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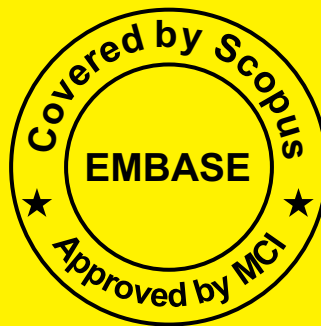
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Contents

Volume 10, Number 7

July 2019

1. Effect of Therapeutic Exercises on Pre-Menopausal Symptoms in Sedentary Life Style Women 1
Aishwarya V. Ahiwale, S. Anandh, Pranjali Gosavi
2. Does Commercially Available Tooth Brushes in India follow Recommended American Dental Association (ADA) Norms? 6
V. Anu, N. SaiSwetha, C. Ramya, N. Ruksana, D. Ranjani
3. Maternal Mortality at a Tertiary Care Hospital in North India: A 4 Year Review 11
Pratima Mittal, Garima Kapoor, Bindu Bajaj
4. Dose Response Relationship of Child Centered Task Oriented Training in Children with Cerebral Palsy- A Randomized Controlled Study. Study Protocol 17
Kovela Rakesh Krishna, Dhanesh Kumar K U
5. Association between Obesity and Elevated Blood Pressure among School Going Adolescents- A Cross Sectional Study 21
Lipilekha Patnaik, Sumitra Pattnaik, Trilochan Sahu, E. Venkata Rao, Saswatika Beura
6. The Effectiveness of Constraint-Induced Movement Therapy and Placing Technique of Bobath on Upper Limb Function in Hemiparetic Individual 25
Manali N. Hanphode, G. Varadharajulu, Suraj Kanase
7. Effect of Manual Positioning as an Adjunct to Intercostal Drainage in Hydropneumothorax 31
Monali M. Kashyap, Javid Hussain Sagar, G. Varadharajulu
8. Effect of Motor Control Training on Isolated Lumbar Stabilizer and Core Muscle Training in Chronic Low Back Pain Patients 37
Namrata P. Mane, G. Varadharajulu, Sandeep Shinde
9. Enterprise Gamification: A Motivational Drive at Workplace 43
P. S. Buvaneswari, M S Swetha
10. Design and Implementation of Performance Improved Medical Signal Filters with and without Multiplier 49
P.Saravanan, B. Latha, K. Bhoopathy Bagan
11. Effect of Inpatient Physiotherapy Intervention Versus Delayed Outpatient Physiotherapy Intervention in Post Stroke Hemiplegic Individuals 56
Pragati V. Salunkhe, G. Varadharajulu, Suraj Kanase
12. Effect of Therapeutic Intervention and Hand Muscle Training on Pain and Quality of Hand Function in Subjects with Chronic Tennis Elbow 61
Pranali Desai, G. Varadharajulu, Smita Kanase, Sandeep Shinde

13. Assessment of Balance in Children with Developmental Coordination Disorder in Indian Context 67
U. Ganapathy Sankar, R.Monisha
14. A Comparative Study to Determine the Effectiveness of the Taping and Mulligan’s Mobilization with Movement Techniques on Pain in Knee Osteoarthritis 71
Balaji R. Pawar, A. Jeganathan, R. Monisha
15. Perception of Undergraduates and Postgraduates of the Scope of Periodontics 76
F. Mariyam Niyas, Radhika Arjunkumar
16. Correlation between the Nature of Toothpaste and the Prevalence of Brushing Habits of Children Residing in Chennai 83
Rinieshah Nair R. Baskran, Deepa Gurunathan, Madhusudhan Vasantharajan
17. Effect of Structured Therapeutic Exercises Protocol on Physical Functional Status in Women with Varying BMI 88
Ruchita R Shah, S. Anandh, G. Varadharajulu
18. Effect of Choice-Based Sensory Stimulation as a Coma Stimulation Technique on Traumatic Brain Injury 94
Sayli D. Deshpande, G. Varadharajulu, Suraj Kanase
19. Knowledge Attitude Practice on the Oral Hygiene Practices in Children Below 12 Years 100
Shivani N, Revathy Gounder
20. Role of Tumour Necrosis Factor Alpha (TNF- α) in Pulmonary Pathophysiology of Chronic Obstructive Pulmonary Disease 105
Smriti Gupta, Ajit Kumar, Vishwajeet Rohil, Anuj K. Bhatnagar
21. Effect of Closed Kinematic Chain Exercises on Distal Muscle Weakness in Post Guillain Barre Syndrome 111
Sneha G. Narlawar, G. Varadharajulu, Suraj Kanase
22. Rugoscopy: An Adjunctive Diagnostic Tool for Malocclusion? 117
Swapna B V, Sheetal Shetty, Smitha S Shetty
23. Effect of McKenzie Approach and Neck Exercises on Forward Head Posture in Young Adults 123
Vishnupriya Deshpande, Khushboo Bathia, Smita Kanase, Amrutkuvar Pawar, Prachi Jain, Gatha Patel
24. Socio-economic, Hygiene and Nutritional Status of Indian Slums: A Scoping Review 128
K. Jansi Rani, S. Kavitha Maheswari, Sebastian Kot, A. Hariharasudan
25. Study of Correlation between Serum Lipid Profile and Thyroid Function in a Tertiary Care Hospital 133
Aryankumar, Ajit Sontakke, Sangita Patil, Dhirajkumar Mane
26. Self Management and Knowledge among People with Type 2 Diabetes 139
Aldrin Vas, Elsa Sanatombi Devi, Sudha Vidyasagar
27. Anti-Inflammatory Activity of Silver Nanoparticles Prepared from Ginger Oil—An Invitro Approach . 145
M. Maajida Aafreen, Roy Anitha, Rachel Christina Preethi, S. Rajeshkumar, T. Lakshmi
28. Comparative Evaluation of Maximum Bite Force and Facial Morphology—A Cross Sectional Study ... 150
Shweta Tiwari, Arathi Rao, Ramya Shenoy, Suprabha BS
29. Comparative Evaluation of Tensile Bond Strength and Shear Bond Strength of Mineral Trioxide Aggregate with Composite Resin and Resin Modified Glass Ionomer 156
Radhakrishnan S, Arathi Rao, Ramya Shenoy, Suprabha BS

30. A Study to Assess the Effectiveness of Planned Teaching Programme on Knowledge Regarding Prevention of Abuse among the Children of 11–14 Years of Age at Selected Schools of Sangli, Miraj, Kupwad Corporation Area 163
Bhavana Cristopher Samson, Manisha Sunil Kulkarni
31. Risk Factors Associated with Overweight and Obesity among Population of Ahmedabad, India 168
Bhoomi Arora, Snehal S. Patel, Banshi Saboo
32. Fast-Food Marketing and Children’s Fast-Food Consumption: A Trigger to Childhood Obesity 173
Binkey Srivastava
33. Retina Identification System Using Machine Learning and Multiple Regression Model 178
D. Nagarajan, R. Sujatha, J. Kavikumar, Udaya Mouni Boppana, Dhivyapriya
34. Breast Cancer Prediction Using Ensemble Techniques 183
G. Manikandan, B. Karthikeyan, P. Rajendiran, R. Harish, T. Prathyusha, V. Sethu
35. Effects of Pesticides on Lung Function Test in Farmers of Satara District, Maharashtra, India 186
Gauri Joshi, A. G. Joshi, S. N. Patil, Ajit Sontakke
36. A Study to Assess the Effectiveness of Planned Teaching Program on Knowledge Regarding the Care of Permanent Pacemaker at Home among Patients at Selected OPDs of Sangli and Kolhapur City 192
Jesica Dileep Mali, Sunil. Kulkarni
37. A Study to Assess the Effectiveness of Planned Teaching Programme on Knowledge Regarding Selected Pediatric Emergencies among Mothers of Under Five Children at Selected Anganwadi’s of Sangli, Miraj and Kupwad Corporation Area 195
Jesica Prashant Malap, Shaila Mathew
38. Comparative Evaluation of the Effect of Radiation Therapy on Surface Micro Hardness of Three Restorative Materials—An in Vitro Study 200
Karthik Shetty, Mary Byju, Chong Hao Phin, P U Saxena, Challapalli Srinivas
39. Evaluate the Association between Acrochordons and Systemic Diseases 205
Malar Mangai E., Harsha Vardhan K., Bhuvanarachagan A.
40. The Logical Investigation of the Digitalization and its Capacities, Particularly those Influencing Conduct in Human Brain Research on Based on the Psychological Distress 210
Nandita Sikari, K HariKrishnan
41. To Study Behavioral and Socio Economic Factors of Non Communicable Diseases in Northeast India Using NFHS-4 214
Phrangstone Khongji
42. A Study to Assess the Knowledge and Self Reported Practices Regarding Care of Arterio Venous Fistula among Patients at Selected Haemodialysis Units of Sangli City 220
Pratik N Amrao, Swati C. Kurane
43. A Study to Assess the Effectiveness of Topical Application of Honey on LSCS Wound Healing among Postnatal Mothers from Selected Maternity Hospitals of Sangli, Miraj and Kupwad Corporation Area 223
Priti D Khade, Archana Dhanawade
44. A Study to Assess the Level of Burden and Coping Strategies among Caregivers of Patient with Affective Disorders at Selected Hospitals of Sangli, Miraj, Kupwad Corporation Area 228
Ramesh Giramalla Honamore, Narayan K Ghorpade

45. Factors Affecting Awareness and Perception of Youth Regarding the Public Health and Hygiene Related Campaigns through Social Marketing	233
<i>Roktim Sarmah, Dheeraj Nim</i>	
46. Three Stepped Approach to Screening of Cervical and Breast Cancer among Rural Women	239
<i>Asha K. Pratinidhi, Radhika Joshi, Vaishali Vhawal, Pandurang Chougule, Sunita Tata, Satish Kakade</i>	
47. Single-Visit versus Dual-Visit Endodontics—A Comparative Study	244
<i>Sanjay M Londhe SM, Sonali Sharma, Sheetal Lal</i>	
48. A Study to Evaluate the Effectiveness of Ginger Tea on Morning Sickness among Antenatal Mothers in Selected Area of Sangli, Miraj, Kupwad, Corporation	251
<i>Seema D Shiradwade, MS. Regina Satvekar</i>	
49. Contraceptive Methods: Knowledge, Practice and their Attitude among the Women of Rural Population in and around Bangaluru City of Karnataka State, India	257
<i>SenigalaKuruba Anusuya, Sudha Patil</i>	
50. Comparison Prophylactic Glycopyrrolate, Dexamethasone, Metoclopramide in Control of Nausea and Vomiting after Spinal Anaesthesia for Caesarean Delivery	261
<i>Gautam Malhotra, Suresh Y. V., Anupama Suresh Y, Shaik Gulam Osmani, Kavya Prabhu</i>	
51. A Study to Assess the Effectiveness of Eucalyptus Oil on Knee Pain among Osteoarthritis Patients in Selected Areas of Sangli, Miraj and Kupwad Corporation	267
<i>Siddhant N. Shirgaokar, Pravin Dani</i>	
52. A Study to Assess the Knowledge Regarding Self-Care Management among the Pregnant Mother with PIH Attending Selected Maternity OPD's of Tertiary Hospitals in Sangli, Miraj and Kupwad Corporation Area	272
<i>Silviya John Gaikwad, Vijaya Kumbhar</i>	
53. A Study to Assess the Relationship between Job Satisfaction and Burnout among Staff Nurses Working in Selected Hospitals of Sangli, Miraj and Kupwad Corporation Area	277
<i>Umesh Kisan Rathod, Satish Salvi</i>	
54. A Study on Awareness among Employees on Health Care and Appraisal System Adopted in Pharmacy Companies	281
<i>S. Poongavanam, S. Jivita</i>	
55. A Study on Impact of Occupational Health and the Changing Business Scenario of Corporate Appraisal	285
<i>S. Poongavanam, S. Jivita</i>	
56. An Empirical Study on Employee Health and FIRO-B Relationship	289
<i>S. Poongavanam, K. Viswanathan</i>	
57. An Empirical Study on Environmental Hazards and Recruitment Process in Health Care Companies, Chennai	293
<i>S. Poongavanam, K. Viswanathan</i>	
58. Impact of Health Care Laws and Employee Relationship, Policies in Pharma Companies—A Study	296
<i>S. Poongavanam</i>	
59. Antioxidants and Antibodies in Structural Thyroid Diseases	299
<i>Anita P Javalgi, B R Yelikar, Kusal Das</i>	

60. Enhancement of Facial Aesthetics and Function in Posteriorly Edentulous Mouth:
An Orthognathic Surgical Case Report 305
Ashith M. V., Mustafa Khader, Utkarsh Mangal, Mithun K
61. A Study on Development of Processes for Verification and Validation in Medical Device Domain 312
P. Shireesha, P. Niranjana
62. A Technique for Network Design and Requirements for Medical Sensors 317
V. Chandra Shekhar Rao, P. Niranjana, A. Sowmikadurga
63. Breast Self-Examination and Clinical Breast Examination: Knowledge, Practice, and Awareness
Towards Breast Cancer among Females in and around Mangaluru 323
Sadhwi, Gayathri M Rao, Aradhana M, Saritha Kamath U
64. Emotional Intelligence Level of Students and Mental Ability Belonging to Rural and Urban Backgrounds 329
Shailaja Sangaraboina
65. Caries Risk Profiles of Rural and Urban 12 Year Old School Children in Mangalore Using the Cariogram 334
Jyotsna Malhotra, Ashwini Rao, Ramya Shenoy, Mithun Pai BH
66. Role of Trust and Privacy Concerns towards Usage of E-Health Services—
An Extension of Expectation-Confirmation Model 339
K Anil Kumar, Subhashree Natarajan
67. Risk Factors Associated with Onset of Neck Pain: A Review 346
Neha Gupta, Aparna Sarkar, Deepak Kumar
68. Prediction of COPD Using CT Measurements of Pulmonary Artery and Aortic Diameter 352
Priyanka, Abhijith A, Adarsh Veer Sisoudiya, Saikiran Pendem
69. Acute Anticonvulsant Activity of Diltiazem, Nimodipine and Flunarizine in Wistar Albino Rats by
Maximum Electroshock-Induced Seizure 357
Saniya K, BG Patil, Madhavrao, Prakash KG
70. Isolated and Combined Effect of Plyometric and Weight Training on Selected Physical Fitness and
Hematological Variables of Football Players 362
K. S. Saran, K. Vaithianathan, Mithin Anand, T. Arun Prasanna
71. Effect of Game Specific Circuit Training and Plyometrics on Selected Physiological and
Hematological Variables of Handball Players 365
Mithin Anand, K. Vaithianathan, K. S. Saran, T. Arun Prasanna
72. “A Study to Assess Coping Strategies among Parents of Mentally Challenged Children at Selected
Special Schools of Miraj, Kupwad and Kolhapur Corporation Area” 368
Akshay Bhupal Pawar, Rajesh Gaikwad
73. Effectiveness of Curry Leaves Powder on Blood Sugar Level among Diabetic Patients 373
Kunal V Jadhav, Basavant Dhudum
74. A Framework Analysing Patient Adherence Level in Cardiovascular Disease in Delhi-NCR Region 379
Navjot Kaur, Supriti Agrawal, Hemendra Gautam
75. A Study to Assess the Effect of Pineapple Extract on Episiotomy Wound Healing among Postnatal
Mothers in Selected Hospitals of Sangli, Miraj and Kupwad Corporation Area 384
Sindhu R. Gaikwad, Nilima R. Bhoré

76. Assessment of Clinical Profile of Patients with Blunt Abdominal Trauma Admitting to Emergency Department	389
<i>Ashok Y Kshirsagar, Pratik D. Ajagekar, Ajay Aggarwal, Shekhargouda Deshetti</i>	
77. Comparative Study of Semen Analysis in Fertile and Infertile Males	393
<i>Joy A K Ghoshal, Anil Kumar Reddy</i>	
78. Recharging Ground Water using Age–Old Traditional Mechanisms	399
<i>Manbeer Kaur, Mona Prashar</i>	
79. MRI Image Training and Finding Acute Spine Injury with the Help of Hemorrhagic and Non Hemorrhagic Rope Wounds Method	404
<i>Sk Hasane Ahammad, V Rajesh, N Hanumatsai, A Venumadhav, NSS Sasank, KK Bhargav Gupta, Syed Inithiyaz</i>	
80. Cloud Computing Based Diagnosis for Cancer Detection	409
<i>Syed Shameem, Surya Teja S, Anoop P, Pavan Kalyan R, Vijay V, P. S. Srinivas Babu</i>	
81. A Cross-Sectional Study to Assess the Knowledge about Prevention and Home Management of Diarrhoea among the Mothers of Under Five Children in an Urban Area of Amritsar, Punjab	415
<i>Amanpreet Kaur, Harpreet Kaur, Harpreet Kaur, Priyanka Devgun</i>	
82. A Study to Assess the Parents Satisfaction Regarding Pediatric Care Services Rendered by Staff Nurses from Selected Pediatric Units of Sangi City	421
<i>Karishma D. Mulla, Aparna Kale</i>	
83. Effect of Depression on Treatment Outcome in Multi-Drug Resistant Tuberculosis Patients Under Programmatic Management of Drug Resistant TB Services in Amritsar, Punjab	427
<i>Manisha Nagpal, Naresh Chawla, Priyanka Devgun</i>	
84. Incidence of Pulmonary and Extrapulmonary Tuberculosis among Jaintia Tribes, Meghalaya: A Hospital based Study	433
<i>Arpita Mitra, Roumi Deb</i>	
85. An Automatic Disease Early Prediction and Diagnosis Recommendation Framework for Brain Tumours	438
<i>Nandan Bodapalli, Kunjam Nageswara Rao, Parada Vara Prasad Dora</i>	
86. Does Right Hand Second Digit to Fourth Digit Ratio Correlate with Primary Infertility in Males?	444
<i>Narendran Krishnamoorthi, Nikhil Shetty, Nandita Shenoy, Ashok Shenoy, Christopher C Pais, Muralidhara Yadiyal</i>	
87. Prevalence and Characterization of Opportunistic Candidal Infection among Patients with Type II Diabetes Mellitus	448
<i>Sandhya Rani T, R. Srikumar, E. Prabhakar Reddy, S. Latha</i>	
88. Child Life Program Through Drawing Play Activity as Efforts to Minimize Stress Hospitalization in Children with Leukemia	454
<i>Yuni Sufyanti Arief, IlyaKrisnana, Praba Diyan Rachmawati, Nursalam, IDG Ugrasena, Shrimarti R. Devy</i>	
89. The Correlation between Diabetes Status and Hair Loss among Aged Women in Alor Setar Area	459
<i>Thin Thin Aung, Fatin Farhana Binti Shahnon</i>	
90. Differences in Caries Prediction Test of Cariostat and Plaque Formation Rate Index (PFRI) on Children	465
<i>Prima Nerito, Boy Sandy Sunardhi, Tito Yustiawan</i>	

91. Customers' Service Expectations in Dental Hospital: Using Servqual Model	470
<i>Firdauzi Rimadhan, Devita Tintasari, Fredy Mardiyantoro</i>	
92. The Nurse's Work Culture Relationship with the Quality of Nursing Service Between the Government Hospital and Private Hospital: Comparative Study in 2018	475
<i>Dilgu Meri, Meri Neherta, Zifriyanthi Minanda Putri</i>	
93. Relationship of Hand-Hygiene Compliance Score with Nurse's Engagement in Intensive Care Unit	480
<i>Boy Sandy Sunardhi, Prima Nerito, Tito Yustiawan</i>	
94. Development of Management Skills Head of Public Health Center Based on Analysis of Management Skills Theory of Cameron and Quinn	484
<i>Martha Wahani Patrianty, Nyoman Anita Damayanti, Tito Yustiawan</i>	
95. Assessment of the Anatomical Causes of Persistent Nasal Obstruction after Primary Septorhinoplasty .	490
<i>Salim Hussain Ibrahim</i>	
96. Diagnosis of <i>Trichomonas Vaginalis</i> Infection by Detection of Glutaminase (<i>Glut</i>) Gene by Nested PCR	496
<i>Faten Ahmed Hassan, Huda Dhafer Al-Marsomy, Suhad Asaad Mustafa</i>	
97. Burnout Syndrome among Physicians Working in Primary Health Care Centers in Baghdad, Al-Rusafa Directorate, Iraq	502
<i>Abdul Munem Al Dabbagh, Ali Hassan Hayyawawi, Maha Saber Kochi</i>	
98. Influence of Low Power He-Ne Laser on the Skin Thickness of Swiss Mice	508
<i>Zainab Abd ALjalil, Ali Kamel Mohsin, Ali Mahdi Mutlag</i>	
99. The Effect of Electric Stimulation in the Development of the Explosive and Speeding Ability of the Arms to Achieve the High Snatch of the Weightlifters Karbala Youth Club	515
<i>Alaa M. Dhahir</i>	
100. Monte Carlo Simulation to Estimate the Male and Female Effective Dose due to Radon Exposure in Al-Najaf	520
<i>Mokhalad Ali Zbalh, Hussien Abid Ali Bakir, Ali Abid Abojassim, Adhraa Baqir Hassan</i>	
101. Impact of Material of Water Storage Tanks on Bacterial Quality in Shualat Al-Sadrain City in Baghdad	525
<i>Amel Mustafa Kamil, Khadeja Shaaban Hasan, Sajad Mahdi Hasan</i>	
102. A Descriptive Study on Pulmonary Tuberculosis in Salahaddin Governorate, Iraq	531
<i>Hasan Ismail Sultan, Noor Alhuda Sadoon Khalaf</i>	
103. The Relation between Homocysteine, Oxidative Stress and Atherosclerosis Disease	537
<i>Ekhlash Abdallah Hassan</i>	
104. Comparison of the Educational Effect of Two and Three Dimensional Books on Dental Anxiety in Children with Hearing Impairment (Aged 7–9 Years)	543
<i>Eva Fauziah, Selyyra Rachmawati, Aprillia Puspita Rachmadani, Cahyanti Wydiastuti Susilo</i>	
105. Effectiveness of an Education Program for School Age Children Related to Management of Growth Hormone Deficiency University of Baghdad-College of Nursing	547
<i>Fatima H. Abbas, Eqbal GH. Ma'ala</i>	
106. The Impact of Smart Phones on Musculoskeletal Pain on Students in Tikrit University	553
<i>Firas Tariq Ismaeel</i>	

107. Risk at the Educational Laboratory in Indonesia 558
Frida Qurbasari D., Putri Ayuni Alayyannur, Dani Nasirul Haqi, Meirina Ernawati, Fauziah Mukti Sugiharto
108. Split Face Comparative Study of the Efficacy and Outcome of ND: YAG Laser and Intense Pulsed Light System for Hair Removal 563
Haider Al-Sabak, Muhsin Al-Dhalimi, Eman Mohammed
109. C-reactive Protein and its Relationship with Lipid Profile in Suicidal and Non Suicidal Adults with Major Depression 569
Hassam M. Al-Amarei, Suaad Mohammed H. Rasheed, Ali J. Eidan
110. Considered Absorption Spectra for Identification of Blood Constituents 574
Hassan Abdullah Mahdi, A. A. Al-Rubaiee, Muhanad M. Azzawi
111. Evaluation of the Concentration of Some Heavy Elements of Selected Soils from Shatrah City 578
Ibtihaj Ahmed kadhim, Mohammed Abdulabbas Hasan
112. The Effect of Theory of Planned Behavior Models to Behavior of Cadres as the First Aiders of Stroke Attacks 584
Imelda Feneranda Seravia Tambi, Yuyun Yueniwati, Setyoadi
113. Factors Associated with Women's Treatment for Urinary Incontinence in Hasan Sadikin Hospital 590
Indra Gazali Syamsudin, Karina Shasri Anastasya, Benny Hasan Purwara, Edwin Armawan, Jusuf Sulaeman Effendi, Budi Handono, Hadi Susiarso
114. Histopathological Changes in the Liver and Kidney of Albino Mice on Exposure to Zinc Toxicity 596
Ishraq J. Hassan, Ihsan S. Sahi
115. Microbial Inhibition to Water Hyacinth (*Eichhornia Crassipes* [Martius] Solms-Laubach) in Abu Zirk Marsh by Using Selected Fungi 601
Jameelah Wthaij Ogali Al-Yosef, Abdul-Rahman Abduljabbar Al-Kubasi, Ihsan Flayyih Hasan Al-Jawhari
116. Complications and Lipid Parameters Status among 50 Years and above Age Group Hypertension Population at Primary Health Care Centres of Buraidah City 606
Asim Fahad AlKhalifah, K. Chandra Sekhar, Abdulaziz Sulaiman Alsaif, Alya fahad Alkhalifah
117. Cardiac Failure in Misan, Iraq 612
Khalid Obaid Mohsin
118. Dilated Cardiomyopathy in Children 616
Khalid Obaid Mohsin
119. Effect of Exercise and Body Mass Index (B.M.I.) on Fitness 621
Khalidah Nayyef Mustafa
120. Analysis of Related Factors with Anxiety Occurrence in Population with the Risk of Coronary Heart Disease in Indonesia 626
Titin Andri Wihastuti, Fajaruddin Fajaruddin, Tina Handayani Nasution, Kumbayono Kumbayono, Yulia Candra Lestari
121. What are the Staffing Levels and Maternal Outcomes? A Descriptive Study in Referral Hospitals in Java, Indonesia 631
Makhfudli Makhfudli, Ferry Efendi, Anna Kurniati, Retnayou Pradanie, Susy Katikana Sebayang

122. Estimation of Procollagen Type III Peptide (PIIIP) Level in β Thalassemia Patients 637
Maryam Kadhim Al-Shemery, Arshad Noori Al-Dujaili
123. Study Prevalence of Breast Cancer and the Relation it's with Some Risk Factors and Blood Group in Al-Najaf Governorate, Iraq 643
Maysoon K.A. AL-Hadrawi, Noor Ibrahim, Esaam Mohmmmed Turkey, Noor Ismeal Nasser, Ali k. Meetab
124. Strengthen the Spiritual-Based Family Resilience to Overcome the Family Stigma of Leprosy 647
Nasrudin, Ah Yusuf, Rachmat Hargono, Tjipto Suwandi
125. Association between Socio-economic Status and Breast Feeding Practices in a Group of Women Delivered During the Previous Year in Kirkuk City 653
Nazar Ahmed Mahmood, Qasim Husein Mohammad, Kasim Sakran Abass
126. Quantitative Assessment of Factors Affecting Visual Acuity by Changing the Luminance 658
Osama Q. Abdullah, Fadia W. Al-Azawi, Sara T. Hassan
127. Effect of Adding Probiotic with Different Levels of Citric Acid in Feed Supplementation to Laying Hens on Bacteria Content of Feed, Litter and Egg Shell 663
Rashid H. hameed Al-Dalawi, Qana Hussein ameen, Mahdi Salih Jasim
128. Occurrence of MBLs and Carbapenemases among MDR and XDR *Acinetobacter baumannii* Isolated from Hospitals in Iraq 668
Safa Hasan Radhi, Alaa H. Al-Charrakh
129. The Effect of the Adding *Ganoderma Lucidum* Fungus Powder in the Production Performance for the Brown Japanese Quail Bird 675
Samawal S. Al-Tikriti, Abdul Haq Ismail Al-douri
130. Effect of Non-pharmacological pain Management Methods on Reduction the Severity of Labor Pain in Primigravida Women at AL-Elwya Maternity Teaching Hospital 680
Sarab Nasr Fadhil, Rabea Mohsen Ali
131. Cholera Outbreak in Iraq, 2017 686
Shakir Mohsen Zgheir, Nabil Mansur Mustafa, Ali Abdalkader Ali, Jawad Al-Diwan
132. White Blood Cell, Procalcitonin, C-Reactive Protein and TNF- α as Prognostic Factors in Pediatric Sepsis 692
SittiAizah Lawang, Idham Jayaganda, Dasril Daud
133. Reactive Thrombocytosis after Caesarean Section and Normal Vaginal Delivery: Implications for Maternal Thromboembolism and its Prevention 698
Suha Abduljaleel Wadi, Ahmed Rifat Shahr, Farah Muayyed Gebriel Shammass Youisif
134. The Impact of Hormonal Replacement Therapy on Herpes Simplex Infection and Gingival Health in Post-Menopausal Women 705
Suzan Mohammed Abdul Raheem, Esra Hassan Abd Ali, Mahmoud M A Elian
135. The Relationship between Neck Pain and Hand Dexterity among Violinists in Kota Kinabalu, Sabah, Malaysia 710
Tay Xin Le, Rajkumar Krishnan Vasanthi, Jim Brown Clement
136. Antibiotics Usage and Their Cost in the Pediatric Wards of Salah Aldin Teaching Hospital 716
Thikra M. Al-Kumait, Emad Maarroof Thakir, Hind Mutar Ibrahim, Alaa H. Alwan

137. Education Conducted By Pharmacist in Improving Hyperlipidemic Patient Adhearance 723
Vidia Arlaini Anwar, Delina Hasan, Sesilia Andriani Keban, Yardi Saibi
138. The Effect of Exercise Technique Altering with Use Heavyweight Rackets in the Development of Concentration (Sodium, Potassium) in the Blood and Smash Skill for Player’s Badminton 729
Wissam Salah Abdul Hussein, Abeer Ali Hussein, Ebtighaa Mohammed Qasim
139. Evaluate the Level of Application of Sports Marketing Practices for the First Iraqi Football Clubs 734
Yaseen Ali Khalaf, Ibrahim Younis Waga
140. Knowledge, Attitudes, and Behavior of Pregnant Women in Preventing of Pregnancy Complication and Childbirth: Application Study of Yudhia Model 740
Yudhia Fratidhina, Nina Herlina, Desri Suryani, Yandrizal
141. Intra and Inter-Rater Reliability of Web Plot Digitizer Software in Quantifying Head Posture Angles ... 745
Yughdtheswari Muniandy, Devinder Kaur Ajit Singh, Suresh Mani, Baharudin Omar
142. Proton Pump Inhibitor to the Hepatic Cirrhosis Patients with Hematemesis Melena: A Retrospective Study 751
Zakiyah, Didik Hasmono, Muhammad Noor Diansyah, Christiawan Ardianto
143. Acceleration of Socket Healing by Using Placental Collagen with BDNF: Radiological and Histological Studies 758
Athraa Y. Al-Hijazi, Imad K. Abbas Al-Rifae, Zaid M.Akram, Luay Nafaa Kaka
144. Study the Effect of *Lycium barbarum* Polysaccharide on Bone and Thyroid Gland in Hyperlipidemic Healthy Male Albino Rats 764
Heba A. Abd-alsalam Alsalam
145. Effect of Exposure Biochinin-A During Gestation Stage on HoxA10 Gene Expression and Histological Change in Uterus of Healthy Female Rats 769
Huda A. Najy, Ayyed H. Hassan
146. Prevalence and Associated Risk Factors of Forward Head Posture among University Students 775
Vinodhkumar Ramalingam, Ambusam Subramaniam
147. Exploration of Patients Value as in Accordance with Bugis Philosophy in Public Hospital at the Sulawesi Selatan, Indonesia 781
Armin, Indahwati Sidin, Indrianti Sudirman, Harun Achmad
148. Validation of the Emotional Competency Module 787
Asma Perveen, Nurul Ain Hidayah Abas, Hazalizah Hamzah, Pau Kee, Ebru Morgul, Fauziah Binti Mohd Sa’ad, Pavithrah Jaya Kumar
149. Community Led Total Sanitation (CLTS) in Cikupa Village and Teluknaga Village in Tangerang, Indonesia 792
Devi Angeliana Kusumaningtiar, Gisely Vionalita
150. The Prevalence of Explained and Unexplained Subfertility—A Case Study: Kirkuk City (Iraq) 797
Eman I Fathi
151. Cellular Immunity of River Water Consuments and Bandarmasih Municipal Waterworks Consuments 802
Huldani, Bayu Indra Sukmana, Rahmiati, Anindya Pujiningtyas, Eldha Savitri, Fauziah, Ummi Nihayah
152. Role of Sentinel Lymph Node Biopsy in Staging of Early Endometrial Cancer 808
Mohamed Soliman Elmahdy, Gamal Abdelhalim Amira, Mohamed Abdelfatah ElZohairy, Abdelhamid Mohamed ElKalawy, Zeiad Samir Gad, Eman Naguib Khorshed

153. Inorganic Nitrogen Salts in Fibrinolytic Enzyme Production from *Bacillus Megaterium* BM 9.1 with Solid State Fermentation 813
Mukti Hapsari, Achmad Toto Poernomo, Amiruddin Prawita
154. Relationship Exclusively Giving Mother's Milk with Growing Baby819
Mustamin Mustamin, Chatarina Umbul, Shrimarti Rukmini Devy, Rudy Hartono
155. Application of Community Models in an Effort to Control Smoking Behavior824
Ria Rezeki Sudarmin, Andi Zulkifli, Masni, Suriah, Habibi, Helmy Gani, Muhammad Azrul Syamsul
156. Level of Type L Metacrylate Acid Copolymer as Microparticle Matrix Improves *Lactobacillus casei* Protection against Gastric Acid 829
Ayun Dewi Rahayu, Dwi Setyawan, Sugiyartono
157. The Influence of Tell Show Do Method Based on Individualized Educational Program (IEP) to the Tooth-Brushing Behavioural Change among Slow Learner Children in Bukittinggi, Indonesia 835
Febrian, Ghina Ukhtia Fajrani, Arymbi Pujiastuty
158. Hyperglycemic and Hypertension are Major Component of Metabolic Syndrome that Caused Circulatory Morbidity in Hajj Pilgrims 839
Iche Andriyani Liberty, Nasrin Kodim, Mukaramah
159. The Determinant Factors of Child's Immunization Status: A Cross Sectional Study on the Dayak Pitap Tribe in the District of Balangan Indonesia 845
Ida Hastutiningsih, Oedojo Soedirham, M. Bagus Qomaruddin, Boerhan Hidayat
160. The Use of Diuretic Drugs in Heart Failure Patients 851
Lolla Junny Avianda, Didik Hasmono, Meity Ardiana, Ruddy Hartono
161. The Antibacterial Activity of Kersen Leaves (*Muntingia Calabura*) Extracts against *Aeromonas Hydrophilia*; in Vitro Study 857
Onny Kurnia Sari, Wahyu Tjahjaningsih, Sudarno
162. Could the Severity of Infected Gingiva in Pregnant Woman Affect the Quality of Life? 862
R. Darmawan Setijanto, Novia Setyowati, Taufan Bramantoro, Achmad Aghasy
163. Age and Education Distribution Patterns of Working Mothers on Dental Health Behavior in Preschool Children in Mid-Class Society 867
Isnawati, R. Darmawan Setijanto, Taufan Bramantoro, Dinda Dewi Zalinda
164. Relationship between Behavior and the Use of Personal Protective Equipment to Pesticide Consumer Farmers in Tonrong Rijang Village Baranti District Sidenreng Rappang District 872
Zaenab, Ashari R, Nurmin
165. Hazard Identification, Risk Assessment, and Determining Controls in Laboratories 877
Ais Assana Athqiya, Dani Nasirul Haqi, Putri Ayuni Alayyannur, Indriati Paskarini, Fauziah Mukti Sugiharto
166. Risk Analysis of Accidents and Occupational Disease in Ohs (Occupational Health and Safety) Laboratory884
Muhammad Yusuf, Dani Nasirul Haqi, Putri Ayuni Alayyannur, Endang Dwiyaniti, Nur Laili R
167. Gluten-Free Diet: Positive and Negative Effect on Human Health 889
Botagoz Kulushtayeva, Maksim Rebezov, Aidyn Igenbayev, Yulia Kichko, Nina Burakovskaya, Vladimir Kulakov, Mars Khayrullin

168. Comparing Lower Grades and Higher Grades Astrocytoma in Three Age Groups: by CD133 Antibody 893
Zainab Zahid Saadoon, Huda Mahdi Al-Khateeb, Khitam Abdul-Razak Alkhafaji
169. Differences in Growth of Children with Autism and Normal in Surabaya, Indonesia 899
Dewi Setyowati, Budi Prasetyo, Dominicus Husada
170. Functional Outcome after Conventional Open Discectomy for Patients with Herniated Lumbar Disc:
One Year Follow Up 904
Mohammed Hassan Razoki
171. Early Complications Following Bipolar Hemiarthroplasty as Primary Treatment for Displaced
Femoral Neck Fracture in Elderly Patients 909
Mohammed Hassn Razoki, Adnan Essa Elkelaby
172. Assessment of the Anterior Talofibular Ligament(ATFL) Thickness in Chronic Stroke
Patients by Ultrasound 915
Mohammed Hassn Razoki, Nada Rida Alharis, Haider Kadhim Hussain
173. Classroom Control Patterns and its Relation to the five major Factors of the Personality of
Sports Education Teachers in Babil Governorate 921
Aied Kareem Abdaun, AbdulrhmanGhadhab AL-SADI, Haedar Sami Mohammed
174. Effect of Speed Training Technique in Determining the Effectiveness of Creatine and
Phosphorus for Advanced Volleyball Players 926
Amal Sabeeh Salman Al-Tamimi
175. Study of the Effect of Different Intensity and Duration of LED Light on Shear Bond Strength and
Adhesive Remnant Index of Metal Orthodontic Brackets 932
Zahraa M. Al-Fadhily, Sattar J. Abdul-Zahra Al Hmedat, Zuha Ayad Jaber
176. Comparative Study between Muscle-Split Versus the Classical Muscle-Cut Subcostal Incision for
Open Cholecystectomy 938
Awni Ismail Sultan, Khalid Khairi Hussein
177. Association of Idiopathic IUGR with Placental Histological Morphometry 943
Mohammed E. Ghanem, Samia A. Eleiwe, Nagham K. Tayeh
178. Evaluation of Polycystic Ovarian Syndrome Women as a Result of Clomiphene Treatment 949
Zainab Abdul wahed Naji
179. Variance Analysis of Acute Myocardial Infarction Clinical Pathway in The Era of National Health Insurance 954
Fadlia Fardhana, Kurnia Sari, Atik Nurwahyuni
180. Indoor Particulate Matter (PM₁₀) and Health Risk on Junior High School Students in Depok 960
Sasnila Pakpahan, Bambang Wispriyono
181. Analysis of Typhoid Fever Clinical Pathway Implementation in the Era of
National Health Insurance in Indonesia 965
Widia Puspa Hapsari, Atik Nurwahyuni
182. Analysis of Primary Health-Care Resource Preparedness for Implementation of Maternal
HIV Screening in Indonesia's Urban Areas 971
MM.Puspitasari, Purnawan Junadi

183. Getting Married to a Suspected Bisexual Man: A Silent Mode of HIV transmission among Married Women in Indonesia 976
Najmah, Sharyn Graham Davies, Sari Andajani
184. mHealth Development for Village Midwives to Improve the Performance of the Maternal Health Program in the Babakan Madang Sub-District, Bogor, Indonesia 981
Rico Kurniawan, Kemal N. Siregar, Nimas S. Martiana, Indriana K. Wardhani
185. The Influence of Dental Health Education on the Gingival Health of Students at STIKES Muhammadiyah Palembang 987
Dientyah Nur Anggina, Resy Asmalia
186. A Smart Nutrition Management System and Nutrition Related Diseases in Humans 992
Kardokh H. Kaka Bra, Eko Supriyanto
187. Dominant Hypertension Factors of Adolescents in West Java, Indonesia 997
Mujahidil Aslam, Trini Sudiarti, Ratu Ayu Dewi Sartika, Engkus Kusdinar Achmad
188. Discogenic Low Back Pain, Diagnostic Criteria 1003
Mahmoud Ramadan Adly, Ahmed Hossameldin Hussein, Oymya Sayed Mahmoud
189. Ultrasound Guided Enhanced Recovery Program in Colorectal Surgery: Kasralainy Modified Protocol 1009
Ahmed FA Farag, Hany MS Mikhail, Hamed H Elsheshiny, Moataz F Mohamed, Osama RM Refaie, Haitham SE Omar, Ahmed MSM Marzouk
190. The Use of Intra-articular Steroid Injection to improve functional outcomes in Tibial Plateau Fractures 1014
Sherif Hamdy Mohamed Zawam, Ahmad Salah Muhammad Abu Taleb
191. Relationship between Hygiene and Sanitation with Coliform Bacteria Contamination in Refill Drinking Water 1019
Indah Ananda Jamaluddin, Agus Bintara Birawida, Ruslan
192. Relationship between Work Posture and Musculoskeletal Disorders (Msds) at Processing Workers in PtToarco Jaya, Rantepao City year 2017 1025
Januarty Triani Rimba, Furqaan Naiem, Muhammad Rum Rahim
193. A Study on Frequency of 12-23 Months of Children Visits to Integrated Service Post (Posyandu) 3 Months in a Row against Developments in the Work Areas, Makassar City 1030
Khalis Muliamar, Djunaedi M. Dachlan, Burhanuddin Bahar
194. Analysis of Ability to Pay National Health Insurance Contributions to Communities on Lakkang Island, Makassar City in 2017 1035
Andi Sahriana, Dian Saputra Marzuki, Muhammad Yusri Abadi
195. Factors Associated with Musculoskeletal Disorders (MSDs) Complaint on the Workers of Cargo Unit at PT. Angkasa Pura Logistics, Makassar in 2017 1040
Firmita Dwiseli, Muhammad Rum Rahim, Awaluddin
196. Relationship between Heat Pressure and Age with Work Fatigue among Workers at Department Factory I of Pt. Maruki International, Makassar in 2017 1045
Ulfa Rahman, Masyitha Muis, FurqaanNaiem
197. Relationship of Health Service Quality with Inpatients' Loyalty at RSUD M akassar City 1050
Sri Wahyuni, Nurhayani, H. Indar

198. Relationship of Marketing Mix with Loyalty of Patients of Dental Poly in BatuaPuskesmas, Makassar City in Year 2016	1056
<i>Suciana Aprilia Angraeni, Nurhayani, H. AmranRazak</i>	
199. Relationship of Marketing Mix with Return of Outpatients' Interest at Dr.TadjuddinChalid Specialist Hospital, Makassar in 2017	1061
<i>YustiamkaPermana, H. Indar, Nurhayani</i>	
200. The Factors Related to Work Fatigue of Block Paving Workers at CV. SumberGalian in 2017	1066
<i>Putri Yanti, Andi Wahyuni, Awaluddin</i>	
201. Factors toward Diabetes Mellitus Type II Occurrence among Patients in Tenriawaru Hospital, Bone Regency 2014	1071
<i>Jumriani Ansar, Indra Dwinata, Hardiana</i>	
202. Mapping of Dengue Fever Incidence in Majjene Province, West Sulawesi 2016	1075
<i>Jufri, Agus Bintara Birawida, Fajaruddin Natsir</i>	
203. Factors Contribute to KB Contraception Equipment Service in Reproductive Age Couples in Tamalanrea Public Health Center	1080
<i>Karmiah, Muhammad Yusran Amir, Muh. Yusri Abadi</i>	
204. Factors toward Dengue Haemorrhagic Fever Occurrence in Patte'ne Village, North Wara District, Palopo City	1085
<i>Sari Puspa Bachtiar, H.A. Arusnan Arsin, Dian Sidik Arsyad</i>	
205. Factors that Influence Patients in Utilizing Outpatient Services in Hasanuddin University Hospitals ...	1090
<i>Alamsyah, Fridawathy Rivai, Rini Anggraeni</i>	
206. Relationship of Marketing Mixes with the Return Interest of Patients at ArifinNu'mang Hospital	1095
<i>Ardiyansah H. Lammade, Asiah Hamzah, Sukri Palutturi</i>	
207. Relationship Analysis between the Quality of Health Services and Patients Satisfaction in Kapasa Health Center Makassar City	1100
<i>Fidelia Lolo Pirade, AmranRazak, Nurhayani</i>	
208. Factors Related to Complaints of Low Back Pain in Workers in Pt Maruki International Indonesia Makassar City	1105
<i>Ridha Astuty T, Syamsiar S. Russeng, Awaluddin</i>	
209. Relationship of Marketing Mixes and Utilization of Dental Poly in KassiKassi Health Center	1110
<i>Sitti Arabiyah Yunus, Darmawansyah, Nurhayani</i>	
210. Factors Related to the Fatigue in Workers in the Cargo Unit of Pt. AngkasaPura Logistic Makassar ...	1115
<i>Syur Aulia Jufri, Andi Wahyuni, Muhammad Rum Rahim</i>	
211. Relationship of Climate Factors with Diarrhea Evaluation in City of Makassar	1120
<i>Tri Hastuti Handayani, Anwar Daud, Makmur Selomo</i>	
212. Analysis of Health Service Quality on Patient Satisfaction in Malimongan	1125
<i>Putri Lisyah Tome, Nurhayani, Darmawansyah</i>	
213. Work Fatigue Overview in Female Workers in PT Manakarra Unggul Lestari	1130
<i>Gracella, Awaluddin, Andi Wahyuni</i>	

214. Factors Related to the Satisfaction of Patients in Pelamonia Hospital 1135
Andi Nahlah, Sukri Palutturi, Muh. Yusri Abadi
215. Risk Factors of Pulmonary Tuberculosis Relapse in Working Population of Makassar City 1140
Irmawati, Ridwan A, Jumriani Ansar
216. Health Belief Model and Its Association with Cervical Cancer Screening Among Malaysian Women . 1145
Fadzilah Siraj, Md Radzjohari, Nur Azzah Abu Bakar, Faizzudin Sahazudin
217. Level of Spirituality and Demographic Factors among People Living with HIV/AIDS 1152
Rajwani Md. Zain, Zarina Mat Saad, Fatimah Zailly Ahmad Ramli
218. Description on the Quality of Life among Elderly Affected by Dental and Oral Health in Jagir Health Centre Surabaya 1159
Rima Arsyilviasari, Tiara Meilena, Ayu Setyowati, Retta Gabriella Pakpahan, Nur Latifah Zuniati, Alvita Wibowo, Darmawan Setijanto
219. Genetic Diversity of Anopheles sp as Malaria Vectors Who Carries Plasmodium Falciparum and Plasmodiumvivax Which Can Infect Human in Jayapura Municipal, Papua Province, Indonesia 1163
Yohana Sorontou, Henny Sesanti Budi Hastuty
220. The Use of Portable WSD Wound Models to Improve Student Clinical Lab Skills 1169
Pramita Iriana, Ratna Sitorus, Agung Waluyo, Sutanto Priyo Hastono
221. The Role of SOD, Catalase, HSP-27, HSP-70, and TNF- α Expression in Apoptosis of Retinal Ganglion Cells After Intra Ocular Pressure Increase on Rattus Norvegicus 1174
Nurwasis, Gatut Suhendro, I Ketut Suidiana
222. The Relationship Between Nurse Caring Behavior and Patient Satisfaction Level at Inpatient Wards of Bayangkara Hospital Jayapura 1179
Jems K. R. Maay, Ester Rumaseb, Arwam Hermanus
223. Job Satisfaction and Mental Health among Bank Employees of Chidambaram Town 1184
N. Madhavan
224. Neurodevelopmental Screening—A guide for Early Intervention in at-Riskinfants 1188
N. Meena
225. Local Wisdom in Pregnancy, Childbirth, Childcare in Mee Tribe, Papua 1193
Heni Voni Rerey, Cristina Tien Popang, Butet Agustarika, Ester Rumaseb
226. Implementation of Fixed Procedures for Care Action of Archipelago Surgery in the Regional General Hospital of Doc II Jayapura 1198
Demianus Tafor, Jems K. R. Maay, Arwam Hermanus, Ester Rumaseb
227. The Affairs of Anopheles Mosquito in the Working Area 2015 Hamadi Puskesmas Kota Jayapura 1203
Marlin Mayling Jarona, Henny Sesanti Budi Hastuty, Muhammad Abas, Arwam Hermanus
228. Intervention Effect of Ultra Violet and Exhaust Lights on Microbial Density Decreasing in Honai in Kurulu District, Jayawijaya District, Papua Province 1208
Frans Manangsang, Ester Rumaseb, Abdul Ganing, Suningsih Suabey, Arwam Hermanus, Jems KR Maay
229. A Model of Malaria in Pregnancy Prevention Counseling in Clinics District of Jayapura, Papua 1213
Ester Rumaseb, Hari Kusnanto, Djaswadi Dasuki, Siswanto A Wilopo, Jems KR Maay, Arwam Hermanus

230. Molecular Docking Studies of a Chalcone Derivative Compound *p*-hydroxy-*m*-methoxychalcone with Tyrosine Kinase Receptors 1219
Retno Arianingrum, Adam Hermawan, Hari Purnomo, Dyaningtyas Dewi, Edy Meiyanto
231. Clean Healthy Living Behaviours (Phbs) Household Order Kampong Sarmi Regency Bonggo Subdistrict Armopa Papua in 2017 1225
Arwam Hermanus MZ, Ester Rumaseb, Renold M Mofu, Jems KR Maay, Demianus Tafor, Zeth Robert Felle, Frengki Apay
232. Global Trend on Incivility Research 1229
Nurul Ain Hidayah Abas, Aidi Ahmi, Mei-Hua Lin, Asma Perveen
233. A New Approach to Detect Macular Hole from Optical Coherence Tomography Images 1235
M. Anand, C. Jayakumari
234. Synthesis and Characterization of Graphene Quantum Dots from Turmeric Powder (*Berberis aristata*) and Its Biomedical Applications 1239
Anooj E. S., V. Suganthi, P. K. Praseetha
235. Development of Novel Classifying System to Identify the Right Sense of Image Sharing in Social Networks Using Deep Convolution Neural Network 1244
P. Nirupama, E. Madhusudhana Reddy
236. Identification and Molecular Phylogenetic Relationship of Selected Medicinal Plants-Ethano Medicinal Importance 1248
Lekshmi Gangadhar, P. K. Praseetha
237. Accuracy of Out of Field Photon Dose Calculations by a Treatment Planning System 1253
Silpa Ajay Kumar, MM Musthafa, Jaya Prasad Tripathy, Karthickeyan Duraisamy, Resmi K Bharathan, Suja Cheruliyil Ayyappan, Geetha Muttath
238. Evaluating the Biological Potential of Phyto-compounds from *Myristica fragrans* Seeds 1260
Vibala B. V., P. K. Praseetha
239. Evaluating the Biological Applications of *Myristica fragrans* Seeds for Bactericidal and Cytotoxic Effects 1267
Vibala B. V., V. Suganthi, P. K. Praseetha
240. Elevated Anticardiolipin Titer as a Stroke Factor in Young Patients in Kirkuk City 1273
Raad Hassan Najim, Bilal Jamal kamal
241. ODAP: The Natural Toxin Present in The Lathyrus Sativus (Grass Pea) 1277
Durar Kamil Jabbar, Habeeb Kadhum
242. Safety Disposal of Electrophoresis Gels and PCR Contaminate with Ethidium Bromide and Alternative Methods 1283
Amal Raqib Shamran, Methaq Hadi lafta
243. Enhancement in Segmentation of Brain Tumors on MRI Using Region Growing Algorithm 1286
K. V. Shiny, N. Sugitha, B. Swaminathan, B. Bhuvaneshwaran
244. Design of a Prototype System to Determine Ammonia Concentration in Exhaled Human Breath in the Diagnosis of Kidney Failure 1292
Nihitha Rajendran, P Vinupritha, D Kathirvelu

245. Enhancing Blood Cell Images using Denoising Filters for the Detection of Hematological Disorders 1297
Aldrin Karunharan K, Om Prakash
246. Development of Gas Sensor Device for Primary Health Care Monitoring System 1303
Shifa Anas, Gnanavel S.
247. A Descriptive Study on Mental Stress, Time-Management & Worklife-balance among Ph.D. Scholars 1308
Aalim P. N., Ambily R
248. Image Segmentation for Diabetic Retinopathy Using Modified Bacterial Foraging Optimization Algorithm 1313
Hema Rajini N
249. Segmentation of Human Eye Pupil with Novel Grid Based Localization Computing 1320
G. Sumathy, J. Arokiya Renjith
250. Cardiac Tele-care 1326
D. Pavithra, P. Raja Rajeswari Chandni, D. Padmini, S. Vishnu Priya, R. Vanithamani
251. A Map Reduce Framework for Identifying Association Rules between Clinical Traits of Asthma 1329
S. Poorani, P. Balasubramanie
252. A Study on Knowledge, Attitude and Practices towards Breast Cancer among Reproductive Age Group Women in an Urban Area of Coimbatore 1332
Jasmine J Nirmal, Prabhu N J, Sugunadevi G
253. Health Promoting Lifestyle Practices: A Comparative Study on Health and Non-Health Professional Students 1337
Bitty Joys, Sonamtsomu G, Dekey Yanzom
254. Effectiveness of Stress Management Strategies on Occupational Stress in Educational Institution 1343
Jasmine Joseph, C. Lalroluahpuii, Chime Dolkar, Yojna Chettri
255. Effectiveness of Station-based Skill Training Model through Objective Structured Clinical Examination (OSCE): Nursing Students' Skills in Performing the Clinical Procedures 1349
Rinu Mathew, Sujata Regmi, Bombo Ekane Dorothee V
256. Cogency of Aggression Management Training Programme on Competency of Nursing Students in a Selected College in Bangalore 1355
Meenu Cherian, Jenila J, Swetha Sharma
257. To Assess the Knowledge and Attitude Towards the Prevention of Traffic Collisions among College Students 1361
Sowbagya Lakshmi A, Komal Sharma, Monica
258. Classification of Retinal Disorders Based on Fluid Patterns in OCT Images 1367
Venkatraman K., M. Sumathi
259. Analysis of Skin Cancer using K-Means Clustering and Hybrid Classification Model 1371
Bethanne Janney J, S.Emalda Roslin
260. Application of Harmony Search Algorithm in Retinal Biometric System 1379
J. Sivakamasundari, A. Devi Lakshmi, P. Madhumitha, Pallabi Ghosh
261. Application of Clustering Techniques on Statistical Features of EEG Signals for Seizure Detection 1384
P. Grace Kanmani Prince, J. Premalatha, D. Marshiana, Krishnamoorthy Raghavan, Suresh Kumar

262. Face and Finger Vein Recognition for Security Based Electronic Voting Machine Using Raspberry Pi 1390
T. Thaj Mary Delsy, G. Rajalakshmi, D. Jamuna Rani, V. Amala Rani, S. Sidharthan, Praveen K. Pradeep
263. Health Parameter Analyses of Living Organism in Underwater Environment 1394
T. Thaj Mary Delsy, D. Jamuna Rani, D. Marshiana
264. Recent Medical Image Fusion Techniques: A Review 1399
V. Amala Rani, S. Lalithakumari
265. A Literature Study on Detecting Gall Bladder's Wall Thickness for Finding Early Abnormalities using Ultrasonic Images 1404
G R Jothilakshmi, Rubina R, V Rajendran, Y Sreenivasa Varma
266. Skin Reflectance Based Diagnosis and Monitoring of Thyroid Diseases 1408
J.Sofia Bobby, Ralan Barathi E, Srinithi V, Salome G, Jayasurya A
267. Wound Healing Properties and Cytotoxicity of Gold Nanoparticles on MDCK Cell Lines (in Vitro Study) 1412
Najwa Kahtan Aljbory, Nissren Jalal Mohammed, Rana A. Ghaleb
268. Spinal Anesthesia for Knee Arthroscopy without Fluid Preloading 1418
Isra Hamed Saeed
269. Femoral Nerve Block and Adductor Canal Block for Postoperative Analgesia of Total Knee Replacement, Comparative Study 1421
Isra Hamed Saeed, Mohammed Asi Jabbar
270. The Serum Micro RNA-375 Utility to Diagnosis of Men with Prostate Cancer in Iraq 1425
Kadhun J. Mowayeiz, Najat Abudlrazaq Hasan, Alaa G. Hussein, Estabraq AR. Al-Wasiti, Usama S. Al-Nasiri
271. Anticardiolipin Antibodies in Comparison to B-HCG Titer and Serum Progesterone as Indicator for Ectopic Pregnancies 1431
Wasan Wajdi Ibrahim



Indian Journal of Public Health Research & Development

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CONTENTS

Volume 10, Number 7

July 2019

272. Knowledge Regarding Risk Factors of Hypertension among Young Adult Students 1436
Sanjivani Maral, Muskan Marwah, Sahil Vijaykumar Lahoti, Arindam Das
273. Incidence of Anxiety among First Year College Going Students 1442
Diana Prasad
274. A Study to Assess the Effectiveness of Structured Teaching Programme on Knowledge Regarding Substance Abuse and Its Impact on Health among Higher Secondary Students among Atulya Healthcare, Pune 1446
Tejashri Ligade, Sagar Kulkarni, Aejaz Ahmad
275. Awareness and Assessment of Level of Disaster Preparedness among Nurses of Hospitals 1451
Jasneet Kaur, Sheela Upendra, A. Seeta Devi, Sheetal Barde, Sheetal Waghmare
276. Integrating High Fidelity Simulation with Patient Assessment Using International Trauma Life Support (ITLS) Protocols for Prehospital Scenarios amongst Emergency Medical Services (EMS) Students of Pune, India..... 1454
Parag Rishipathak, Shrimathy Vijayraghavan, Anand Hinduja
277. Assessment on the 'Impact of Nutrition Exhibition 'on Knowledge level among Rural Women in Selected area of Pune District 1458
Sheela Upendra, Jasneet Kaur, Seeta Devi, Sheetal Barde, Shitalwaghmare
278. A Study to Assess the Effectiveness of Structural Teaching Program on Knowledge and Attitude of Nurses Regarding Fecal Microbial Therapy (FMT) in Selected Hospitals of Pune City..... 1462
Deepak Sethi, Shobha Naidu, Maj Kirti
279. Knowledge regarding Total Parenteral Nutrition (TPN) among the ICU Nurses in Selected Hospital of Pune City..... 1467
Manisha Vikrant Mistry
280. Awareness of Students Regarding the Effect of Mobile Phone Usage on Health at an Indian University..... 1472
Milind Chukhare, Sammita Jadhav
281. A Study to Assess the Effectiveness of Structured Teaching Programme on Bio-waste Management with reference to Knowledge among Nurses..... 1478
Ranjana Chavan, Sheela Upendra
282. Effect of Flipped Classroom Teaching on Improvement of Clinical Performance in Labour Room among Nursing Students 1481
Seeta Devi, Sheela Upendra, Jasneet Kaur, Shitalwaghmare, Sheetal Barde

283.	Development of Norms for Cardiovascular Endurance Test for Youth Aged 18 – 25 Years.....	1486
	<i>Amritashish Bagchi, Nayana Nimkar, Rajiv Yeravdekar</i>	
284.	Analysis of Pesticide Content in Selected Onion Samples by Chromatography and Mass Spectrometry.....	1492
	<i>Ankita Kulkarni, Vaishnavi Soman, Avril Jacques, Pratima Jasti, Selvan Ravindran</i>	
285.	Effects of Dance (Bharatanatyam) on the Body Composition, Nutritional Status, Fitness and Mental Abilities of Children and Adults– A Narrative Review	1497
	<i>Apoorva Rao, Sneha Majumder, Kavitha Menon</i>	
286.	Prevalence and Determinants of Vitamin-D Status in Subjects with Type II Diabetes Mellitus.....	1503
	<i>Arti Muley, Uma Iyer</i>	
287.	Management of Complete Placenta Previa – A Case Study.....	1509
	<i>Deepa Patil, Manisha Vikrant Mistry</i>	
288.	Effect of Educational Intervention on Menstrual Hygiene on Knowledge, Perception and Practices of Adolescence Girls.....	1513
	<i>Dipali Dumbre, Seeta Devi</i>	
289.	A Study on Prevalence of Metabolic Syndrome (M.S.) and Associated Risk Factors among Rural Women at Rural Block of Pune District.....	1516
	<i>S G. Joshi, Mangesh V. Jabade, Shital V Waghmare, Ranjana Chavan</i>	
290.	Study on Acute Respiratory Diseases among Children of below Five Years in India	1522
	<i>Rohit Singh Tomar, Parag Rishipathak</i>	
291.	The Effectiveness of use of Electronic Medical Record System at University Health Centre	1526
	<i>Alaka Chandak, Rajesh Shinde</i>	
292.	Hypertension and its Association with Low HDL and High LDL in Cardiovascular Disorders	1532
	<i>Jenu Maria Thomas, Sammita Jadhav</i>	
293.	Perception of Healthcare Education Ecosystem among International Students Pursuing Medical Technology Specialisation in Western India.....	1638
294.	Impact of Dietary Interventions on Anxiety, Depression and Stress – A Narrative Review	1544
	<i>Gayatri Shanbhag, Pooja Panchal, Kavitha Menon</i>	
295.	An Exploratory Pilot on Body Composition and Nutrient Intake Associated With Premenstrual Syndrome among Young Women.....	1551
	<i>Harshada Thakur, Priyanka Pareek, Suhas Otiv</i>	
296.	Pocrescophobia: It's Influence on Eating Habits.....	1557
	<i>Leeja Bonny Thomas, Shital Barde</i>	
297.	A Study to Assess the Effectiveness of Self-Instructional Module on Knowledge and Practices of Needle Stick Injury among the Nurses Working in Selected Hospitals of Pune City.....	1562
	<i>Mangesh V. Jabade, S G. Joshi, Ranjana Chavan</i>	
298.	Understanding Reasons for Rise in Conflict Situation in an Indian Hospital and Suggesting Measures to Minimize Them	1566
	<i>Meenal Kulkarni</i>	

299.	Back Stretch Exercise Vs Pelvic Tilt on the Backache among Antenatal Mothers.....	1571
	<i>Pallavi Shinde, Merlin Suji</i>	
300.	Effectiveness of Demonstration on Neonatal Resuscitation Practices among the Nurses.....	1577
	<i>Manu Acha Roy</i>	
301.	Serving Vegan Palates Nutritiously: Fortification of Vegan Cake with Garden Cress Seeds and Rose Petal Preserve as Functional Ingredients.....	1582
	<i>Neelam Giraje, Radhika Hedao</i>	
302.	Assessment of Patient Safety Culture in a Tertiary Care Hospital In Pune.....	1588
	<i>Neha Ahire, Kurapatti Ambika Shrinivas</i>	
303.	Intelligence Quotient and Nutritional Status of 4-6 Year Old Children from Fishermen Community of Goa, India.....	1594
	<i>Neha Sathe, Devaki Gokhale</i>	
304.	A Review of the Nutritional Quality of School Canteen Foods in South Asia.....	1600
	<i>Purva Sharma, Surabhi Singh Yadav, Kavitha Menon</i>	
305.	A Study to Assess the Social Functioning Level of Alcohol Dependents in Selected Rehabilitation Centre.....	1607
	<i>Roma Sunil Shinde, Sheela Upendra</i>	
306.	Perspectives of Service Users While Choosing a Clinical Laboratory for Testing	1611
	<i>Sanjivani Maral, Suvarna Joshi, Ashish Banerji³, Snehal Kale</i>	
307.	Time Line Practice of Yoga on the Level of Depression	1617
	<i>Sharadha Ramesh</i>	
308.	Effectiveness of Music Therapy on Anxiety among Elderly Residing at Selected Geriatric Homes at Pune City.....	1621
	<i>Sheetal Barde, Sheela Upendra, Kalpana Sawane, Shital Waghmare, Seeta Devi</i>	
309.	A Comparative Electromyographical Investigation of Latissimus Dorsi and Biceps Brachii Using Various Hand Positions in Pull Ups.....	1624
	<i>Shiny Raizada, Amritashish Bagchi</i>	
310.	A Protocol for Improving Nursing Performance Towards Placental Examination among Staff Nurses at the Labor Room in Selected Hospitals of Pune City.....	1630
	<i>Shital V Waghmare, Sheela Upendra, Seeta Devi A, Jasneet Kaur, Sheetal Barde, S.G Joshi</i>	
311.	Low Doses Ionizing Radiations: A Risk for Cancer and Cardiovascular Diseases.....	1634
	<i>Yogita Dhas, Neetu Mishra</i>	
312.	Molecular Epidemiology of Japanese Encephalitis Virus in India.....	1640
	<i>Azima Khan, Sammita Jadhav</i>	
313.	Neglected Bacterial Foodborne Pathogens in India.....	1645
	<i>Azima Khan, Sammita Jadhav</i>	
314.	Utility of High Fidelity Simulation Training in Improving Adherence to Critical Actions During Cardiopulmonary Arrest.....	1650
	<i>Parag Rishipathak, Monesh Bhandari, Anand Hinduja</i>	

315. Clinical Diagnostic Marker for Early Detection of Epithelial Ovarian Cancer: Classical biomarkers and MicroRNAs.....1654
Joyita Banerjee, Neetu Mishra
316. Assess the Knowledge Regarding Prevention of Dental Carries Among Schoolchildren..... 1662
Priyanka Kadam, Mangesh V. Jabade, Ranjana Chavan

Getting Married to a Suspected Bisexual Man: A Silent Mode of HIV transmission among Married Women in Indonesia

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ABSTRACT

A married woman is susceptible to contract HIV from her husband if he practices unsafe sex, especially with other men. Unsafe sexual practice (heterosexual and homosexual sex) are the major factors of significant increase of HIV in Indonesia for the last decade. The aim of this study is to reveal one woman's story about living with HIV. She contracted from her husband after he was unsafe sex with men.

Feminist Participatory Action Research was conducted in 2017 with HIV positive women, health workers from public and private organisations. Qualitative research methods were used in line with purposive sampling method and thematic analysis.

Men who have sex with men (MSM) may contract HIV through unsafe homosexual practices. Women need to be informed about the risk factors of contracting HIV and Prevention of Mother to Child Transmission-PMTCT of HIV services. In addition, compulsory antenatal HIV testing is urgently needed to early diagnosis of HIV among pregnant women and a non-discriminatory practice of comprehensive Prevention of Mother-to-Child Transmission of HIV (PMTCT) services is urgently required to prevent HIV transmission for infants.

Keywords: MSM, bisexual man, a married woman, mother to child transmission, PMTCT service, Indonesia

Introduction

In the past decade, four out of every 10 people diagnosed with HIV in Indonesia were women and the highest number of late stage of HIV (AIDS) suffers are married women or housewife ⁽¹⁾. Married women are considered a neglected group in HIV prevention in Indonesia ^(2,3). As a consequence of the lack of focus on married women, they have become a 'silent majority' of new HIV-positive cases ⁽¹⁾. In Indonesia, the majority women living with HIV find out their HIV status after their husband or children die, or after they themselves become ill ⁽⁴⁻⁶⁾. Unsafe sexual practices are now the main cause of increases in HIV rates in Indonesia ^(1,7). There is a little knowledge about lived stories of a married woman who is more likely to contract HIV from their husband who experiences to have unsafe sex practice with other men in Indonesia context.

Method

Research Paradigm and Methodology: Feminism is chosen as our epistemological stance and Feminist Participatory Action Research (FPAR) as the research methodology. Feminism includes a philosophical belief system that addresses who can be the real knower of women's problem and solution and care for the relationships between the female researcher and the research participants ^(8,9). Feminist research also seeks to contribute to women's empowerment ⁽¹⁰⁾, as women have the potential means to contribute to the development of collective consciousness, through their active participation, shared knowledge, and collaboration in the research itself ^(9,11). Within FPAR, three main dimensions of social transformation allow the necessary place and space to reposition gender, race and class, "to excavate indigenous cultural knowledge and generate voices"; and "to deploy intersectionality as an analytic tool for transformation" ⁽¹²⁾, pp 331. In addition, focusing gender and diversity of women's experience and voices are an integral part of this FPAR in challenging a patriarchal culture ⁽¹³⁾.

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Participants: This study is a part of the whole study of FPAR that was conducted in 2017 with a group of 18 HIV-positive women, a group of 26 health workers, and a group of nine NGO workers. The voices of these groups were travelled visually to the final group of 12 stakeholders related to HIV in Palembang. Purposive sampling was undertaken to recruit participants in Palembang (capital city of South Sumatra) Indonesia.

Data Collection and Analysis

The methods used included informal or “go-along” or informal interviews⁽¹⁴⁾, focus group discussions and participant observations over four months in Palembang. In addition, participatory visual methods were used during the Focus Group Discussions and interviews. These methods allowed for HIV-positive women and other groups to express their thoughts through visual representations, such as drawing, collages and mind-mapping⁽¹⁵⁻¹⁸⁾. The data collection was conducted by the first author, who was born and raised in Indonesia and was fluent in the local dialect of Palembang. Thematic analysis and reflective analysis were then conducted.^(13, 19-22)

Result

Preventing Mother-to-child Transmission: Mira recalled the time when she started to feel that the labour was coming. Her pain was excruciating, and the contraction came closer to each other. Psychologically, she felt very worried that her baby would be infected with HIV during delivery. Mira, accompanied by Kuyung then rushed to the emergency unit at a public hospital. At the admission, she reported her HIV status: “I am positive HIV, I needed a Caesarean Operation”. The admission nurse at that time, however, did not believe her and Mira insisted for the nurse to contact the Voluntary, Counselling and Testing (VCT) centre where she and her husband had been treated for HIV. The nurse contacted the VCT centre and got confirmation of Mira’s status. She was scheduled to have the caesarean.

During the waiting time, or at about 6 pm, Mira felt her contractions intensified. Yet the nurses kept telling her that she would be fine. Two hours later, at about 8 pm, Mira had delivered her baby naturally. She felt very tired and shaken and after her delivery Mira realised she did not have any meals or drinks since 2 pm as a requirement for the surgery. Following the delivery of

Toleh, Mira’s second child, both the mother and baby were transferred to the maternity ward and shared her in-patient room with other female patients.

Vulnerability and discriminatory practice: During her recovery process, Mira recalled some incidents when she received blame, discriminatory treatments from the nurses. For example, one of the nurses had asked her “*you knew that you were HIV-positive, why did you decide to be pregnant and deliver your baby?*”. Other nurses would give signs to her peers of her HIV status, mocking on Mira, while Mira was present in the room. At the same time, Mira felt hopeless. She was angry and disappointed with the treatment she received, but there was not much she could do then hoping for some ‘empathy’ from the nurses, midwives or doctors at the hospital. After a few months of her recovery, she asked about a family planning of Intra Uterine Devices in the same hospital, however, she got rejection after she disclosed her HIV status. Fortunately, after 18 months of being treated with a preventative HIV medication, her son, was declared HIV free.

HIV vulnerability: deception in marriage: During her second pregnancy in 2015, Mira recalled going to the community health centre to have a check on her vaginal rashes and itchiness. The test results confirmed she had syphilis and HIV. Her CD4 count of 350 cells/mm³. Feeling shocked, Mira told Kuyung and demanded for Kuyung to take a blood test. Kuyung was diagnosed HIV with a CD4 count of 450 cells/mm³. Mira or Kuyung was likely to be infected with HIV about four years ago year⁽²³⁾. Both Mira and Kuyung were referred to the VCT clinic for Antiretroviral treatment and accessed PMTCT services to prevent HIV to Toleh.

Mira was not sure who whether she or her husband acquired the HIV or syphilis first by saying “I did not know, who got it first, he [Kuyung] is a man”. At some point, Mira was also suspicious she might have acquired HIV from an unsterile syringe used by one of the staff at a family planning clinic. A year prior to her problem, Kuyung had told her about having genital itch and there were reddish-brown sores around his genital area.

HIV vulnerability: norms on heterosexual marriage: To gain further understandings on MSM in Palembang, the first author decided to seek further information and meeting peer support workers and outreach HIV workers who had been working with bisexual and gay communities

and health workers in VCT centres. Learning from lived stories of the insiders, the authors became aware of life of MSM in Palembang that may differ from MSM from other countries, like New Zealand. MSM, either bisexual or gay man, may contract to HIV through unsafe sex practice, have relationship with a female partner and not all of MSM may disclose their sexual orientation and HIV status to their male and female partners.

Discussion

In Mira and Kuyung's marriage, there was a complex interplay of deception, stigma around homosexuality, heterosexual morality and HIV stigma in health setting. Kuyung might have engaged in homosexual sex prior to him marrying Mira, yet there was no knowledge whether Kuyung continued his sexual practice with men after his marriage with Mira. Kuyung also had never disclosed his sexual orientation to Mira nor had he ever seek to do an HIV test although he was infected Syphilis one year prior to Mira.

This spouse was eager to seek Caesarian Section and disclose their HIV status, however they were failed to get one. The risk of Mother To Child Transmission can be reduced from up to 50 % without accessing any treatments to less than 5% by women accessing effective treatment during pregnancy, safe labour practice, and formula milk-feeding (or breastfeeding with certain rules) through PMTCT services^(24, 25). Caesarian section is seen main alternative for safe delivery for pregnant women living with HIV in limited CD4 and viral load test⁽²⁵⁾. We suggest in Mira and Kuyung's life were embedded to their 'perception of susceptibility'⁽²⁶⁾. Mira, and most Muslim women, are taught that being a mother is prestigious and a high status job in Islam as per the famous hadith: "Paradise lies at the feet of the mother"⁽²⁷⁾.

HIV among MSM may bridge HIV transmission to married women as this present study also highlights being a bisexual and gay men was a considered as a lifestyle choice by participants. Being bisexual and gay man is perceived as 'abnormal' and 'sinful' within the discourse of heterosexual morality^(28, 29), hence, bisexual and gay men in Indonesia may give up and decided to getting married to adhere to heterosexual normality in Indonesia⁽²⁹⁾. To reduce social risk on their gayness, MSM generally did not open about their sexual orientation in public space, including to their female partners⁽²⁹⁾. Unfortunately, unsafe homosexual practices

may contribute the significant increase of HIV among MSM in Indonesia^(1, 7, 30). The risk of HIV transmission through anal sex is 18 times higher than vaginal sex without use of condom⁽³¹⁾, however, the rate of condom use, which is effective for preventing HIV and other STIs, is very low amongst married couples^(7, 32).

Preventing HIV among men having sex with men is still complex as their sexual practices are perceived as immoral and sinful. Consequently, this may actively prevent them from seeking HIV tests or disclosing their sexual orientation to their wives or other sexual partners^(28, 29, 33). As a result, unsafe heterosexual and homosexual relationship, a long period of asymptomatic HIV and deception within marriage may result in 'silent' HIV epidemic among Indonesian women. Another threat of this complexity of HIV transmission is a new mutation of HIV virus or recombinant strain of HIV is more likely to be occurred in Indonesia, like a recent study case among MSM in China⁽³⁴⁾.

Conclusion

This paper indicates that sexual transmission of HIV occurs among married women and men in a number of ways, including unsafe sexual practice between a married woman with a husband who has sex with men. Consequently, heterosexual married women have become a 'silent majority' of new HIV-positive cases. The notion of the shame, sinful, a hidden life-style about being a bisexual or gay man means that people do not talk about HIV and homosexual sex within a marriage. Unfortunately, there is limited HIV screening of pregnant women meaning women unknowingly pass HIV to their babies. Consequently, women need to be informed about the web of risk factors of contracting HIV within a deception and unsafe sex practice of men having sex with men with their heterosexual partners. Women should be empowered to make responsible decisions in their own right to reduce contracting HIV from their partner and transmitting HIV to their babies. In order to reduce of the risk of mothers transmitting HIV to their children and to enhance their early access to PMTCT services, these services need to be aware and address these gender discriminatory factors in their training and policies.

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