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A STUDY TO ASSESS THE PLANNED TEACHING PROGRAMME OF PERINATAL DEPRESSION IN TERMS OF KNOWLEDGE AND ATTITUDE AMONG STAFF NURSE WORKING IN MATERNITY WARD OF SELECTED HOSPITALS

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INTRODUCTION

Mental health is an integral part of health and is more than the absence of mental illnesses. It refers to a broad array of activities directly or indirectly related to the mental well-being, prevention of mental disorders and treatment and rehabilitation of people affected by mental disorder. **(World Health Organization)**

BACKGROUND OF THE STUDY: -

According to WHO Report, one in 4 people in the world will be affected by mental or neurological disorders. Around 450 million people currently suffer from mental disorders worldwide.

Antenatal care refers to the care given to an expectant mother from the time the conception until the beginning the labour. It includes monitoring the progress of pregnancy, providing appropriate support to the women and her family and providing information. Ideally the antenatal mother should visit the antenatal clinic once a month during the first seven months, twice a month during eighth month and there after once a week if ever thing normal.

The term puerperium or puerperal period or immediate postpartum period is commonly used to refer to the first six weeks following childbirth. The **World Health Organization (WHO)** describes the postnatal period as the mostcritical and yet the most neglected phase in the lives of mothers and babies; most maternal and newborn deaths occur during the postnatal period.

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite and poor concentration. Moreover, depression often comes withsymptoms of anxiety.

Perinatal depression is a term used to describe a major depressive episode during pregnancy (also referred to as antepartum or antenatal period) and after the birth or adoption of baby. Perinatal depression is more than the baby blues.

Antenatal depression also known as prenatal depression is a form of clinical depression that can affect a woman during pregnancy and can be a precursor to postpartum depression if not properly treated.

The postnatal period is well established as an increased time of risk for development of serious mood disorders. There are three common forms of affective illness: the blues (baby blue, maternity blues), postpartum depression (postnatal depression) and puerperal psychosis (postpartum psychosis). Each of which differs in its prevalence, clinical presentation and management, **(World Health Organization, 2008).** Postpartum depression is more severe than the baby blues and can occur anytime in the first year postpartum. PPD typically emerges over the first two to three postpartum months but may occur at any point after delivery. May start with the same symptoms as the baby blues but the symptoms don't resolve within two weeks and they become more severe. History of major depression increases risk by 25% and past history of postpartum depression increases recurrence rates by 25%.

Mental health disorders in the perinatal period are particularly important because they occur at a critical time in the lives of the women, her baby and her family. For most women, having a baby is a very exciting, joyous and often anxious time. But for women with perinatal depression, it can become very distressing and difficult. Perinatal depression is a serious but treatable mental illness involving feelings of extreme sadness, anxiety, as well as changes in energy, sleep and appetite. It carries risk for the mother and child. Pregnancy and the period after delivery can be aparticularly vulnerable time for women. Mothers often experience immense biological,

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emotional, financial and social changes during this time. Some women canbe at an increased risk for developing mental health problems, particularly depression and anxiety. (**American Psychiatric Association)**

Perinatal depression is different from the "baby blues" in that it is emotionally and physically debilitating and may continue for mothers or more. Getting treatment is important for both the mother and the child. Untreated perinatal depression is not only a problem for the mother's health and quality of life, but can affect the well- being of the baby who can be born prematurely, with low birth weight. Perinatal depression can cause bonding issues with the baby and can contribute to sleeping and feeding problems for the baby. In the longer-term, children of mothers with perinatal depression are at greater risk for cognitive, emotional, development and verbal deficits and impaired social skills. The relationship between the women and herpartner may also be negatively affected. (**American Psychiatric Association)**

NEED OF THE STUDY

According to **World mental health day 10th October 2012,** Depression is significant contributor to the global burden of disease and affects people in all communities across the world.
Depression is the fourth leading contributor to global burden of disease and the leading cause of disability according to **World Health Organization.**
The reported prevalence of postpartum depression in India ranges between 15.3%and 23.0% with an incidence of 11%. Around 14% of mothers continue to have symptoms of depression till up to 6 months after delivery. Economic and interpersonal relationship issues, partner violence, alcohol use by spouse and genderof newborn child are among the major determinants of postpartum depression.
Worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is even higher, i.e., 15.6% during pregnancy and 19.8% after child birth. In severe cases mother's suffering might be so severe that they may even commit suicide. In addition, the affected mothers cannot function properly. As a result, the children's growth and development may be negatively affected as well. Maternal mental disorders are treatable. **(Maternal mental health, WHO)**
Postpartum depression can start soon after childbirth or as a continuation of antenatal depression and needs to be treated. The global prevalence as 100-150 per 1000 births. Based on the random effects model, the overall pooled estimate of the prevalence of postpartum depression in Indian mother was 22% (95% CL: 19-25). The estimated overall pooled prevalence was highest in the southern region of the country (26%), followed by eastern (23%), south western (23%) and western regions (21%). The northern regions of India had the lowest prevalence (15%). (**WorldHealth Organization)**
Early studies found that 50% to 70% of women experience postpartum blues during the first few weeks after delivery. **American psychiatric association** estimated that accordingly, 01 out of 08 postnatal women may experience blues in their life time, it affects 11.5 million people every year. In India, the prevalence of postpartum psychiatric morbidity was 33.4% and 6.5% of cases had major illness withpostnatal depression and psychosis. In India, the incidence of depressive disorders is more in the state of Goa and rural South India are detected depressive disorder in 23%and 16% respectively, with depression persisting six months after child birth in 11-14% of women. (American **psychiatric association)**
A recent meta-analysis showed that about 20% of mothers in developing countries experiences clinical depression after childbirth. This is much higher than theprevious figure on prevalence coming mostly from high income countries. Suicide is an important cause of death among pregnant and postpartum women. Evidence indicates that treating the depression of mothers leads to improved growth and development of the new born and reduces the likelihood of diarrhea and malnutrition among them. (**Maternal Mental Health, WHO)** A community based prospective study in India found out incidence of postpartumpsychiatric disorder in rural women to be around 11% which is comparable to incidence in western culture where 10-15% of all women are affected with PPD. In adolescent mothers it was around 26%. Family history of mental illness was observed in 25% of patients. (**International Journal of Reproduction, Contraception, Obstetrics and Gynecology)** While postpartum depression has historically been associated primarily with mothers, recently there has been increased awareness of the experience of fathers and strategies to address postpartum depression in men. For both men and women, PPD is defined as moderate to severe depression diagnosed in the postpartum period, hichis shortly after or up to one year following delivery. Perinatal depression is a mental disorder that is pervasive in the world and affects us all. Unlike many large-scale intervention problems, a solution for depression is at hand. Efficacious and cost-effective treatments are available to improve the health and the lives of the millions of people around the world suffering from depression.
Perinatal psychiatric disorders are prevalent among the perinatal mothers. Nurses are the workers, whose main responsibility is to provide safe and effective care with constantly evolving health care systems, also should be alert for the sign of perinatal psychiatric disorders and be prepared to help, promote attachment between mother and baby, referral of the mother and the family for support services and counseling and assisting the family in prioritizing and performing necessary family functions. The nurse can help the mother acknowledge her new role and to maintain strong maternal role and bonding. To provide optimum care to perinatal mothers,

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the nurse should have adequate knowledge in perinatal mental health and its management.

OBJECTIVES OF THE STUDY

To Assess the Knowledge of Staff Nurses before and after administration of a Planned Teaching Program on Perinatal Depression among Staff Nurses.
To Assess the Attitude of Staff Nurses before and after administration of a Planned Teaching Program on Perinatal Depression among Staff Nurses.
To Find out the Correlation between Post Test Knowledge and Post Test Attitude on Perinatal Depression among Staff Nurse.
To Find out the Association of Pre-Test Knowledge Score with SelectedDemographic Variables among Staff Nurses.
To Find out the Association of Pre-Test Attitude score with Selected Demographic Variables among Staff Nurses.

HYPOTHESIS OF THE STUDY

H_1: The Mean Post Test Knowledge score will be significantly higher than their MeanPre-Test Knowledge score of Staff Nurses after administration of A Planned Teaching Programme on Perinatal Depression as determined by Structured Knowledge Questionnaire at 0.05 level of significance.
H_2: The Mean Post Test Attitude score will be significantly higher than their Mean Pre-Test Attitude score of Staff Nurses after administration of A Planned Teaching Programme on Perinatal Depression as determined by Likert‟s Attitude Scale at 0.05 level of significance.
H_3: There will be significant Correlation between Post Test Knowledge and Post Test Attitude of Staff Nurses after administration of A Planned Teaching Programme on Perinatal Depression.
H_4: There will be significant Association between Pre-Test Knowledge score and Demographic Variables of Staff Nurses.
$H_{5:2}$ There will be significant Association between Pre-Test Attitude score and Demographic Score.
OPERATIONAL DEFINITION: -

- **Assess:** In this study assess means to find out the level of Knowledge and Attitude regarding Perinatal Depression among Staff Nurses working in Maternity Ward of Selected District Hospitals of Gujarat State.
- **Effectiveness:** Effectiveness is defined as the capability of producing a desired effect. In this study effectiveness refers to the efficiency of a Planned Teaching Program is increasing the Staff Nurses Knowledge and Attitude regarding Perinatal Depression.
- **Planned Teaching Program:** In this study Planned Teaching Program is the program of teaching activities designed well in advanced by the investigator for imparting knowledge through conducting the class using lecture cum discussion method.
- **Perinatal Depression:** In this study Perinatal depression is a term used to describe a major depressive episode during lab our and after the birth (also referred to as the postpartum or postnatal period). Perinatal depression is more than the baby blues.
- **Knowledge:** In this study the Knowledge refers to the range of information, theoretical understanding or awareness of Staff Nurses regarding Perinatal Depression while responding to the Structured Knowledge Questionnaire prepared by the investigator for the study.
- **Attitude**: In this study it refers to expressed feeling, opinion, beliefs of Staff Nurse regarding Perinatal Depression while responding to the Likert‟s Attitude Scale prepared by investigator for the study.
- **Staff Nurse:** Nurse who refers to having Diploma or Degree of nursing by INC and GNC through recognized institution and registered as R.N.R.M., who has adequate knowledge, experience and skill in their area of work.
- **Maternity Ward:** In this study Maternity Ward refers to a ward in a hospital allocated for the treatment and care of women and babies during pregnancy, during childbirth and after childbirth.
- **Hospital:** The term Hospital is used here to mean a hospital at the secondary referral level of responsible for a district of a defined geographical area containing a defined population. In this study, hospitals refer to the area, where the registered staff nurses are providing care for mother during perinatal period.

DELIMITATIONS

This study is limited to:
1. Staff Nurses working in Maternity Ward of the Selected District hospitals ofGujarat state.
2. Sample size only 50 Staff Nurses working in Maternity Ward of the SelectedHospitals of Gujarat state.
3. The Staff Nurses who are present at the time of data collection.
4. The Staff Nurses who are willing to participate in the study.

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CONCEPTUAL FRAMEWORK

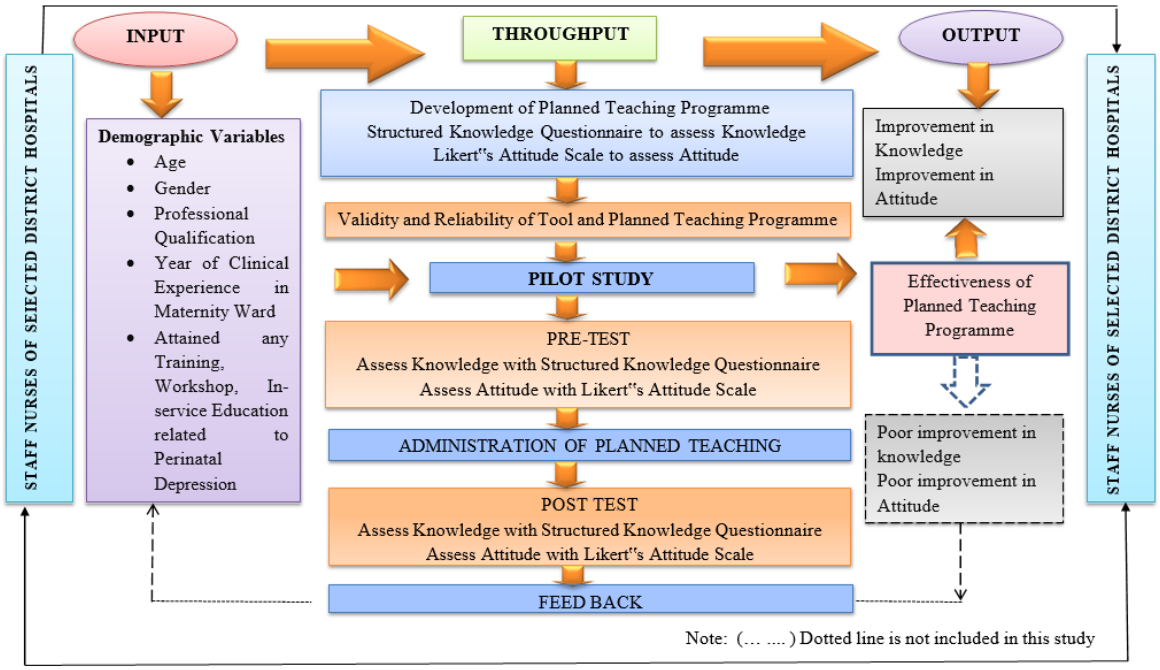

Figure 1: Conceptual Framework based on General System Theory Model

METHODOLOGY

The methodology of research indicates the general pattern of organizing the procedure for gathering valid and reliable data for the purpose of investigation (**Polit D.F. and Hungler, 2007).** The content of this chapter includes research approach and its rational, description of settings and populations, sampling technique, tool selection,construction, description and rationale of the tool, development and description about the Planned Teaching Programme, validity and reliability of the tools, pilot study, procedure of data collection and plan for data analysis.

VARIABLES OF THE STUDY: -

Independent Variables: Planned Teaching Programme on Perinatal Depression **Dependent Variable:** Knowledge and Attitude of Staff Nurses regarding PerinatalDepression

Demographic Variable: Age, Gender, Professional Qualification, Year of Clinical Experience in Maternity Ward, attained any Training, Conference, Workshop.

Rationale

The rationale for selecting hospitals is familiarity with setting, availability of samples, feasibility of conducting the study and availability of subject, easy access to subjects' same infrastructure. It provides preventive, promotive, curative and rehabilitative treatment. It also has facilities for education and research and well equipped with advanced technology. These entire departments have trained and registered nurses.

DEVELOPMENT OF THE TOOL: -

The development of tool is a step-by-step procedure in order to make the tool more practical oriented. The investigator reviewed the literature regarding Perinatal Depression, such as books, articles, published and unpublished thesis to develop the tool to assess the Knowledge and Attitude regarding Perinatal Depression among Staff Nurses.

1. Development of Structured Knowledge Questionnaire

Development of Structured Knowledge Questionnaires were prepared to assess the Knowledge regarding Perinatal Depression among Staff Nurses working in Maternity Ward of Selected District Hospitals of Gujarat State by an expensive research and non-research literature and also look the opinion of the experts. The Structured Knowledge Questionnaire consists of total 20 items and maximum score was 20. Each item contained 4 options of answer. Every correct answer was given a score of one and wrong answer was given a zero score. The responses were given by the Samples is addressed by putting tick mark (√) on tool prepared.

2. Development of Likert"s Attitude Scale

A five-point Likert"s Scale type of Attitude Scale was constructed to assess the Attitude of Staff Nurses regarding Perinatal Depression. Likert"s Attitude Scale consists of 20 items. In this 10 Positive and 10 Negative statements.

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On a five-point scale as Strongly Agree, Agree, Undecided, Disagree, strongly disagree, the response was given by the Staff Nurses by putting tick mark (√) on the rating scale. The overall minimum score forthe test is 20 and the maximum score is 100.

3. Development of A Planned Teaching Programme

A Planned Teaching Programme on Perinatal Depression was developed for the Samples. By an expensive research and non-research literature and also look the opinion of the experts. For developed the Planned Teaching Programme, content was to selected and organized. Research guide and experts validated the content.

DESCRIPTION OF TOOL: -

The investigator was to prepare a data collection tool consisting of three sections.
The personal data of the Samples to assess the Demographic Variables of theSamples,
Structured Knowledge Questionnaire to assess Knowledge and Likert‟sattitude scale
to assess the Attitude of Staff Nurse.

VALIDITY OF THE TOOL: -

For content validation, the Structured Knowledge Questionnaire, Likert‟sAttitude Scale along with statement and a Planned Teaching Programme on Perinatal Depression was submitted to 9 experts comprising of 4 Master of Nursing in Mental Health Nursing, 2 Master of Nursing in OBG, 2 MD psychiatrist and 1 MDGynecologist. Investigator has developed the tool under the guidance of research guide and co-guide and expert opinion to make items clearer and easier to understand for the samples. The first draft of tool consisted of 20 items on Knowledge and 20 items on Attitude.

RELIABILITY OF TOOL

The reliability is a criterion for measuring adequacy, consistency and accuracy of tool. The reliability of Structured Knowledge Questionnaire and Likert's Attitude Scale was determined by carrying out an initial try out on Staff Nurses working in Maternity Ward of selected District Hospitals of Gujarat State.

The reliability of the Structured Knowledge Questionnaire was determined by Test-Retest Method using „Karl Pearson's Formula‟. Reliability of Structured Knowledge Questionnaire was 0.78 which was more than 0.5; hence the questionnairewas found to be reliable. The reliability of Likert‟s Attitude Scale was determined by Test-Retest Method using „Karl Pearson‟s Formula‟. The Likert‟s Attitude Scale was 0.88 which is more than 0.5 hence the Attitude Scale was found to be reliable.

PILOT STUDY

Pilot study is a small-scale version of trial for the major study. The function isto obtain information for improving the project or assessing its feasibility. (**Polit & Hungler, 1995)**

The pilot study was conducted on Date 24th September 2019 and 1st October in M.G. General Hospital Navsari. The investigator personally contacted the Nursing Superintend of CIVIL HOSPITAL and discussed about the purpose of the study. The formal permission was taken from the concerned authorities, the additional director from Gandhinagar. The pilot study was conducted in two parts. Pre-Test was conducted and administered Planned Teaching Programme on Perinatal Depression. After 7 days, Post Test was conducted. Total 05 samples were selected for Pilot Study. The Samples were approached individually, objectives of the study were discussed and consent for the participation in the study was obtained. The data was collected through Structured Knowledge Questionnaire for knowledge and Likert‟s Attitude Scale for attitude regarding Perinatal Depression among Staff Nurses. The duration for Pre-Test and Post Test of Knowledge questionnaire was 20 minutes and the duration for Pre-Test and Post Test Attitude was 20 minutes and Planned Teaching Programme was 45 minutes. The data was collected from 05 Samples and analysis and interpretation of data done by using Descriptive and Inferential statistics. The Mean Post Test Knowledge score (16.8) was higher than Mean Pre-Test Knowledge score (10.6) with the Mean difference of 6.2 and Mean percentage gain was 31%. The Mean Post Test Attitude score (77.8) was higher than the Mean Pre-Test Attitude score (56) with Meandifferences (21.8) and Mean percentage gain was (21.8%). Significance of the difference between Pre-Test and Post Test Knowledge and Attitude were statistically tested using paired "t" test and it was found significance positive. Hence it wasproved that the Planned Teaching Programme was effective in improving the Knowledge and Attitude of Samples. The finding of Pilot Study shows that the tool was found to be consistent and reliable for final study. It was feasible to conduct the study as planned. No problem was faced during pilot study. Therefore, the plan for data collection was finalized Depression. Time duration provided for the Pre-Test was 20 minutes. After 7 days ofP0re Test investigator have conducted Post Test of the Samples.

(N =50)

Sr. No	Demographic Variables	Frequency (f)	Percentage (%)
1	**Age Group**		
	a. 21 – 30 years	20	40.0
	b. 31 – 40 years	13	26.0
		10	20.0

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	c. 41 – 50 years d. More than 50 years	7	14.0
2	**Gender** a. Male b. Female	 00 50	 00 100
3	**Professional Qualification** a. GNM b. Basic B.Sc. Nursing c. Post Basic B.Sc. Nursing d. M.Sc. Nursing e. Any Other	 03 01 07	 68.0 10.0 6.0 2.0 14.0
4	**Year of Clinical Experience inMaternity Ward** a. Less than 1 year b. 1-5 years c. 5-10 years d. More than 10 years	 15 14 08 13	 30.0 28.0 16.0 26.0
5	**Have you attended any Training, Conferences, Workshop or In- service Education RegardingPerinatal Depression?** a. Yes b. No	 11 39	 22.0 78.0

(N=50)

Area	Max Score	Pre-test Knowledge score of Samples			Post-test Knowledgescore of Samples			Mean difference	Mean % Gain
		Obtained score	Mean score	Mean Percentage	Obtained score	Mean score	Mean Percentage		
Introduction and Definition	04	97	1.94	48.5	157	3.14	78.5	1.2	30
Causes and Risk Factors	02	52	1.04	52	79	1.58	79	0.54	27
Sign and Symptoms	01	26	0.52	52	42	0.84	84	0.32	32
Screening and Early Detection	01	16	0.32	32	37	0.74	74	0.42	42
Complication	02	45	0.9	45	86	1.72	86	0.82	41
Prevention	02	57	1.14	57	87	1.74	87	0.6	30
Treatment	05	108	2.16	43.2	200	4	80	1.84	36.8
Nursing Responsibility	03	84	1.68	56	125	2.5	83.33	0.82	27.33
TOTAL	**20**	**485**	**9.7**		**813**	**16.26**		**6.56**	

	Max. score	Obtained score	Mean score	Mean %	Mean Difference	Mean % Gain
Pre test	20	485	9.7	48.5%		
Post test	20	813	16.26	81.3%	6.56	32.8%

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(N = 50)

Knowledge	Mean	Mean Difference	SD	SE	Calculated „t" Value	Tabulated „t" Value
Pre-Test	9.7		2.65			
Post Test	16.26	6.56	2.34	0.5	37.66	2.0096

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Note: t = p ≤ 0.05, df = 498

(N=50)

	MaxScore	Obtainedscore	Meanscore	Mean %	Mean difference	Mean percentage % Gain
Pre-Test	100	2934	58.68	58.68		
Post Test	100	4122	82.44	82.44	23.76	23.76 %

(N = 50)

AttitudeScore	Classification of score	Pre-Test		Post Test	
		Frequency(f)	Percentage(%)	Frequency(f)	Percentage(%)
Negative	20-60	38	76.0	02	4.0
Positive	61-100	12	24.0	48	96.0
Total		**50**	**100**	**50**	**100**

(N = 50)

Attitude	Mean	Mean Difference	SD	SE	Calculated „ t " Value	Tabulated „ t " Value
Pre-Test	58.68		7.90			
Post Test	82.44	23.76	8.53	1.64	33.04	2.0096

Note: t = p ≤ 0.05, df = 49

(N=50)

Post Test Knowledge mean score(x)	Post Test Attitude mean score (y)	Number of samples	Karl Pearson"s (r) Correlation n coefficient	Inference
16.26	82.44	50	0.71	Significant strong positive correlation at 0.05 level ofsignificant

(N = 50)

Professional Qualification	Pre-test Knowledgescore		Total	Calculated value of 2 x	TabulatedValue of 2 x
	Poor	Average			
GNM	06	28	34		
Basic B.Sc. Nursing	00	05	05		
P. B. B.Sc. Nursing	00	03	03	**2.60**	**9.49**
M.Sc. Nursing	00	01	01		
Any Other	02	05	07		
Total	**08**	**42**	**50**		

Significant at 0.05 level, df = 04

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(N = 50)

Age Group	Pre-test Attitude Score		Total	Calculateed value of χ^2	Tabulated Value of χ^2
	Positive	Negative			
21 – 30 years	08	12	**20**		
31 – 40 years	04	09	**13**		
41 – 50 years	00	10	**10**		
More than 50 years	00	07	**07**	**8.47**	**7.82**
Total	**12**	**38**	**50**		

Significant at 0.05 level, df =03

(N = 50)

ProfessionalQualification	Pre-test Attitudescore		Total	Calculated value of χ^2	Tabulated Value of χ^2
	Positive	Negative			
GNM	04	30	34		
Basic B.Sc. Nursing	04	01	05		
P. B. B.Sc. Nursing	01	02	03		
M.Sc. Nursing	00	01	01	**13.16**	**9.49**
Any Other	03	04	07		
Total	**12**	**38**	**50**		

Significant at 0.05 level, df =04

SUMMARY

This chapter deal with the analysis and interpretation of data collected from 50 Samples, to assess the Effectiveness of a Planned Teaching Programme on Perinatal Depression among Staff Nurses working in hospital in terms of Knowledge and Attitude. Descriptive andInferential statistics methods were used to analyses the data. The mean Post Test Knowledge score 16.26 was higher than mean Pre-Test Knowledge score 9.7 with mean difference of 6.56. The mean Post Test Attitude score 82.44 was higher than mean Pre-Test Attitude score 58.68 with the mean difference of 23.76 significance of the difference between Pre-Test and Post Test Knowledge and Attitude score were statistically tested using paired "t" test and it was found significantly positive. Hence, it was proved that the Planned Teaching Programme was effective in increasing Knowledge and Attitude regarding Perinatal Depression.

CONCLUSION

In the Demographic variables of samples, that out of 50 samples under study, in age group 40% were 21 to 30 years and 14% were more than 50 years. In gender 100% were female. In professional qualification 68% were GNM and 2% were M.Sc. Nursing professional qualification. In year of clinical experience in maternity ward 30% were less than 1 year experience and 16% were 5-10 years of experiences. 39 (78%) were not attended any training, workshop, conference and In-service education regarding Perinatal Depression. The investigator concluded that the Mean Post Test knowledge score 16.26was higher than the Mean Pre-Test Knowledge score 9.7 with mean difference of 6.56and calculated „t" value 37.66 was greater than the tabulated "t" value at 0.05 level of significance which was statistically proved. So, the Planned Teaching Programme waseffective in terms of Knowledge and the Null hypothesis was rejected and Research Hypothesis was accepted. The Mean Post Test Attitude Score 82.44 was higher than Mean Pre-Test Attitude Score 58.68 with the Mean Differences of 23.76 and calculated „t" value 33.04 was more than tabulated „t" value 2.0096 with 0.05 level of significance which was statistically proved. So, the Planned Teaching Programme was effective in terms of attitude and the Null hypothesis was rejected and Research Hypothesis was accepted. There was strongly positive correlation between Post Test Knowledge and Post Test Attitude score of Samples.

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