcountryBolivia[Internet].2004.[(Thesis)Submittedtofacultyofhealthsciences university of copengahen]: Bolivia ,department of international healthinstitute for public health. Available from:

50. plagball.org.po/file/thesis%20plagball%20version%20completea%20en%20ing.lef.pdf.

51. Aiwerasia VF, Ngowi,David N,MaedaTimo J Partanen. Assessment ofthe ability of health care providers to treat and prevent adverse health effectsof pesticides in agricultural areas of Tanzania. Int J of Occupational Med andEnvnt H. 2001 ; 14(4):349—56.Available from:http://www.imp.lodz.pl/upload/oficyna/artykuly/pdf/full/Ngowi4-04-01.pdf

52. Alirol E, Sharma SK, Bawaskar HS, Kuch U, Chappuis F. Snake bite inSouthAsia: areview2010 Jan 26: 4(1):e603.

53. Currie BJ, Canale E, Isbister GK, (2008). Snake bites treated by pressureimmobilisation at Australia in pediatric emergency dpt,Journal of society ofpediatric Nurses.5(2).

54. Dr.Owen Lewis. (2004) .Clinical Management of Snake Bite In South EastAsianRegion, Nepal. Vol (58).

55. Discipline of Emergency Medicine, School of Primary, Aboriginal and RuralHealthCare,UniversityofWesternAustralia,Level2,RBlock,QueenElizabethIIMedicalCentre,Nedlands,WA 600.

56. Daniels P. Drowning Physiology After the rescue. 2009 April 20.[Cited

2010May6].http://www.lib.niu.edu/1982/ip820732.html.

57. MassGeneralHospitalforChildren.Firstaidtraining.2010.[cited2010May5].http://www.mgh.harvard.edu/children/ professionals/default.aspx.

58. Roy N. Murlidhar V. Where there are no emergency medical services prehospital care for the injured in Mumbai,   India.   [online]   2010   [cited   2010   Nov5]Available fromURL:http://www.ncbi.nih.gov/pubmed/20467994

59. Jain   A.MenzesRG.   Twowheeleraccidentson   Indiaroads- astudyfromMangalore,India.[online]2009[cited2010Nov5]AvailablefromURL:http://www.ncbi.nih.gov/pubmed /19239962

60. Sosada.k,Zurawinski   w,StepienT.   Evaluation   of   the   knowledge   of   teachers andhighschoolstudentsinSilesiaontheprinciplesoffirstaid.IndianJpublicHealth.2004Lan-mar;39(1):23- 5.URL:http://www.ncbi.nih.gov/pubmed/17474616

61. GuptaS.,RoyChowdhuryU.B.,DebP.K.,etal(2003),AvailablefromURL:http://www.ncbi.nih.gov/pubmed/199152 76.

62. Arbon   Paul.,   Hayes   Jo   (2000)   with   the   aim   on   first   aid   and   Harm   minimizationforvictims ofroadTraumaWesternaustralia

63. Eva   M.Larsson.,   Niklas   L.   Martensson.,   Kristina   A.E.   Alexanderson   (1998)   onFirstAidTraining andBystanderActionsatTrafficCrashes–

64. Vikas Bhatia, Sonia Puri, Chetna Mangat, Amrit Pal Kaur.An Interventionalstudy to strengthen first aid care in schools of Chandigarh, India. Int. Jou2010(8):1

65. PRUITT.V.M,workrelatedburnsjournalofoccupationalenvironmentalmedicine,2006, 5 (2): pageno. 423 – 433

66. Divya   K   A.   evaluate   the   effectiveness   of   SIM   on   knowledge   of   IT employeesregardingpreventionofhypertension,RajivGandhiUniversityofHealthSciencesBangalore,(Unpublished thesis)

67. SharmaSK.Nursingresearchandstatistics.1[st]ed.Haryana:Elsevier;2011.p.288-297. p. 153-155.

68. CarolL.MacneeandSusanMcCabe.UnderstandingNursingResearch.2[nd]edition.Philadelphia:LippincottWilliamsa ndWilkinsPublishers.p.no.180-184

69. Gulla.J.(2004).KnowledgeofFirstAid.DepartmentofemergencyMedicine.   StonyBrookUniversity.USA(20).

70. LubranoR,RomeroSetal,UniversitydeglistudidiRomaLaSapeinza324,0016Roma, Italy:2005 march:64(3):303 – 7

71. PradhanS.K,firstaidknowledgeassessmentinanurbanslumof   Delhi.

72. Indian JournalofCommunitymedicine. (2007).