ASSESS THE KNOWLEDGE PREFERRED CHOICES AND THE
PROBLEM FACED REGARDING THE METHOD OF
CONTRACEPTION ADOPTED BY MARRIED
WOMEN IN SELECTED TRIBAL AREAS OF
KANYAKUMARI DISTRICT.

A DISSERTATION SUBMITTED TO THE TAMIL NADU
Dr. M.G.R. MEDICAL UNIVERSITY, CHENNAI, IN
PARTIAL FULFILLMENT OF REQUIREMENT
FOR THE DEGREE OF MASTER OF
SCIENCE IN NURSING

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COMMITTEE ON : 15-09-2009

RESEARCH GUIDE : Prof.(Mrs).SAN THI APPAVU, M.Sc(N), M.Phil(N),
PRINCIPAL,
CHRISTIAN COLLEGE OF NURSING, NEYYOOR.
KANYA KUMARI DISTRICT.

CLINICAL GUIDE : Mrs. JASMIN SHYL AJA, R.N.R.M., M.Sc(N),
PROFESSOR,
CHRISTIAN COLLEGE OF NURSING, NEYYOOR.
KANYA KUMARI DISTRICT.

MEDICAL GUIDE : DR. REENA RAJESH, M.B.B.S., M.D, D.G.O,
HEAD OF THE DEPARTMENT,
DEPARTMENT OF GYNECOLOGY,
C.S.I. HOSPITAL, NEYYOOR,
KANYAKUMARI DISTRICT.

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Submitted in partial fulfillment of the requirement for the degree of Master of Science in Nursing, The Tamil Nadu DR. M.G.R. Medical university, Chennai.

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Internal Examiner                                External Examiner

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CHAPTER I
INTRODUCTION

“Children by choice not by chance”

Birth control is a regimen of one or more actions, devices, sexual practices, or medications followed in order to deliberately prevent or reduce the likelihood of pregnancy or childbirth (Stacey and Dawn 2009).

World Contraception Day (WCD) is a worldwide campaign with a vision for a world where every pregnancy is wanted. Its mission is to improve awareness of contraception to enable young people to make informed decisions on sexual and reproductive health. Under the motto ‘Contraception: It’s Your Life, it’s your responsibility’, WCD 2010 focuses on the need to encourage young people to take responsibility for contraception to prevent an unplanned pregnancy or sexually transmitted infection (STI) (USAID, 2010).

On September 26, 2009, World Contraception Day will shine a light on the growing need for contraception awareness and education regarding reproductive and sexual health. World Contraception Day is an annual, multinational campaign, and was launched in 2007. Each year’s theme focuses on a different aspect of contraceptive needs. This year’s theme is “Your Life, Your Voice: Talk Contraception” (USAID, 2010).

Over the decades, contraceptive use has been increasing in India. At the same time, there is a substantial unmet need for contraception. The contraceptive scenario is also
characterized by the predominance of non-reversible methods, limited use of male/couple-dependent methods, substantial levels of discontinuation, negligible use of contraceptives among both married and unmarried adolescents and wide regional variations (Pachauri and Santhya 2002).

With a population of over a billion, India sure needs a comprehensive family planning program and a contraceptive culture in place. Also, with rising incidence of HIV/AIDS the usage of condoms both as a contraceptive and protection from sexually transmitted diseases (STD) is vital. With increasing number of women concentrating on their careers and delaying their marriages and pregnancy, the practice of contraception assumes even more significance (Pachauri and Santhya 2002).

Contraception is effective when one has the knowledge of various forms of contraceptives and their usages. Lack of knowledge and the belief in the myths around contraception result in unwanted pregnancies and sometimes unsafe abortions. It is important to educate ourselves and remove any doubts on contraception to lead a healthy and balanced family life (Shan 2005).

Contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time (WHO, 2010).

Current data on adolescent birth rates and contraceptive prevalence reflect persistent disparities among regions, whether defined by relative wealth, level of development or geography. Globally, more women are using contraception, and fewer girls are becoming mothers every year. But the rate of progress has generally slowed since 2000. Meanwhile, declines
in adolescent birth rates have also slowed, and in many countries, especially the least-developed ones, rates may have even increased slightly. For contraceptive prevalence, the rates for least-developed countries remain relatively low: 28 per cent using any method and 22 per cent using modern methods of contraception. These rates are far lower than in the more-developed regions, where 68 per cent of women use any method of contraception and 58 per cent use modern methods, and the less-developed countries, where 61 per cent of women use any method, and 55 per cent use modern methods (The state of the world population 2010).

Estimated pregnancy rates during perfect use of condoms, that is for those who report using the method exactly as it should be used (correctly) and at every act of intercourse (consistently), is 3 percent at 12 months. (WHO1991).

The most frequently cited condom effectiveness rate is for typical use, which includes perfect and imperfect use (i.e. not used at every act of intercourse, or used incorrectly). The pregnancy rate during typical use can be much higher (10-14%) than for perfect use, but this is due primarily to inconsistent and incorrect use, not to condom failure. Condom failure – the device breaking or slipping off completely during intercourse – is uncommon(WHO 1991).

A new report from the Worldwatch Institute argues that assuring all women have access to contraception and taking steps to improve women's lives should be among key strategies in the fight against global climate change (Robert 2010).
International Conference on Population and Development (ICPD) states that there is a global contraceptive use rises. The global contraceptive prevalence use is 63.3% in which the China ranks first with 90.2% UK second with 82% and France stands in the third position with 81.8% (International Conference on Population and Development ICPD 2010).

United Nations analysis of contraceptive prevalence estimates for the world by region, given low, medium, and high assumptions, confirms a global trend toward rising contraceptive use and declining fertility. Given medium assumptions, the percentage of married women of reproductive age who were using a contraceptive method in late 1983 was 51% for the entire world, 45% in developing regions (33% when China was excluded), and 70% in developed regions. This rate was 14% for Africa, 74% for East Asia, 34% for South Asia, and 56% for Latin America. On a global level, the most widely used forms of fertility control are sexual sterilization (36%), the IUD (19%), oral contraception (15%), condoms (10%), withdrawal (8%), and periodic abstinence (7%). Although these statistics confirm that significant progress has been made toward raising contraceptive use, the total fertility rate must drop from its present level of 3.4 to 2.2 by the year 2025 if the world's population is not to exceed 8.5 billion at that latter time. The total fertility rate declines by an average of 0.7/woman for every 10% increase in contraceptive prevalence. Thus, contraceptive use is going to have to rise still more—from the current level of about 50% to 72% by 2025—if population goals are to be met (Haupt 1989).

**NEED FOR THE STUDY**

Getting family planning services to people in developing countries requires the availability of clinicians, counselors, information and
educational materials, some sort of facility and, of course, the contraceptives themselves. Indeed, without an adequate and reliable supply of contraceptives, programs simply cannot succeed in responding to the growing demand for services worldwide (Cohen 2006).

Yet, there is a huge financial gap between the amount international donors contribute to the global reproductive health supplies initiative and the cost of meeting the needs of the approximately 561 million women and their partners in developing countries who, according to estimates from the United Nations Population Fund (UNFPA), are currently using modern contraceptives. And that gap does not even account for the additional 200 million women who wish to avoid or delay pregnancy but are not using modern methods (Cohen 2006).

USAID provides more than one-third of the total donor support for contraceptive commodities worldwide UNFPA provides roughly another third. The remainder comes from a combination of other country donors and from social marketing organizations that sell contraceptives at reduced prices and then apply the proceeds to subsidize the purchase and distribution of more supplies. As of 2004, all of these donors combined had contributed about one-fourth toward the actual cost of the contraceptives dispensed in developing countries; they provided about one-fifth of the combined cost of contraceptives and condoms for STI prevention. The gap between the amount of donor support and the amount expended is made up largely by recipient country government contributions, the commercial sector and individuals' out-of-pocket
expenses. Although the ultimate goal is that all developing countries achieve self-sufficiency in terms of their contraceptive supplies, it is clear that most will need to rely heavily on donor support for the foreseeable future. It is up to the donor community, then, to muster adequate financial resources to provide enough supplies and to support efficient systems (Cohen 2006).

Despite the advances that have been made in contraception over the past fifty years, an estimated 150 million women worldwide cannot get the birth control they desire. In many parts of the world most young women become mothers before they are 20 years old. A woman who bears children at a younger age tends to have more children over all, is less able to care for them, and is more likely to suffer ill health. Maternal mortality remains the leading cause of death for women of childbearing age an estimated 500,000 women die each year from pregnancy related causes, with 78,000 deaths resulting from unsafe abortion. Having access to safe, appropriate family planning methods and safe abortion when needed, can make the difference in women’s lives (The Politics of Women’s Health 2000).

People in the earth are in grave, grave trouble. There are 3,6 billion human beings on the face of the Earth. According to our best estimates, there are somewhere between three and seven times more people than this planet can possibly maintain over a long period of time. Non-renewable resources are being exhausted at a horrendous rate, and we are destroying the capability of the planetary ecosystem to renew the supply of renewable resources (Hinrichs 2008).
The worse however is yet to come. Here are some numerical data that are present in John Laffin's. The Hunger to Come: "About 2050 the population will be 15.000 million, a century later 82.000 million and by 2350 a frightening 440.000 million will be reached". We need to realize the necessity of a population plan which will make us more optimistic as far as our future is concerned. This plan must be based on the fact that the control of the rapid population growth is necessary globally; otherwise, earth's environment will be put into greater danger, the overexploitation of natural resources will continue and poverty will rise in most of the world's countries (Hinrichs 2008).

Thus population in a country can be effectively controlled by contraception. Hence the researcher was interested to know the knowledge preferred choices and problem faced in contraception in the tribal areas of Kanyakumari district. Kanyakumari is the educated district in Tamilnadu so the urban and rural people are well educated when compared with other districts of Tamilnadu that's the reason the researcher has chosen the tribal area. Apart from that rural and urban people can be easily approached when compared with the tribal areas that's the reason the researcher has chosen tribal area.

**PROBLEM STATEMENT**

A study to assess the knowledge preferred choices and the problem faced regarding the method of contraception adopted by married women in selected tribal areas of Kanyakumari district.
OBJECTIVES

1. To assess the existing knowledge of married tribal women regarding various methods of contraception.

2. To indentify the most preferred choice of contraception (temporary or permanent) among married tribal women.

3. To determine the problem faced by married tribal women after using various permanent and temporary methods of contraception.

4. To find out the association of knowledge of married tribal women regarding family planning methods with selected factors like age, education, occupation, income, type of family, and number of living children.

HYPOTHESES

a. There will be a significant association between knowledge and selected demographic variables like age, education, occupation, income, type of family, and number of living children.

b. There will be a significant association between preferred choices and selected demographic variables like age, education, occupation, income, type of family, and number of living children.

c. There will be a significant association between problem faced and selected demographic variables like age, education, occupation, income, type of family, and number of living children.

OPERATIONAL DEFINITION

Assess

The act of evaluating the knowledge on contraception among married women in tribal areas.
**Knowledge**

It refers to the correct verbal response of knowledge questions regarding contraception as measured by structured knowledge questionnaire.

**Contraception**

It is act of controlling the birth process

**Preferred choice**

It is the best method of contraception that the couples like to follow either temporary or permanent.

**Tribal area**

In this study it refers to women who resides in hilly area.

**ASSUMPTION**

1. The tribal women has moderate to inadequate knowledge regarding contraception.
2. Most of them prefer permanent method of contraception.

**LIMITATION**

1. The study was limited to a period of six weeks only.
2. The study was limited to 50 married women who have adopted the contraceptive methods. Hence generalisation is possible only for the selected sample.
3. The study was limited to adopted married women
4. The study was limited to tribal area.

**PROJECTED OUTCOME**

1. The study will help to know the knowledge on contraception among the tribal women.
2. The study will help to know the preferred choices on contraception among the tribal women.

3. The study will help to know the problem faced on contraception among the tribal women.

CHAPTER II
REVIEW OF LITERATURE

The literature review is arranged in the following sections,

- Studies related to contraception
- Studies related to preferred choice of contraception

STUDIES RELATED TO CONTRACEPTION

A study was done in the department of Obstetrics and Gynaecology Kolkata to assess contraceptive practice of the tribal women in the tea garden area of North Bengal. 860 tribal tea garden women were surveyed by detailed questionnaire. The findings were Majority 85% were illiterate. Contraceptive prevalence was 40.2% but most of the current users were subjected to tubal sterilization (Saha, et al 2007).
Mauldin WP 1988 from population council New york had done a study on prevalence of contraceptive use trends and issues. In this they found that contraceptive use has increased rapidly in Asia and Latin America and less in Arab countries and Sub Saharan Africa. World wide 340 million married couples use modern method. Sterilization is the most widely practiced method of contraception in the world, with tubal ligations far outnumbering Vasectomies (Mauldin 1988).

A study had been done in All India Institute of Medical Sciences New Delhi on agreement and concordance regarding reproductive intentions and contraception between husband and wives in rural Ballabgarh. This was cross sectional survey carried in 200 randomly selected married couple. A greater degree of agreement was observed for reproductive health events as compared to family planning attitudes and intentions. An indepth analysis of responses in the current study provides further evidence of male domination in decision making (Yadhav, Singh and Goswami, 2010).

Contraceptive use among clients of the Atlanta Feminist women’s health center at 3-5 weeks post abortion was done in Washington DC. 54.2% of women had engaged in sexual intercourse in the immediate post abortion period. Of these 30.8% were not using any contraceptive method or were not using it effectively (Moslin and Rochat 2010).

Cross sectional study was done among 300 women on withdrawal users experience of and attitudes to contraceptive methods. 210 women
indicated that they were used modern contraceptive method previously. The mean duration for withdrawal use was 6.5 and for modern contraceptive it was 2.3 years (Rahnama, Ghazanfari and Montazeri 2010).

A prospective and descriptive study was done among 1065 persons on use of male condom at schools and universities through and anonymous inquiry questionary. The findings were 56.4% of target population used male condom. Boys who used condoms were unmarried and they used for preventive purpose against STD\ AIDS and for contraception in 82.5% cases (Moreau, et al 2002).

Johansen conducted a study in Denmark on insertion of intrauterine device in general practice, which women choose the IUD and how is the procedure done. 88 General practitioners 562 IUD inserted women participated in the study by filling the questionnaire. IUD was mostly used by women above 25 years and who had given birth to a child. There were no differences in the insertion procedure. 59% of them were previous users of IUD 25% reported that they have long lasting menstruation before insertion. 4.6% insertion were described as difficult (Johansen, Dupont and Obel 2001).

A study was done to evaluate regional differences in Knowledge, attitudes and practice in emergency contraception use among Brazilian university students by semi structured questionnaire. 96% of the students had heard about emergency contraception 42% in the sample
had already used emergency contraception 8% thought emergency contraception involves health risks. No significant differences was observed between regions of the country regarding use and attitudes towards emergency contraception (Silva, et al. 2010).

In centre for disease control and prevention, Atlanta a systematic review on contraceptive use among women with inflammatory bowel disease was carried out. From 207 articles 10 studies met the inclusion criteria. Limited evidence suggests that there is no increased risk of disease and there seems to be no differences in the absorption of higher dose combined oral contraceptives between women with mild ulcerative colitis and small ileal resections and healthy women (Zapta, et al. 2010).

Two surveys were done to examine doctors contraceptive prescribing behavior and women’s attitudes towards contraception. The study was done among 419 doctors and 1623 women in France, Germany, Spain, Italy and Russia. By complying with guidelines and heeding women’s concerns doctors can individualize their contraceptive recommendation to improve safety, acceptance and compliance and ultimately reduce the risk of unintended pregnancy (Grove and Hooper 2010).

A study was done on contraceptive practices among university students the use of emergency contraception by 487 young students at a public university. A structured questionnaire was sent by email and completed online in December 2007. Female and male students reported
a high proportion of contraceptive use mainly condom and pill. Half of the student had already used emergency contraception. The option for emergency contraception proved to be closely related to inconsistencies in the use of regular methods than to lack of their use and can thus be considered a marker for discontinuity in regular contraception (Borges , et al 2010).

A cohort study was done among 2811 adolescents on factors associated with maintenance of contraception among adolescents . Factors such as personal issues, family, sexuality and sexual partner characteristics are strongly associated with contraceptive continuation among single nulliparous female adolescents (Molina, et al 2009).

Quantitative survey was done among 12450 unmarried college students on knowledge, attitude, practice related to contraception among college students in Beijing. The results showed that the prevalence of unmarried sexual intercourse, the rate of taking contraceptive measures was low and the incidence of unexpected pregnancy was high. It is urgent to strengthen the education and service programs on contraception among college students (Zhou , et al 2009).

Elizabeth Chacko had done a study on women’s use of contraception in rural India. The study was conducted among married women in four villages in rural West Bengal. The findings of the study were factors that most influence a women’s use of contraception includes her age, number of living sons, and her religious affiliations. The study also
showed that availability and quality of permanent village based government health care affects the use of modern contraception. The use of temporary family planning method is negligible in the area (Elizabeth 2001).

A prospective study was carried out in 972 married women in rural areas of Lalgani block of Vaishali district in Bihar on contraceptive practices of women living in rural areas of Bihar. Tubal sterilization was the commonest method of contraception among women surveyed. Birth spacing or delaying the birth of the first child by the use of reversible forms of contraception is not the common practice among those women (Kumari 2006).

A cross sectional survey of 117,465 eligible women to obtain information from rural women regarding their contraceptive knowledge practice and utilization of services. Contraceptive prevalence was 45.2% of which 34.2% had used permanent method. Among the current users the contraceptive had been availed mainly from either Primary health centre(31.5%) or hospital (42.1%). Around half the women had received counseling and in 20.3% information regarding other methods. Almost all women were using a contraceptive method with the knowledge of their husband and had his support for continuing the same (Chandhick , etal 2003).

Large retrospective case series report was done in department of OBG in university of Utah among 276 IUD operated women. There were
95 operative IUD removals for perforations, 157 operative procedures for inability to remove and IUD in office, 42 pregnancy related complications that were managed in the operating room. Ectopic pregnancy was the most common diagnosis among pregnant women (Turok, et al. 2010).

Numerous models of contraceptive vaginal rings (CVRs) have been studied, but only two have reached the market: NuvaRing, a combined ring that releases etonogestrel (ENG) and ethinylestradiol (EE), and Progesterone Ring, a progesterone-releasing ring for use in lactating women. The main advantages of CVRs are their effectiveness (similar to or slightly better than the pill), ease of use without the need (Brache, Faundes and May 2010).

Cross sectional study was done in Zimbabwe among 6083 women regarding knowledge and practice of family planning in Zimbabwe. The contraceptive prevalence rate was 59.6%. The median number of live birth was two among all women and seven among women aged 40-49 years. Health concerns were the main reason for both discontinuation and postponement of contraceptive use (Schwartz, Tshimanga and Shodu 2003).

In university clinical center Maribor a study was done among 1435 patients to evaluate the frequency of human papilloma virus 16 and 18 infections in patients with cervical intraepithelial neoplasia according to the use of various contraceptive methods. In that 27.2% used no
contraception.3.1% used barrier method 49.1% used oral contraceptives and 20.7% used intrauterine device (Lovrec and Takac 2010).

The study examined diaphragm and gel-related skills, patterns of use, and problems, among women in Zimbabwe and South Africa. Employing face-to-face interviews with intervention arm participants, patterns of use and comfort using the products were measured at Month 3 and Exit, and reported problems with the products were assessed quarterly. At baseline, 72.5% of women correctly inserted removed the diaphragm within one attempt. At exit, over 90% of intervention women were very comfortable inserting, wearing, cleaning and removing the diaphragm; however, 31.8% reported usual removal of the diaphragm before the prescribed six hours after sex. During the 12-24 month follow-up period there were only 133 reported problems with the diaphragm and gel (Montgomery et al. MIRA team 2009).

A cross-sectional multicenter study was designed to assess self-described impact of noncompliant behavior among 26,250 typical users of a combined hormonal contraceptive method. A self-administered questionnaire was completed. Sixty-five percent of women used the pill, 23% the vaginal ring and 12% the transdermal patch. Noncompliant behavior was recorded in 71% of pill users, 32% of patch users and 21.6% of vaginal ring users. About 40% of women in all groups called or visited a physician. Noncompliant behavior negatively affected work activities and or couple relationships in 10-20% of cases. More than 50% of women reported they were worried and about 20% were scared due to inconsistent use of the contraceptive method (Lete et al. 2008).
In university health centre Granada study was done on insertion and three year follow up experience of 372 etonogestrel subdermal contraceptive implants by family physicians. 372 women participated in the study. Data were available for 365 women. The average age was 27.2 years and 47.7% were nulliparous. Continuation rates were 91% at 1st year, 74.7% at 2nd year and 65.1% at 2 year and 9 months. The reason for discontinuation were excessive bleeding, wish to become pregnant (Arribas, et al 2009).

In college of public health study was done on condom misuse among adjudicated girls. This was cross sectional survey done on 134 female teens by audio computer assisted self interviewing. Five forms of condom use and problems were common, 34.3% not discussing condom use with the partners, 21.6% starting sex before application, removing condoms before sex 26.9% and breakage 32.8%. Significant associations were found between condom problems and drug and alcohol use (Crosby, et al 2007).

**STUDIES RELATED TO PREFERRED CHOICES IN CONTRACEPTION**

Edlow conducted study in the department of OBG Boston on hormonal contraceptive options for women with headache. The results shows that the effect of hormonal fluctuations on headache is provided with recommendations regarding contraception. Counselling in patients who experiences headache while taking hormonal contraception (Edlow and Bartz 2010).

Cohort study was conducted among 1387 women regarding hormonal contraceptive method choice among young, low income women, how important is the provider. Ring and patch initiator were more likely than women starting oral contraceptive to report that they chose their method due to provider counseling. Contraceptive knowledge in general
was low. Women's report of provider counseling and their own contraceptive knowledge after the visit was significantly associated with hormonal method initiated (Harper, Brown, Rosales, Raine 2010).

A global cross-sectional self-administered online survey was done in New Jersey USA on attitudes, awareness, compliance, and preferences among hormonal contraceptive users. 5120 participated in the study. The findings demonstrated that a range of factors influence a woman's choice of contraception. This highlights the importance of individualized counseling during contraceptive selection (Hooper 2010).

A community-based cross-sectional survey was conducted to estimate the prevalence and factors associated with practice of modern contraceptive methods among currently married women in district of Naushahro Feroze. 420 samples participated in the study. The prevalence of modern contraceptive method was 29.9% with husband agreement women could go alone to a health care provider. Women who had three or more children were more likely to use modern methods compared to those who have who have two or less children (Rozi and Mahmood 2004).

A prospective study was done in England among 40 pregnant women who used opiates in the index pregnancy regarding postnatal contraception in opiate using women. Implants had a good continuation rate when used for postnatal contraception in women who used opiates in pregnancy. Depo provera may not be a suitable choice since all the women
who chose this contraceptive method failed to continue with it (Sinha, Guthrie and Lindow 2007).

**CONCEPTUAL FRAME WORK**

Rosentoch’s, Becker and Maiman’s Health Belief Model (1975) is adopted for this research Study. This model consists of 3 Components. They are individual perception, modifying factors, likelihood of action.

**INDIVIDUAL PERCEPTION**

In this study individual perception is perception of every individual regarding contraception

**MODIFYING FACTORS**
In this study the modifying factors are structured variables such as age, educational qualification, income, type of family, religion, number of living children, occupation and the knowledge of ill effects on contraception.

**LIKELIHOOD OF ACTION**

A person takes preventive action based on his perception of benefits of taking that particular action. If the perceived benefits outweighed barrier, the individual is likely to take action to improve his health.

In this study if the persons perception on contraception outweighed its barriers then the person adopt that and it leads to improvement of his health.
FIGURE 1: ROSENOCH’S, BECKER AND MAIMAN’S HEALTH BELIEF MODEL (1975)
CHAPTER III
METHODOLOGY

Research methodology is designed to develop or refine methods of obtaining, organizing or analyzing data (Polit, 2006). This chapter deals with research approach, the research design, the setting, population, sample and sampling technique, description of the tool, validity and reliability of the tool, pilot study, data collection procedure, plan for data analysis and protection of human rights.

RESEARCH APPROACH

The present study was designed to assess in terms of knowledge, preferred choices, problem faced regarding the contraception. To accomplish the objective of the study researcher used quantitative research.

RESEARCH DESIGN

In this study a descriptive design was adopted to assess the knowledge, preferred choices, problem faced regarding the methods of contraception adopted by the tribal women in Kanyakumari district.

SETTING OF THE STUDY

Setting is the physical location and condition in which data collection takes place in the study (Polit, 2008). The present study was conducted at Arukanni, Pathukanni tribal villages in Kanyakumari district. The total population of the villages are around 5000. The eligible couple of that villages were 1308 couples. It is 40 kms away from
The reason for selecting these villages are that in Kanyakumari only three villages comes under the tribal areas by lottery method researcher had chosen Pechiparai for pilot study and other villages for the main study. The villages for the main study comes under the Kaliyal panchayat.

**POPULATION**

The target population selected for this study was the married women who has adopted any one of the family planning methods living in the tribal area.

**SAMPLE**

Women who has adopted any one family planning method were the samples of the study. Women who fit in to the criteria were selected as samples.

**SAMPLE SIZE**

The sample consisted of 50 married women.

**SAMPLING TECHNIQUE**

The sampling technique used was purposive sampling technique. It was a type of non probability sampling. The researcher approached the village health nurse for details regarding the area.

**CRITERIA FOR SAMPLE SELECTION**

The sample was selected based on the following criteria.

*Inclusion criteria*
1. Married women and adopted any one of the family planning method
2. Women within the age group of 15-45 years
3. Should have minimum one child
4. Who are willing to participate

Exclusion criteria
1. Who are not able to understand and speak English or Tamil
2. Women without any disease condition

DEVELOPMENT OF TOOL
The tool used for the study were demographic data, questionnaire on knowledge, preferred choice, problems in adopted women. The questionnaire were prepared after going through the related literature and with the guidance of experts in the field of obstetric and gynecological nursing, community health nursing. After getting adequate information from the experts the tool was prepared in to tamil.

DESCRIPTION OF THE TOOL
The data collection tools consisted of 2 sections

SECTION A
This section deals with demographic data related to women’s age, type of family, education, occupation, monthly income, religion and number of living children.
SECTION B

It comprised of structured knowledge questionnaire. The questionnaire had 36 items to assess the knowledge on contraception. Each questionnaire had one correct response. A score of ‘one’ was allotted for the correct answer and score ‘zero’ was allotted for the wrong answers. The total attainable score was 36. Then the score was converted into percentage and the resulting score was ranged in to

- Adequate knowledge: 76-100%
- Moderate adequate knowledge: 51-75%
- Inadequate Knowledge: 0-50%

SECTION C

It consisted of questionnaire regarding the preferred choices of contraception and problems faced in their respective methods.

TESTING OF THE TOOL

Content Validity

The extent to which a measurement gives consistent results. The content validity of the tool was determined by submitting the tool to five experts in nursing field and one obstetrician. Based on their suggestion the tool was structured. Then the tool was translated in to tamil by language experts. Again the tool was retranslated in to English. There was no change in the content and meaning.

Reliability
Reliability is the consistency of a set of measurements or of a measuring instrument, often used to describe a test (Polit, 2006). For assessing the reliability of the tool, the tool was administered to five married women in tribal area of Pechiparai by Karl Pearson correlation coefficient formula. Reliability \( r=0.7 \).

**PILOT STUDY**

In order to test the feasibility, relevance and practicability of the study pilot study was conducted in Pechiparai among 5 married women in which the final study could be done. Prior permission was obtained from the village leader. The pilot study revealed that the study was feasible.

**DATA COLLECTION PROCEDURE**

The data was collected from 1\(^{st}\) May to 14\(^{th}\) June for six weeks between 10am-4pm.

In the first week Arukanni and Pathukani village primary health centre were approached for the details regarding the population and familiarity with the subjects. Village health nurse guided researcher in getting permission from the village president. Formal permission was obtained from the village president for data collection. The inclusive criteria were selected by purposive sampling method. The researcher approached the Village health nurse for the address. Then door to door survey was done for identifying the samples. In the second to six week
data was collected. Before collecting the data rapport was established between the mother. The data was collected by administration of structured interview questionnaire on knowledge, preferred choice and problem faced. The samples participated in the study cooperated very well.

**PLAN FOR DATA ANALYSIS**

This was planned according to the objectives and hypotheses of the study. Descriptive and inferential statistics were used to analyze and for interpreting the data.

**PROTECTION OF HUMAN RIGHTS**

The proposed study was conducted after the approval of the dissertation committee of Christian college of nursing, Neyyoor. Permission was obtained from the village president. Oral consent was obtained from each sample subjects before starting the data collection. Assurance was given to the study subjects that anonymity of each individual would be maintained.

This chapter dealt with research approach, research design, setting of the study, population, sample and sampling techniques, criteria for sample selection, development of tool, scoring procedure, testing of the tool, pilot study, data collection procedure, plan for data analysis and protection of human rights.
CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of the data to assess the knowledge preferred choices and problem faced by married women after adopting contraceptive methods in tribal areas of
Kanyakumari district. The data obtained are classified, grouped and analysed based on the objectives of the study.

**ORGANISATION OF THE FINDINGS**

In order to find the relationship between the variables and also to find out the knowledge, preferred choices and problem faced by the tribal married women, data gathered were tabulated, analysed and interpreted by using descriptive statistics. The data and findings are presented under the following headings.

1. Frequency and percentage distribution of sample characteristics of the study
2. Findings related to frequency and percentage distribution of knowledge scores of sample subjects regarding contraception.
3. Findings related to frequency and percentage distribution of preferred choice of contraception.
4. Findings related to frequency and percentage distribution of problems faced by sample subjects after adopting contraceptive methods.
5. Relationship between knowledge scores and selected demographic variables.

**FREQUENCY AND PERCENTAGE DISTRIBUTION OF SAMPLE CHARACTERISTICS OF THE STUDY**
Samples of 50 married women who had adopted any one of the contraceptive method were selected for the study. The demographic data collected include age, type of family, educational qualification, religion, income, occupation and number of living children.

The distribution of samples in each of these categories is presented in table -1
### TABLE -1: FREQUENCY AND PERCENTAGE DISTRIBUTION OF SAMPLES ACCORDING TO SELECTED DEMOGRAPHIC VARIABLES.

\( (N=50) \)

<table>
<thead>
<tr>
<th>SI. NO</th>
<th>CHARACTERISTICS</th>
<th>FREQUENCY (f)</th>
<th>PERCENTAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>16-20 years</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>1.2</td>
<td>21-25 years</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>1.3</td>
<td>26-30 years</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>1.4</td>
<td>31-35 years</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>1.5</td>
<td>36-40 years</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>2.1</td>
<td>Nuclear family</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>2.2</td>
<td>Joint family</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>3.1</td>
<td>Uneducated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3.2</td>
<td>Primary</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>3.3</td>
<td>Middle school</td>
<td>19</td>
<td>38</td>
</tr>
<tr>
<td>3.4</td>
<td>Higher secondary</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>3.5</td>
<td>Graduates</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>4.1</td>
<td>Not working</td>
<td>28</td>
<td>56</td>
</tr>
<tr>
<td>4.2</td>
<td>Medical professionals</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4.3</td>
<td>Non medical professional</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>5.1</td>
<td>Less than 2000 rupees</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>5.2</td>
<td>2001-5000 rupees</td>
<td>36</td>
<td>72</td>
</tr>
<tr>
<td>5.3</td>
<td>5001-8000 rupees</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>5.4</td>
<td>above 8001 rupees</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6.1</td>
<td>Hindu</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>6.2</td>
<td>Christian</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>6.3</td>
<td>Muslim</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7.1</td>
<td>One</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>7.2</td>
<td>Two</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>7.3</td>
<td>Above three</td>
<td>14</td>
<td>28</td>
</tr>
</tbody>
</table>
Table 1 shows that out of 50 samples for the study, 18% (9) were between 16-20 years, 32% (16) were between 21-25 years, 22% (11) were between 26-30 years, 18% (9) were between 31-35 years, and 10% (5) were between 36-40 years. In the type of family, 36% (18) were nuclear family and 64% (32) were joint family. Regarding educational qualification, none of them were uneducated, 24% (12) had completed primary education, 38% (19) had completed middle school, 30% (15) had higher secondary, and 8% (4) were graduates. In Occupation, 56% (28) were not working, none of them were medical professionals, and 44% (22) were non-medical professionals. Regarding monthly income, 6% (3) earn less than Rs 2000, 72% (36) earn between Rs 2001-5000, 22% (11) earn Rs 5001-8000, and none of them earn above Rs 8001 per month. Regarding Religion, 36% (18) were Hindus, 64% (32) were Christians, none of them were Muslims. Regarding the number of living children, 8% (4) had one child, 64% (32) had two children, and 28% (14) had above three children.

Comparison of percentage distribution of married women who had adopted any one contraceptive method according to the sample characteristics were shown in the figure 2-8 in the form of bar diagram.
FIGURE 2: DISTRIBUTION AND COMPARISON OF MARRIED WOMEN ACCORDING TO THEIR AGE

FIGURE 3: DISTRIBUTION AND COMPARISON OF MARRIED WOMEN ACCORDING TO THEIR TYPE OF FAMILY
FIGURE. 4: DISTRIBUTION AND COMPARISON OF MARRIED WOMEN ACCORDING TO THEIR EDUCATIONAL STATUS

FIGURE. 5: DISTRIBUTION AND COMPARISON OF MARRIED WOMEN ACCORDING TO THEIR OCCUPATION
FIGURE 6: DISTRIBUTION AND COMPARISON OF MARRIED WOMEN ACCORDING TO THEIR MONTHLY INCOME

FIGURE 7: DISTRIBUTION AND COMPARISON OF MARRIED WOMEN ACCORDING TO THEIR RELIGION
FIGURE 8: DISTRIBUTION AND COMPARISON OF MARRIED WOMEN ACCORDING TO THE NUMBER OF LIVING CHILDREN
Findings related to Frequency and Percentage Distribution of Knowledge Scores of Sample Subjects Regarding Contraception.

It deals with the distribution of sample subjects based on their Knowledge score.

**TABLE – 2 : DISTRIBUTION OF SAMPLE SUBJECTS ACCORDING TO THE level OF KNOWLEDGE REGARDING CONTRACEPTION**

(N=50)

<table>
<thead>
<tr>
<th>S.NO</th>
<th>LEVEL OF KNOWLEDGE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Two</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Above three</td>
<td>28%</td>
<td></td>
</tr>
</tbody>
</table>
The above Table 2 showed the knowledge about contraception among the tribal married women. 18%(9) of them had adequate knowledge 64%(32) had moderate knowledge and 18% (9) had inadequate knowledge on contraception.

The distribution of level of knowledge is shown in the figure 9 in the form of pie diagram.

### Table 2: Level of Knowledge Regarding Contraception

<table>
<thead>
<tr>
<th></th>
<th>(f)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate Knowledge</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Moderate Knowledge</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>Inadequate Knowledge</td>
<td>9</td>
<td>18</td>
</tr>
</tbody>
</table>

**FIGURE. 9: DISTRIBUTION AND COMPARISON OF LEVEL OF KNOWLEDGE REGARDING CONTRACEPTION**
Findings related to frequency and percentage distribution of preferred choice of contraception.

It deals with the distribution of sample subjects based on their preferred choice of contraception.

**TABLE - 3 : DISTRIBUTION OF SAMPLE SUBJECTS ACCORDING TO THE PREFERRED CHOICE OF CONTRACEPTION**

(N=50)
<table>
<thead>
<tr>
<th>S.NO</th>
<th>CHOICE OF CONTRACEPTION</th>
<th>FREQUENCY (f)</th>
<th>PERCENTAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Temporary</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.</td>
<td>Permanent</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

The above Table 3 explained that 100%(50) of the married women preferred choice was permanent method of contraception.

**TABLE – 4 : DISTRIBUTION OF SAMPLE SUBJECTS ACCORDING TO THE PREFERRED CHOICE OF CONTRACEPTION IN TEMPORARY METHOD**

(N=50)

<table>
<thead>
<tr>
<th>S.NO</th>
<th>TEMPORARY METHOD</th>
<th>FREQUENCY (f)</th>
<th>PERCENTAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Oral Contraceptive Pill</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The above Table 4 explained that 12%(6) of them preferred condom and 88%(44) of them preferred Copper T for temporary methods of contraception.

<table>
<thead>
<tr>
<th>S.NO</th>
<th>PERMANENT METHOD</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Coitus interruptus</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.</td>
<td>Condom</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>3.</td>
<td>Copper T</td>
<td>44</td>
<td>88</td>
</tr>
</tbody>
</table>

**TABLE – 5 : DISTRIBUTION OF SAMPLE SUBJECTS ACCORDING TO THE PREFERRED CHOICE OF CONTRACEPTION IN PERMANENT METHOD**

(N=50)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vasectomy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Tubectomy</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

The above Table 5 showed that 100%(50) of the married women preferred tubectomy as permanent method of contraception.

The distribution of sample subjects according to the preferred method of contraception both temporary and permanent method were shown in figure 10 - 12.
FIGURE 11: DISTRIBUTION AND COMPARISON OF PREFERRED CHOICE OF CONTRACEPTION IN TEMPORARY METHOD
FIGURE 12: DISTRIBUTION AND COMPARISON OF PREFERRED CHOICE OF CONTRACEPTION IN TEMPORARY METHOD
Findings related to frequency and percentage distribution of problems faced by sample subjects after adopting contraceptive methods.

It deals with the distribution of sample subjects based on the problems faced after adopting various contraceptive methods.

**TABLE - 6 : DISTRIBUTION OF SAMPLE SUBJECTS ACCORDING TO THE PROBLEM FACED AFTER ADOPTING PERMANENT FAMILY PLANNING METHOD**

(N=30)

<table>
<thead>
<tr>
<th>S.NO</th>
<th>PROBLEM FACED</th>
<th>FREQUENCY (f)</th>
<th>PERCENTAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Back Pain</td>
<td>16</td>
<td>53.33</td>
</tr>
<tr>
<td>2.</td>
<td>Menstrual Irregularities</td>
<td>13</td>
<td>43.33</td>
</tr>
<tr>
<td>3.</td>
<td>Abdominal Pain</td>
<td>1</td>
<td>3.33</td>
</tr>
</tbody>
</table>

The above Table 6 explained the problem faced by the mother who had adopted permanent family planning method. 53.33%(16) of them reported back pain, 43.33%(13) of them complained menstrual irregularities and 3.33%(1) of them complained abdominal pain.
The above Table 7 explained the problem faced by married women after using various temporary methods of contraception. 30% (6) of them complained of menstrual irregularities, 40% (8) of them complained of dyspareunia, 15% (3) of them complained of sexual dissatisfaction, 15% (3) of them complained of abdominal pain.

The distribution of problem faced by the married women after adopting various contraceptive methods were shown in figure 13 and 14.
FIGURE. 13: DISTRIBUTION AND COMPARISON OF PROBLEMS FACED AFTER ADOPTING PERMANENT METHOD OF CONTRACEPTION

FIGURE. 14: DISTRIBUTION AND COMPARISON OF PROBLEMS FACED AFTER ADOPTING TEMPORARY METHOD OF CONTRACEPTION
Relationship between knowledge scores and selected demographic variables.

In order to find out the significant relationship between knowledge score and demographic variable regarding contraception chi-square test was computed.

The relationship between knowledge scores and selected demographic variables were presented in table 8.
TABLE - 8: DISTRIBUTION OF ASSOCIATION BETWEEN LEVEL OF KNOWLEDGE REGARDING CONTRACEPTION AND SELECTED DEMOGRAPHIC VARIABLES.

<table>
<thead>
<tr>
<th>SI. NO</th>
<th>CHARACTERISTICS</th>
<th>ABOVE MEAN</th>
<th>BELOW MEAN</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6</td>
<td>16-20 years</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.7</td>
<td>21-25 years</td>
<td>11</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>1.8</td>
<td>26-30 years</td>
<td>4</td>
<td>7</td>
<td>*16.06</td>
</tr>
<tr>
<td>1.9</td>
<td>31-35 years</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>1.10</td>
<td>36-40 years</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>TYPE OF FAMILY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Nuclear family</td>
<td>10</td>
<td>8</td>
<td>#1.05</td>
</tr>
<tr>
<td>2.2</td>
<td>Joint family</td>
<td>18</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>EDUCATIONAL QUALIFICATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>Uneducated</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>Primary</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>Middle school</td>
<td>8</td>
<td>10</td>
<td>#2.926</td>
</tr>
<tr>
<td>3.4</td>
<td>Higher secondary</td>
<td>11</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Graduates</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>OCCUPATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Not working</td>
<td>16</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Medical professionals</td>
<td>0</td>
<td>0</td>
<td>#1.524</td>
</tr>
<tr>
<td>SI. NO</td>
<td>CHARACTERISTICS</td>
<td>ABOVE MEAN</td>
<td>BELOW MEAN</td>
<td>$\chi^2$</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------</td>
<td>------------</td>
<td>------------</td>
<td>---------</td>
</tr>
<tr>
<td>4.3</td>
<td>Non medical professional</td>
<td>12</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

5. **MONTHLY INCOME**
5.1 Less than 2000 rupees | 2 | 1 |         |
5.2 2001-5000 rupees | 17 | 18 | *15.77 |
5.3 5001-8000 rupees | 9 | 3 |         |
5.4 above 8001 rupees |         |      |         |

6. **RELIGION**
6.1 Hindu | 12 | 6 | #1.81 |
6.2 Christian | 16 | 16 |       |
6.3 Muslim |         |     |         |

7. **NO OF CHILDREN**
7.1 One | 4 | 0 |         |
7.2 Two | 19 | 13 | *5.77 |
7.3 Above three | 5 | 9 |         |

*Significant
# Not significant

The above Table 8 showed that there was significant relationship between knowledge and age, income and number of living children, there was no significant relationship between knowledge and type of family, educational qualification religion.
CHAPTER V

DISCUSSION

The main aim of the study is to assess the knowledge preferred choices and problem faced regarding the methods of contraception adopted by married women in tribal areas of Kanya Kumari District.

The Objectives of the study were

1. to assess the existing knowledge of tribal married women regarding various methods of contraception.
2. to indentify the most preffered methods of contraception (temporary and permanent) among tribal married women.

3. to determine the problems faced by tribal married women after using various permanent and temporary methods of contraception.

4. to find the association of knowledge of tribal married women regarding family planning methods with selected demographic variables like age, education, occupation, income, type of family, and number of living children.

**SAMPLING CHARACTERISTICS**

Table -1 showed the demographic characteristics of the married women in tribal areas of Kanya Kumari District. The major findings of the study are;

- Majority 32% (16) of the tribal married women were between 21-25 Years.
- Majority 64% (32) of the tribal married women belongs to joint family.
- Among the population 38% (19) of the tribal married women were not working.
- Majority 72% (36) the monthly income was between Rs 2001-5000
- Majority 64% (32) were Christian women.
- Regarding number of living children 64% (32) had two children.
DESCRIPTION OF ASSESSMENT OF KNOWLEDGE ON
CONTRACEPTION AMONG MARRIED WOMEN IN TRIBAL AREAS OF
KANYA KUMARI DISTRICT

The first Objective of the study was to assess the existing
knowledge of tribal married women regarding various methods of
contraception.

The first objective was assessed by using descriptive statistics. Table -2 explained the knowledge about contraception among the tribal married women. The mean knowledge score of the tribal women was 22.

DESCRIPTION OF ASSESSMENT OF PREFERRED CHOICE OF
CONTRACEPTION AMONG MARRIED WOMEN IN TRIBAL AREAS OF
KANYA KUMARI DISTRICT.

The second objective of the study was to identify the most preferred methods of contraception (temporary and permanent) among tribal married women.

Table -3 showed the preferred method of contraception 100% (50) of them preferred permanent method of contraception.

Table- 4 explained the preferred choice in temporary method of contraception. In that 88% (44) of them preferred Copper T.

Table-5 showed the preferred choice in permanent method of contraception. In that 100% (50) of them preferred Tubectomoy.
DESCRIPTION OF ASSESSMENT OF PROBLEM FACED AFTER USING VARIOUS CONTRACEPTIVE METHODS (TEMPORARY AND PERMANENT)

The third Objective of the study was to determine the problems faced by tribal married women after using various permanent and temporary methods of contraception.

Table- 6 explained the problems faced by tribal married women after using permanent contraceptive methods. In that 53.33% (16) of the tubectomy underwent mother 53.33% reported to have back pain.

Table- 7 showed that the problems faced by tribal married women after using temporary contraceptive methods. In that 46% (8) of them reported dyspareunia.

ASSOCIATION OF DEMOGRAPHIC CHARACTERISTICS AND EXISTING KNOWLEDGE OF MARRIED WOMEN ADOPTING FAMILY PLANNING METHODS IN TRIBAL AREAS OF KANYA KUMARI DISTRICT

The fourth objective of the study was to find the association of knowledge of married women regarding family planning methods and selected factors such as age, education, occupation, income, type of family, and number of living children.

Table- 8 showed that the association between the knowledge and demographic characteristics. The association between age and knowledge was significant $\chi^2=16.06$ df =8. The association between income and knowledge was significant $\chi^2=15.77$ df =4. The association between number of children and knowledge was significant $\chi^2=5.77$ df =4. The
association between type of family and knowledge was nonsignificant $\chi^2=1.05$ df=2. The association between educational qualification and knowledge was nonsignificant $\chi^2=2.926$ df =8. The association between occupation and knowledge was nonsignificant $\chi^2=1.524$ df =4. The association between religion and knowledge was nonsignificant is 1.81 df =4.
CHAPTER VI

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

This Chapter deals with summary, conclusions, implications and recommendations of the study in the field of Nursing. This also presents the recommendations for future research.

SUMMARY

The study was carried out with a view to assess the knowledge preferred choice and problem faced regarding the method of contraception adopted by married women in tribal areas of Kanya Kumari District.

OBJECTIVES

1. to assess the existing knowledge of tribal married women regarding various methods of contraception.
2. to indentify the most preffered methods of contraception (temporary and permanent) among tribal married women.
3. to determine the problems faced by tribal married women after using various permanent and temporary methods of contraception.
4. to find the association of knowledge of tribal married women regarding family planning methods with selected demographic variables like age, education, occupation, income, type of family, and number of living children.
MAJOR FINDINGS OF THE STUDY ARE FOLLOWS

- Among 50 tribal married women 18%(9) were in the age group of 16-20 years, 32%(16) were in the age group of 21-25 years, 22%(11) were between 26-30 years 18%(9) between 31-35 years and 10%(5) were between 36-40 years.
- Regarding the type of family 36%(18) were living as nuclear family and 64%(32) were living as joint family
- In educational qualification 24%(12) had primary schooling 38%(19) had middle school 30%(15) had higher secondary education and 8%(4) were graduates.
- Regarding occupation 56%(28) were not working 44%(22) were non medical professionals.
- In monthly income 6%(3) had monthly income less than Rs 2000, 72% (36) were between Rs 2001-5000, 22% (11) were Rs 5001-8000 and 0%(0) were above Rs 8001.
- Regarding Religion 36%(18 ) were belong to hindu religion, 64% (32) belong to christian religion.
- Regarding the Number of living children 8%(4) had one child , 64%(32) had two children and 28%(14) had above three children.
- Among 50 samples 18%(9) had adequate knowledge 64% (32) had moderate knowledge and 18%(9) had Inadequate knowledge.
• Among 50 Samples 100% (50) were preferred permanent method of family planning

• In temporary method of contraception 12% (6) of them were preferred condom 88% (44) were preferred Copper T

• In permanent method of contraception 100% (50) of them were preferred tubectomy.

• Regarding problem faced in temporary methods of contraception 30% (6) of them reported menstrual irregularities 40% (8) were complained dyspareunia 15% (3) had sexual dissatisfaction 15% (3) had abdominal pain

• Regarding problems faced in permanent method of contraception 53.33% (16) reported back pain 43.33% (13) reported menstrual irregularities 3.33% (1) were reported abdominal pain.

• Regarding the association between the variables there was a significant association between knowledge and age, income, number of living children and there was no significant relationship between knowledge and type of family, educational qualification, occupation and religion.

**IMPLICATIONS**

The findings of the present study have important implications in the field of Nursing practice, nursing education, Nursing Research and Nursing Administration.

**NURSING RESEARCH**
The need for future research in the field of contraception is important because population explosion affects Indian economy which in turn affects each individual.

Motivate the investigator to conduct study in identifying the barriers in adopting the contraception.

Future research in contraception with less side effects

Motivating the NGO to participate in family welfare programmes.

NURSING PRACTICE

The nurse midwife being a professional care giver has an increased responsibility in motivating the parturient mothers to participate in family planning activities or adopt family planning methods.

The nurse midwife has the responsibility in monitoring the health of the adopted women.

The nurse and other health professionals and health care practitioners able to make significant contributions to promote healthy attitudes and behavior of married women by health education.

NURSING EDUCATION
• The nursing students can be emphasized to the various contraceptive methods and competent in administering contraceptives.

• The nurse educator in planning the clinical plan adequate facilities should be provided for the students to mingle with other governmental and non governmental agencies for implantation of the programme.

**NURSING ADMINISTRATION**

• The nurse administrator can function effectively and can select married women adopting contraceptive methods and attending family welfare clinic. This will help in resolving the problem attending the clinic.

• The nurse administrator can coordinate with NGOs in implementation of family planning and contraception.

**RECOMMENDATIONS**

• Similar study can be conducted with large sample among urban and rural areas.

• The study can be conducted with different group of married women attending hospitals.

• A descriptive study can be conducted to assess the barriers in adopting the contraception.
• Comparitive study can be conducted to assess the effectiveness of two different methods of contraception

• A longitudinal study can be conducted to assess the problems faced from the adoption period to menopause.

• Counselling session can be conducted after parturition.

CONCLUSIONS

Thus the study revealed that majority of the tribal married women had moderate knowledge on contraception. Then it revealed that all the tribal married women prefer permanent method of contraception. In permanent method all tribal married women preferred tubectomy. In temporary contraceptives majority of them preferred Copper T. In permanent method the problem faced is back pain. In temporary method the major problem is dyspareunia. In the study it revealed that there is significant relationship between knowledge and age, income and number of living children and there is no significant relationship between knowledge and type of family, educational qualification, occupation and religion.

REFERENCES

BOOK REFERENCE


JOURNALS REFERENCE
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  subdermal contraceptive implants by family physicians in Granada

  condom at schools and universities survey with 1065 young people:

  practice of the tribal women in tea garden area of North Bengal:

  Contraceptive practices among university students the use of

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  village level study: Health and Place: 7 (3): 197-208.

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  the rural areas of India: Indian journal of medical sciences: 57
  : 303-310.

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ELECTRONIC VERSION


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APPENDIX – I A

COPY OF LETTER SEEKING PERMISSION TO CONDUCT RESEARCH STUDY

CHRISTIAN COLLEGE OF NURSING
C.S.I. KANYAKUMARI DIOCESE
(Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)
Approved by Indian Nursing Council, New Delhi and Tamil Nadu Nurses and Midwives Council, Chennai
NEYYOOR - 629 802
KANYAKUMARI DISTRICT, TAMIL NADU, INDIA.

Principal
Prof. (Mrs.) SANTHI APPAVU, M.Sc.(N) M.Phil
Phone: 04651-221399, Cell: 04651-221411
Fax: 04651-224382
E-mail: can.neyyor@yahoo.com
Web: www.canneyyor.org

03.05.2010

68/M.Sc.(N)/2010

Date: ..........................

To

The Village Administrator,
Pathukami Village,
Pattukani,
Kanyakumari District.

Respected Sir / Madam,

Sub: Requisition for getting permission to do a study to assess the
Knowledge, preferred choices and the problem faced regarding method
of contraception adopted by the married women in selected tribal areas
of Kanyakumari District.

This is to introduce Mrs. R. Beaulin, II year M.Sc. Nursing student of this College.
She is to conduct a research project which is to be submitted to the Tamilnadu Dr. M.G.R
Medical University, Chennai in partial fulfillment of University requirements for the
award of M.Sc. degree in Nursing.

Topic:

A study to assess the Knowledge, preferred choices and the problem faced
regarding method of contraception adopted by the married women in selected tribal areas
of Kanyakumari District.

This student is in need of your esteemed help and co-ordination as she is
interested in conducting her main study in your well esteemed institution.

This is to request you to kindly extend necessary facilities to her work on her
proposed study during the month of May 2010

Thanking you,

Yours Faithfully,
From

R. Beutlin,
M.Sc(Nursing) II year,
Christian College of Nursing,
Neyyoor.

To

Respected Sir / Madam,

I am doing II year M.Sc Nursing in Christian College of Nursing, Neyyoor. As a partial fulfillment of the course, I have chosen a topic of my interest “A study to assess the knowledge preferred choices and the problem faced regarding the method of contraception adopted by married women in selected tribal areas of Kanyakumari district”. I hereby kindly request you to evaluate the tool based on the evaluation criteria. Your opinion and suggestions will help me to the successful completion of my study.

Thanking You,

Yours Truly,
APPENDIX – II A

LIST OF EXPERTS WHO HAVE VALIDATED THE TOOL

- Dr. Mary Nirmala, M.B.B.S., M.D., Amala Hospital, Mulagumoodu (PO) Kanya Kumari District
- Mrs. Henita, M.Sc(N), Dr. SMCSI College of Nursing, Karakonam, Trivandrum, South India.
- Mrs. Suguna, M.Sc(N), Nehru Nursing College, Vallyoor, Trinelveli.
- Mrs. Anitta, M.Sc(N), St Xavier Catholic College of Nursing, Chunkankadai, Nagercoil.
- Mrs. Suja Baby, M.Sc(N), Associate Professor, Dr. SM CSI College of Nursing, Karakonam.
- Mrs. L.M. Majella Livingston, M.Sc (N), St Xavier Catholic College of Nursing, Chunkankadai, Nagercoil.
APPENDIX – II B
EVALUATION CRITERIA CHECK LIST FOR TOOL VALIDATION

Instruction

The expert is requested to go through the following criteria for evaluation of check list. Three columns are given for response and a column for remarks. Kindly place a tick mark in the appropriate column and give remarks.

Interpretation of columns

Column I - Meets the Criteria
Column II - Partly meets the Criteria
Column III - Does not meet the criteria

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<th>S.No</th>
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Any other suggestions

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APPENDIX – III A

SECTION A

DEMOGRAPHIC DATA

1. AGE IN YEARS
   1.1 16-20
   1.2 21-25
   1.3 26-30
   1.4 31-35
   1.5 36-40

2. TYPE OF FAMILY
   2.1 Nuclear family
   2.2 Joint family

3. WOMEN LEVEL OF EDUCATION
   3.1 Uneducated
   3.2 Secondary Education
   3.3 Higher Secondary
   3.4 Graduates

4. OCCUPATION
   4.1 Not Working
   4.2 Medical Professionals
   4.3 Non Medical Professionals

5. INCOME PER MONTH
   5.1 Less Than 2000
   5.2 2001-5000
   5.3 5001-8000
   5.4 Above 8000

6. RELIGION
6.1 Hindu
6.2 Christian
6.3 Muslim

7. NUMBER OF LIVING CHILDREN
7.1 1 Child
7.2 2 Children
7.3 More Than 3 Children

SECTION B
(Choose any one of the following, this questions are used for research purpose and you are free to answer)

1 TYPES OF CONTRACEPTION
1.1 How many types of contraceptives are available
   a) 3
   b) 2
   c) 4
   d) 6

1.2 Name the types of contraceptives
   a) concurrent and terminal
   b) permanent and temporary
   c) temporary
   d) permanent

1.3 Give an example of intrauterine devices
   a) tubectomy
   b) condom
   c) copper t
   d) vasectomy

1.4 Give an example for permanent method of sterilization for female
   a) oral contraceptive pill
   b) tubectomy
   c) condom
d) intra uterine device

2 TEMPORARY METHOD OF CONTRACEPTION

2.1 Temporary methods are used to
   a) prevent pelvic inflammatory disease
   b) prevent ectopic pregnancy
   c) space birth
   d) prevent infections

2.2 Copper T is a
   a) intrauterine device
   b) hormonal device
   c) dilating device
   d) medicinal device

2.3 The apt time for the insertion of copper T is
   a) During Pregnancy
   b) During Menstruation
   c) 5th Day After Menstruation
   d) 3rd Day After Menstruation

2.4 Copper T has to be replaced for every
   a) 1 year
   b) 2-4 year
   c) 3 year
   d) 4-6 year

2.5 Copper T is contraindicated during
   a) menstruation
   b) lactation
   c) pregnancy
   d) ovulation

2.6 The thread in the copper T is made up of
   a) nylon
b) polyethylene  
c) silk  
d) cotton

2.7 T shaped frame is made of  
a) nylon  
b) polyvinyl chloride  
c) polyethylene  
d) plastic

2.8 Copper T insertion is done in  
a) outpatient department  
b) inpatient department  
c) operation theatre  
d) anesthesia department

2.9 Mala D is  
a) subcutaneous contraceptive  
b) oral contraceptive  
c) parentral contraceptive  
d) vaginal contraceptive

2.10 How many tablets are there in Mala D  
a) 20  
b) 30  
c) 28  
d) 18

2.11 What is the constituent of Mala D  
a) estrogen and progesterone  
b) contraceptive pill and iron tablet  
c) lactogen ane estrogen  
d) human chronic gonadotropi and progesterone

2.12 The number of contraceptive and iron pill in oral contraceptive pill is
a) 21 contraceptive and 7 iron pill  
b) 21 contraceptive and 7 iron pill  
c) 25 contraceptive and 5 iron pill  
d) 20 contraceptive and 8 iron pill

2.13 When a woman forgets to take the pill what she can do  
a) miss the pill  
b) take the missed pill  
c) use additional contraception  
d) approach the doctor

2.14 Oral contraceptives are contraindicated in  
a) fever  
b) diarrhea  
c) hypertension  
d) peptic disease

2.15 The action of oral contraceptive pill is  
a) prevent hormone secretion  
b) prevent the release of hormone  
c) prevent the release of ovum from ovary  
d) blocks the tube

2.16 Contraceptive injections are to be taken every  
a) 3 months  
b) 1 month  
c) 2 month  
d) 6 month

2.17 After unprotected sexual intercourse intra uterine device has to be inserted with  
in  
a) 1 day  
b) 5 days
c) 3 days

d) 4 days

2.18 Natural method of contraception is
a) vaginal diaphragm
b) breast feeding
c) rhythm method
d) spermicides

2.19 During ovulation cervical mucus will be
a) white
b) milk white
c) cream
d) egg white

2.20 During ovulation temperature is increased to
a) 1 degree F
b) 0.4 degree F
c) 0.8 degree F
d) 1.4 degree F

2.21 The couples can have sexual act without the fear of pregnancy is during
a) pregnancy
b) menstruation
c) unsafe period
d) safe period

2.22 What is safe period
a) fertile period
b) non fertile period  
c) menstrual period  
d) ovulation period

2.23 The most common method of male contraceptive

a) male pill  
b) condom  
c) vasectomy  
d) spermicides

2.24 The trade name for condom is

a) today  
b) nirodh  
c) femilond  
d) male N

2.25 The additional use of using condom

a) prevents sexually transmitted diseases  
b) prevents pelvic inflammatory diseases  
c) prevent ectopic pregnancy  
d) prevent infection

3 PERMANENT METHOD OF CONTRACEPTION

3.1 Permanent method of female sterilization is

a) vasectomy  
b) tubectomy  
c) laprotomy  
d) oophorectomy

3.2 The best time to perform sterilization after normal delivery is

a) puerperium  
b) lactation  
c) menstruation  
d) after six weeks of post partum

3.3 In laproscopic tubectomy the length of the hospital stay is
a) 3-5 days  
b) 3-4 hours  
c) 1 day  
d) 2 day

3.4 Permanent method of male sterilisation is  
a) vasectomy  
b) tubectomy  
c) laprotomy  
d) orchectomy

3.5 Which exercise is avoided after vasectomy  
a) cycling  
b) jogging  
c) swimming  
d) running

3.6 After vasectomy how many ejaculations the couples should use additional contraception  
a) 10  
b) 20  
c) 30  
d) 40

3.7 For terminal methods the couples should have minimum  
a) 2 children  
b) 1 child  
c) 3 children  
d) 4 children

SECTION C

4.1 The commonest complaint of women in temporary method of contraception is  
a) mestrual irregularities  
b) dysparunia
c) sexual dissatisfaction

d) abdominal pain

4.2 The commonest complaint of women in permanent method of contraception is

a) back pain
b) menstrual irregularities
c) abdominal pain
d) itching

5. PREFERRED METHODS OF CONTRACEPTION

5.1 Which is the preferred method of contraception

a) temporary
b) permanent
c) concurrent
d) terminal

5.2 Which is the preferred method of temporary contraception

a) intra uterine devise
b) condom
c) coitus interruptus
d) rhythm method

5.3 Which is the preferred method of permanent contraception

a) vasectomy
b) tubectomy
c) lapratomy
d) mini laprotomy
APPENDIX - II

1. Section
   1.1 16–20
   1.2 21–25
   1.3 26–30
   1.4 31–35
   1.5 36–40

2. Section
   2.1 Section
   2.2 Subsection

3. Section
   3.1 Subsection
3.2 செல்வாக்கு கலைகள்
3.3 விளக்கநிலைகள் கலைகள்
3.4 செல்வாக்கு கலை
3.5 பாப்பர்கள்

4. நூற்றை
4.1 வாழ்க்கை நூற்றை
4.2 பெற்றியல் நூற்றை
4.3 பெற்றியல் கலைஞர் நூற்றை

5. பரவல் வரலாறு
5.1 200 - க்கு முன்னதான
5.2 2001 - 5000
5.3 5001 - 8000
5.4 8000 - க்கு முன்னதான

6. மரம்
6.1 தோற்றம்
6.2 இரவுபகுதிகள்
6.3 போலகம்

7. காத்துடன் வலுதுக்கள் வலுதுக்கள்
7.1 1
7.2 2
7.3 3 - க்கு முன்னதான

பகுதி - II

(சிறுகுழு விளக்கம் சுருக்கின் கூறு)
1. காத்துடன் வலுதுக்கள் வலுதுக்கள்
1.1 காத்துடன் வலுதுக்கள் வலுதுக்கள் வலுதுக்கள் (அ) வரலாறு
(ஆ) இயற்றுநிலை
(இ) பாம்பல்
(ஈ) அழகு

1.2 காத்துடன் வலுதுக்கள் வலுதுக்கள் பார்வை
(அ) வரலாறு வலுதுக்கள் விளக்கநிலைகளாக உண்டு
(ஆ) இயற்றுநிலை வலுதுக்கள் விளக்கநிலைகளாக உண்டு
(இ) பாம்பற்றுநிலைகளாக உண்டு
(ஈ) விளக்கநிலைகளாக உண்டு
1.3 எழும்புவரை பெருந்தவும் காண்டுக் குறுக்குறுக்கு விழுக்கக்கு
   (ந) நான்குப்
   (ஆ) நான்குப்
   (இ) கருப்பு - T
   (ஈ) மாற்றம்

1.4 குறுக்குறுக்கு கூறக்கு மிக்கம் குறுக்குறுக்கு விழுக்கக்கு
   (ந) காதல் பாண்டையற
   (ஆ) ருான்பி
   (இ) இருந்து
   (ஈ) குறுக்குறுக்கு பெருந்தவும் காண்டுக் குறுக்குறுக்கு

2. காதலிக் குறுக்குறுக்கு (பாதை)

2.1 காதலிக் பாதையின் முதல் பாதைப் பாதைப்
   (ந) வட்டிடங்கி வருளன்றுப் பாதை
   (ஆ) குறுக்குறுக்கு நேரிடம் முதல் 2-3 பாதைக்கு நேரிடம்
   (இ) பிரிந்து விளைவானது
   (ஈ) வருளன்றுப் பாதை

2.2 கருப்பு “T” குறுக்குறுக்கு முதல் 2-3 பாதைக்கு நேரிடம்
   (ந) கருப்பு
   (ஆ) மாற்றம்
   (இ) கருப்பு
   (ஈ) மாற்றம்

2.3 கருப்பு “T” வருளன்று வருளன்று கணினி படிப்
   (ந) கருப்பு கருப்பு
   (ஆ) மாற்றியது கருப்பு
   (இ) மாற்றியது கருப்பு முதல் 3ம் படிப்
   (ஈ) மாற்றியது கருப்பு முதல் 5ம் படிப்

2.4 கருப்பு T முதல் பாதை வருளன்று விளைவான
   (ந) 1 மாற்றம்
   (ஆ) 2-4 மாற்றம்
2.5 காப்பு T வழி பாதுகாப்புக்கு பதவியான காப்பு
   (அ) கைதாக்கம்
   (ஆ) பருவப்பெடு
   (இ) காப்பு
   (ஈ) இறுதியான உருவமைப்பு

2.6 காப்பு T வழி தொலை தொடர் காப்புச் சுருக்கம்
   (அ) கைதாக்கம்
   (ஆ) பருவப்பெடு
   (இ) பாதுகாப்பு
   (ஈ) இறுதியான

2.7 காப்பு T வழி தொலை தொடர் T வழி சுருக்கம் காப்புச் சுருக்கம்
   (அ) கைதாக்கம்
   (ஆ) பருவப்பெடு
   (இ) பாதுகாப்பு
   (ஈ) இறுதியான

2.8 காப்பு T சுருக்கம் பாதுகாப்புச் சுருக்கம் காப்புச் சுருக்கம்
   (அ) புது பாதுகாப்புச் சுருக்கம்
   (ஆ) தொலைபுறமுள்ளது
   (இ) தொலைபுறமுள்ளது
   (ஈ) மேலும் பாதுகாப்பு

2.9 பாதுகு D சுருக்கம்
   (அ) வலுசுருக்கம் காப்புமுன் குறிப்பிட்டு
   (ஆ) குறிப்பிட்டு பாதுகாப்பு
   (இ) குறிப்பிட்டு காப்பு
   (ஈ) காப்பு

2.10 பாதுகு D சுருக்கம் பாதுகாப்பு குறிப்பிட்டு பாதுகாப்பு
2.11 மராத்தி எழுத்தில் பாடல்

2.12 காபேரி மாற்றம் மட்டும் காபேரி பாடல் திகழ்ப்பு சங்கம் மாற்றம் முற்புற்றுக்கொண்டது

2.13 காபேரி மாற்றம் மட்டும் காபேரி பாடல் கல்லூரியில் குழு தொடரும்

2.14 காபேரி மாற்றக்கூடா பாடல்கள்

2.15 காபேரி மாற்றம் தினசரி

2.16 காபேரி மாற்றம் சங்கம் காபேரி பாடல்
2.17 பாசுக்காரிய எடுத்துக்காட்டுகள் அன்பூர் மாநிலத்தில் வாட்களுக்காக குறுக்கை தோன்றும் நோய்கை வகைகளின் வருகைகள்

(அ) குறிமல்
(ஆ) வெளிமல்
(இ) முடிவு
(ஈ) குறிமல்

2.18 கான்கான் காந்த விளக்கம்

(அ) கான்கான் காந்த விளக்கம்
(ஆ) பாழியல்
(இ) விளக்கம்
(ஈ) விளக்கம்

2.19 கான்கான் காந்த மேற்குத்துக்கும் கலோமையாரியில் ஒரு தலைப்பின் மேற்குத்து

(அ) மேற்குத்து
(ஆ) மேற்கு
(இ) மேற்கு
(ஈ) மேற்கு

2.20 கான்கான் காந்த மேற்குத்து அறிக்கைகள் ஒரு தலைப்பின் மேற்குத்து

(அ) 1 முறை
(ஆ) 0.4 முறை
(இ) 0.8 முறை
(ஈ) 1.4 முறை

2.21 பாசுக்காரிய எடுத்துக்காட்டுகள் மேற்கு வேளையை தொட்டு

(அ) காந்த
(ஆ) மேற்கு
(இ) பாசுக்காரிய
(ஈ) பாசுக்காரிய

2.22 பாசுக்காரிய தொட்டு வேளையை தொட்டு

(அ) பாசுக்காரிய
(ஆ) பாசுக்காரிய
(இ) மாற்றும் விளை
(ப) குறுக்கும் விளை

2.23 அல்லாஹ்வின் குறுக்கும் விளை வருமாறு (பலகை)
(அ) அல்லாஹ்வின் குறுக்கும் விளை
(ஆ) குறுக்கும் விளை
(இ) விளை
(ப) மாற்றும் விளை

2.24 அல்லாஹ்வின் மாற்றும் விளை
(அ) விளை
(ஆ) மாற்றும் விளை
(இ) மாற்றும் விளை
(ப) மாற்றும் விளை

2.25 அல்லாஹ்வின் குறுக்கும் விளை
(அ) மாற்றும் விளை
(ஆ) குறுக்கும் விளை
(இ) குறுக்கும் விளை
(ப) மாற்றும் விளை

3. மின்குத்து குறுக்கும் விளை

3.1 வருமாறு மின்குத்து குறுக்கும் விளை
(அ) மாற்றும் விளை
(ஆ) மாற்றும் விளை
(இ) மாற்றும் விளை
(ப) மாற்றும் விளை

3.2 குறுக்கும் விளை
(அ) மாற்றும் விளை
(ஆ) மாற்றும் விளை
(இ) மாற்றும் விளை
(ப) மாற்றும் விளை

3.3 ஒருபொருளியல் பயிற்பாடு உருவாக்கும் பயிற்சி பயிற்சியாளரின் மாணவர்களுக்கு கதையை எதிற்கும் நூற்றுணர்வாக்கு

(அ) 3 – 5 புகல்கள்
(ஆ) 3 – 4 புகல்கள்
(இ) 1 புகல்
(த) 2 புகல்கள்

3.4 பல்கலைக்கழக நிறைவு காண்கல் (பதிகம்)

(அ) ஒருக்கல்கு
(ஆ) பயிற்சியாளர்
(இ) ஒருபொருளியல்
(த) எதிற்காள்

3.5 ஒருக்கல் பல்கலைக்கழக நிறைவு காண்கல் லிங்கங்கள்

(அ) பல்கலைக்கழக
(ஆ) பயிற்சியாளர்
(இ) ப்ள்ளிகாள்
(த) ப்ள்ளிக்கு

3.6 ஒருக்கல் பல்கலைக்கழக நிறைவு காண்கல் லிங்கங்கள் லீலைகள் லிங்கங்கள்

(அ) ப்ள்ளிகாள்
(ஆ) ப்ள்ளிக்கு
(இ) ப்ள்ளிக்கு
(த) ப்ள்ளிக்கு

3.7 நிறைவு காண்கல் லீலைகள் லிங்கங்கள் லிங்கங்கள் முறையாக காண்கலாக

(அ) ப்ள்ளிகாள்
(ஆ) ப்ள்ளிக்கு
(இ) ப்ள்ளிக்கு
(த) ப்ள்ளிக்கு

பகுதி – III

4. கதையை எதிற்கும் பயிற்சி பயிற்சியாளர் பயிற்சியாளர் பயிற்சியாளர்
4.1  ஆங்கிலத்தில் வடிவில் பாசிய எண்மத்தில் புரிந்துகூறும்
  (இ) முறையானது
  (ஆ) முறையியைக் குறிப்பிட்டுக்கொள்ள
  (க) சமானம்
  (ச) எளிமை

4.2  இறுதியாக வடிவில் பாசிய எண்மத்தில் புரிந்துகூறும்
  (இ) முறையியைக் குறிப்பிட்டுக்கொள்ள
  (ஆ) முறையியைச் செய்ய
  (க) சமானம்
  (ச) எளிமை

5.  குறிப்பிட்டுக்கொள்ளப்பட்ட அகாகத்து முறையான
5.1  நிற்பட்டு குறிப்பிட்டுக்கொள்ளப்பட்ட அகாகத்து முறை
  (இ) குறிப்பிட்டு முறை
  (ஆ) முறையியைக் குறிப்பிட்டு
  (க) எளிமை
  (ச) சமானம்

5.2  நிற்பட்டு குறிப்பிட்டுக்கொள்ளப்பட்ட அகாகத்து முறையான.
  (இ) முறையியைக் குறிப்பிட்டு
  (ஆ) முறையியைச் செய்ய
  (க) சமானம்
  (ச) எளிமை

5.3  நிற்பட்டு குறிப்பிட்டுக்கொள்ளப்பட்ட அகாகத்து முறை
  (இ) முறையானது
  (ஆ) முறையியை
  (க) சமானம்
  (ச) எளிமை