THE QUALITY OF LIFE AMONG THE PERMANENT CONTRACEPTIVE ADOPTERS AND NON-ADOPTERS AT SELECTED RURAL AREAS IN SIVAGANGAI DISTRICT, TAMILNADU.

A DISSERTATION SUBMITTED TO THE TAMILNADU DR. M. G. R MEDICAL UNIVERSITY, CHENNAI IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

MARCH - 2010

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A STUDY TO DETERMINE THE QUALITY OF LIFE AMONG THE PERMANENT CONTRACEPTIVE ADOPTERS AND NON-ADOPTERS AT SELECTED RURAL AREAS IN SIVAGANGAI DISTRICT, TAMILNADU.

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ABSTRACT

"A study to determine the quality of life among the permanent contraceptive adopters and non-adopters at selected rural areas in Sivagangai District," Tamilnadu.

To determine the quality of life among the permanent contraceptive adopters and non adopters in selected villages. Descriptive research design was used to conduct the study. WHO quality of life modified scale was used, purposive sampling technique was used for selecting the sample, and sample size was 50 adopters and 50 non adopters.

Objectives of the study:

➢ To assess the quality of life among the permanent contraceptive adopters.

➢ To assess the quality of life among the non-adopters.

➢ To compare the quality of life among the permanent contraceptive adopters and non – adopters.

➢ To find out the association between quality of life among the permanent contraceptive adopters and selected demographic variables such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity and number of children, own house, Latrine facilities smoke outlet, 3 times meal/day. Prefer non vegetarian weekly once. TV/Radio, Vehicle and Land.

➢ To find out the association between quality of life among the permanent contraceptive non-adopters and selected demo variables such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity,

number of children, own house, Latrine facilities. Smoke outlet, 3 times meal/day. prefer non vegetarian weekly once, TV/Radio, Vehicle and Land.

Major findings of the study:

➢ Majority of the samples of adopters were 46% in the age group from 26 to 30 years and non-adopters were 42% in the age group from 31 to 45 years.

➢ Regarding wife education, majority adopters were 38% and non adopters were 62% in elementary education.

➢ Spouse education of adopters were 38% and non-adopters were 54% in higher secondary education.

➢ Regarding occupation, most of the adopters were 54% and non-adopters were 58% as cooly workers.

➢ Husband occupation, majority of the adopters were 48% and non-adopters husband's occupation were 58% as the skilled workers.

➢ Regarding monthly income, majority adopters were 34% from Rs.2500-5000 and non-adopters were 86% less than Rs.2500.

➢ Type of family, adopters were 68% from nuclear family and non-adopters were 54% from joint family.

➢ Regarding religion, maximum adopters were 70% from Hindu and non-adopters were 42% from Christian.

➢ Regarding parity, maximum adopters were 68% less than two and non-adopters were 58% less than two deliveries.

➢ Regarding number of children, 33 (66%) of adopters had 1-2 children and maximum 34 (68%) of non-adopters had 3-4 children.

➢ Regarding own house, maximum adopters were 74% and non-adopters were 66%.

- Regarding latrine facilities, maximum adopters were 64% and non-adopters were 62% who had no latrine facilities.
- Regarding smoke outlet, majority adopters were 68% and non-adopters were 58% who had no smoke outlet.
- Regarding three times meal/day, maximum adopters were 100% and non-adopters were 74% who had three times meal/day.
- Regarding preference of non-vegetarian, majority adopters were 58% who preferred non-vegetarian once in a week and non-adopters were 54% who didn't prefer non-vegetarian.
- Regarding TV/Radio, maximum adopters were 100% and non-adopters were 98% who had TV and radio.
- Regarding vehicle, majority adopters were 70% who had vehicle and non-adopters were 56% who had no vehicle.
- Regarding land, maximum adopters were 54% and non-adopters were 56% had no land.
- The adopters mean score was 65.08 and non-adopters mean score was 44.22 and adopters standard deviation was 4.61 and non-adopters standard deviation was 3.09.
- Regarding level of quality, maximum adopters were 62% and non-adopters were 52% who had moderate quality of life.
- There is a highly significant difference between quality of life among the adopters and non-adopters.
- There is a highly significant association between the adopters quality of life with monthly income and significant association in religion and type of family. But there was no association between adopters quality of life with age, education (wife & husband), occupation (wife & husband), number of children, parity, own house, latrine facility, smoke outlet, prefer non-vegetarian weekly once, vehicle and land.

> There is a highly significant association between permanent contraceptive non-adopters quality of life with age, and significant association in type of family. But there was no association between education (wife & husband), occupation (wife & husband), monthly income, parity, number of children, own house, latrine facilities, smoke outlet, prefer non-vegetarian weekly once, vehicle and land.

Recommendation:

☯ The study can be replicated on larger samples in different settings to validate and generalise results.

☯ A similar study can be conducted with a true experimental research approach.

☯ A comparative study can be done between urban and rural mothers.

☯ A similar study can be carried out by using different teaching strategies.

☯ A case study may be conducted as a quality of life among the acceptors of family planning.

☯ An experimental study can be done to find out the improvement of knowledge.

☯ A comparative study among different religion about contraceptive method can be performed.

Conclusion:

The researcher found out that the couples who adopt the permanent contraceptive can maintain the quality of life by sharing of wealth among small family whereas by non adopters who have poor planning and unnecessary suffering end their life without health and happy.

Providing teaching module is an effective means to increase the knowledge and promote practice of contraceptive methods.

INTRODUCTION

CHAPTER – I

INTRODUCTION

"The quality of your life is the quality of your relationships".

-Anthony Robbins

Quality of life means that any individual who enjoys the life with all comfortless and without stress and strain which comes through own our decision and actions.

In this study, the QOL assessment was carried out for the beneficiaries of a permanent contraception adopters and non- adopters. This is being done to assess whether the quality of life enjoyed by permanent contraception adopters are better than that of non – adopters.

Anderson & Bulck hand (1999) says that medicine cannot by itself determine the quality of life." It can only help the people to achieve the state of health that enables them to cultivate the art of life but in their own way. It implies also the ability for each person to do what he wants to do and become what he wants to become.

Rapid population growth is one of the most important challenges faced by the world today. Large family size adversely affects the health and happiness of each member of the family.

In recent years, there is a growing demand for female sterilization. In India, voluntary sterilization is usually the recommended method of choice for women who have achieved their desired family size.

The family size plays a very important role in the health and welfare of not only the individual, family and community but also the nation.

The planned and small family will promote health, happiness, peace and prosperity in the family. Improve the living standard of people.

India was the first country in the world to start family planning programme in 1953.

The objective of family welfare programme in India is to stabilize the country's population and to improve the health of the women.

The aim of family planning is to have a healthier and happier life of mother and children. The life of children depends on the health status of the mother. A well planned family is a matter of enormous pride and benefit to parents and indeed to the entire country.

According to **National Family Health Survey – II.** Current use of contraception is increase and the extent of unmet need has declined in most of the states in India, there is increased and the extent of unmet need has declined in most of the states in India, there is a need for considerable improvement in the coverage and quality of family planning services, especially in the four large states of Uttarpradesh, Bihar, Madhyapradesh and Rajasthan.

Reproductive and sexual health care including family planning services and information is recognized not only as a key intervention for improving the health of women and children but also as a human right

Developing countries like India face the problem of population explosion. As a result socio-economic development of the country will be affected. It also creates problems like overcrowding. Shortage of house, schools, means of communication, transport, unemployment, poverty, malnutrition, starvation and child labour. High maternal mortality rate, infant mortality rate and other induces which are high rate compared to developed countries because of lack of resources. **(Urula 2005)**

Family planning services available in India. Govt. allotted the funds for permanent sterilization. So most of the women adopted this method. Sterilization is divided into two ie, Tubectomy & Vasectomy.

Small family norm was introduced to stabilize the country's population. The symbol for family planning is inverted triangle. In 1970's norm was 3 child family. In 1980's norm was 2 children family and in 1990's it is one child family.

S.P. Basavanthappa, 1993 states that adopting contraception is considered today as a basic human right.

The **WHO** is giving priority to improve access in high quality care in family planning through a variety of strategies. These include ensuring that women and men rights and perspective are taken with account in this planning, management and evaluation of services, promoting the widest availability of contraceptive methods. So that people may select what is appropriate to their needs and circumstances, ensuring that the contraceptive counseling and service delivery will be based on eligibility criteria that are supported by a scientific rationals and conducting research to develop new family planning methods and improve existing ones.

According to 2008 population research centre, the world population is about 670.5 crores, India population is about 114.9 crores and Tamilnadu population is about 6.68 crores.

Globally contraceptive rate is increased from 59% in 1990-1995 to 63% in 2000 – 2006. - World health statistics - 2009.

According to **NFHS** – 3 2005 – 2006 Current level of contraceptive use in India is 56%

In Tamilnadu, total sterilization acceptors with two living children increased in 2007 is 73% and in 2008 is 73.9%. Acceptors with one child is about 1.84%.

In Sivagangai District total sterilization acceptors with 2 children are 75.2%, and with one child is about 1.49% with acceptance.

NEED FOR THE STUDY:

The best contraceptive is the word no-repeated frequently.

                                                              - Margaret smith.

The national population policy states the objective of economic and social development is to improve the quality of lives. People enhance their wellbeing and provide themselves with opportunities and choice to become productive assets in society.

*According to **MOH & FW 2008** :* Total eligible couples – 188 million, unsterilised couples 119 million, couple sterilized 69 million in India.

According to **FPAI 2008 :** Family planning methods used in India are female sterilization 37.4%, male sterilization 1% pills 3.1%, IUD 1.7%, injectable 0.1% , Condom 5.2%, using traditional method 7.8% not used any method 43.7%.

According to Gandhi Gram institute of rural health 2007 reported that amongst the major states the share of vasectomy is more than that at the national level 2.5% in the cases of Haryana 12.8% Jharkand 6.4% Punjab 6% Chhattisgarh 4.8%, Maharashtra 3.6%, Andrapradesh 3.4%, M.P 3.0%

Population growth in India continues to be high on the account of the Large size of the population in the reproductive age groups high total fertility rate due to the unmet need for contraception and high wanted fertility rate due to the high wanted fertility rate due to the high infant mortality rate and early marriage of girls.

To assess the family size and the quality among Hindu and Muslims rural women at North Delhi. Randomly selected 50 women who were having more than 2 children and interviewed. Findings revealed that 64% of the Hindus preferred small family size and accepted permanent family planning method as compared to 29% of the Muslims. **(Saxena G.B. 2002)**

To assess the attitude of Hindu & Muslim women regarding permanent family planning in district town Chambaram in the state of Bihar. The study was done among 50 Hindus and 50 Muslims women and interviewed. The findings revealed that the attitude of Hindus were found more favourable towards the permanent family planning compare to the Muslim. **(Sharma et al (2001))**

To assess the practice of family planning method among eligible couples in the rural area of Chandigarh, 210 eligible couples were selected randomly and structured questionnaire was administered. The findings revealed that three fourth of the couples wanted to use contraceptive for limiting the family size, but only 43.4% of the couple adopted sterilization. The main reasons for non-acceptance of contraception were desire for male child 44.5% and 25% fear of side effects. **(Singh et al 2001)**

The most important elements in determining action for fertility control is any country are the knowledge attitude of the people and their decision to act on the regulation of family size. A sample of 300 married ladies were considered adequate sample was decided by random sampling. Interviews were conducted, data were collected and analysed. It was found out that 27% of the study group did not have formal education 9.6% studied up to college level, 143 ladies believed that the family should have 3 children. 247 ladies felt that the ideal family should have children of both the sexes. 240 ladies considered that the small family norm 5 important for economic reason followed by 33 for the health of the mother. 255 ladies considered 3 years interval or more and an ideal interval. 186 ladies considered tubectomy as best method. **(Raman 2000)**

Most of the women's think permanent contraception affects the health status. So the nurse is the key person to assess the health status of the adoptors and non – adoptors. The researcher felt the need for doing a study and find out the quality of life among the permanent contraception adopters and non-adopters. Through which it reduces the child birth and improves the health status of women.

STATEMENT OF THE PROBLEM

"A study to determine the quality of life among the permanent contraceptive adopters and non-adopters at selected rural areas in Sivagangai District," Tamilnadu.

OBJECTIVES

- To assess the quality of life among the permanent contraceptive adopters.
- To assess the quality of life among the non-adopters.
- To compare the quality of life among the permanent contraceptive adopters and non – adopters.
- To find out the association between quality of life among the permanent contraceptive adopters and selected demographic variables such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity and number of children, own house, Latrine facilities smoke outlet, 3 times meal/day. Prefer non vegetarian weekly once. TV/Radio, Vehicle and Land.
- To find out the association between quality of life among the permanent contraceptive non-adopters and selected demo variables such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity, number of children, own house, Latrine facilities. Smoke outlet, 3 times meal/day. prefer non vegetarian weekly once, TV/Radio, Vehicle and Land.

Hypothesis

❖ There is a significant difference in quality of life among the permanent contraceptive adopters and permanent contraceptive non – adopters.

❖ There is a significant association between quality of life among the selected demographic variables of adopters such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity, number of children, own house, Latrine facilities, smoke outlet, 3 times meal/day, prefer non-veg weekly once, TV/Radio, vehicle and Land.

❖ There is a significant association between quality of life and selected demographic variables of non - adopters such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity, number of children, own house, Latrine facilities, smoke outlet, 3 times meal/day, TV/radio, vehicle and Land.

OPERATIONAL DEFINITIONS

QUALITY OF LIFE

It refers to the condition of mothers interms of physical, psychological, social and environmental domain which is measured by modified WHO quality of life scale.

Mothers : 50 mothers who had adopted contraceptive in the age group of 15-45 years and having 2 children. 50 mothers who had not adopted the permanent contraception till their third pregnancy.

ADOPTERS

In this study, it refers to the women who adopted the permanent contraceptive. (Tubectomy).

NON- ADOPTERS

Women who did not adopt the permanent contraceptives till their third pregnancy.

ASSUMPTIONS

1. Selected demographic variables may influence the quality of life among the permanent contraceptive adopters and non-adopters.
2. Permanent contraceptive adopters will have better quality of life than non-adopters.
3. Permanent contraceptive adopters may have physical, mental and socio-economically good than the non-adopters.

PROJECTED OUTCOME

❖ The Study findings reveals that the Quality of life of family planning adopters and non- adopters.
❖ Study findings are platform for non-adopters to initiate permanent family planning methods.
❖ The study results helps the health workers to identify and to take initiatives.

LIMITATIONS

❖ The study has been limited to the sample size of 100.
❖ It is limited to the age group of below 15 yrs and above 45 yrs.
❖ It is limited to the period of six weeks of data collection.

CONCEPTUAL FRAMEWORK

The conceptual framework is a group of related ideas, statements or concepts. The term conceptual model is often used interchangeably with conceptual framework and sometimes with grand theories, those that articulate a broad range of the Significant among the concepts of a discipline (Kozier Barbara 2005)

The conceptual framework serves as a spring board for theory development theoretical context, the importance of the study, where a model symbolically represents a phenomenon. The present study is aimed at determining the quality of life among the permanent contraceptive adopters and non-adopters in selected rural areas.

The conceptual framework for this study is based on health belief model. Health beliefs are about health and illness. They may be based on factual information and using information.

Rosenstocke's (1974), Becker's Health belief model addressed the relationship between the person's belief and behaviour. It is a way of understanding and practicing how clients will behave in relation to their health. This model helps the nurses to understand the various behaviour including individual perceptions, beliefs and various behaviour. In this context, the investigator felt that Becker's model is a suitable conceptual framework for this study.

- The **first component** in this model involves the adopters and non-adopters individuals perceptions influenced by demographic variables such as age, wife's education and occupation, husband's education and occupation, Monthly income, type of family religion, Parity, no of children, own house, latrine facilities, smoke

outlet, 3 times meal / day, prefer non-veg weekly once, TV / Radio vehicle and land.

- The **second component** involves modifying factors which is influencing contraception such as religious belief, misconception, willingness of partner, opposition from family members, fear of side effects, availability, cost of contraception, dissatisfaction of sexual activity and shyness.

- The **third component** is their likelihood of action. Determine the quality of life among the permanent contraceptive adopters and non adopters. If the mothers will have good quality of life they practice the contraception. If the mothers will have moderate and poor quality of life they don't practice.

- The **fourth component** involves cues to action. Which is highlighted that nursing focus on preparing and giving health education based on family planning methods related to quality of life through health teaching module.

In order to attain good quality of life and practice the contraceptive methods, the nurse have emphasize and focus on health education to the mothers those who are in moderate and poor quality of life.

CONCEPTUAL FRAME WORK BASED ON "MODIFIED HEALTH BELIEF MODEL" (ROSENTOCKE'S AND BECKER 1974)

Adopters & non-adopters individual perceptions

Modifying Factors

Likelihood of action

Cues to Action

Demographic variables age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity, no of children, own house, latrine facilities, smoke outlet, 3 times meal / day, prefer non - veg weekly once, TV/ Radio, vehicle and Land

- ❖ Religious belief
- ❖ Misconception
- ❖ Willingness of the partner.
- ❖ Opposition from family members
- ❖ Fear of side effects
- ❖ Availability
- ❖ Cost of contraception
- ❖ Dissatisfaction of sexual activity
- ❖ Shyness

Determine the quality of life among the permanent contraceptive

Good

Moderate

Poor

Determine the quality of life among the permanent contraceptive

Good

Moderate

Poor

Nursing focus on preparing and giving health education and teaching module

REVIEW OF LITERATURE

CHAPTER – II
REVIEW OF LITERATURE

This chapter deals with the review of literature related to the study. The primary purpose of reviewing relevant literature is to give a broad ground knowledge or understanding of the information that is available related to the research problem of interest (Burns 1997). Here an attempt has been made to combine the research and non-research literature review related to the present Study, to develop a deeper insight in the problem area. This literature is divided in to two:

1. Studies related to quality of life.
2. Studies related to contraception.

1) Studies related to quality of life.

Skrzypulect et al (2008) conducted a study to evaluate the effect of the levonorgestrel releasing intrauterine, system on the quality of life and sexual functioning of women. The research encompassed 200 women aged between 30 and 45, 52 women using the levonogestrel; 48 women using different type of IUD 50 women using no contraception. Mell krat scale and female sexual function index was used as a research tool. Result shows that levonogestrel releasing intrauterine system increases female quality of life and sexual function.

Drosdzox (2008) conducted a study to evaluate the effect of $30\mu g$ ethinylestradiol and 3μg drospirenone combined oral contraceptive on the quality of life and sexual functioning. 61 women using combined oral contraceptive (coc) 65 women using different types of coc (Control group). Female sexual function index and mell krat scale was used as the research tool. Result shows that the untake of the COC containing 30μg

ethinylestradiol and 3µg dresporenone is associated with an improvement of general quality of life and female sexual functioning.

Aedo etal (2008) conducted a study to evaluate the impact of low – dose oral estrogen therapy on the health related quality of life in 45-64 year old women from the east metropolitan health service in santiago, chile. Observational cross sectional study, random population samples used in PHC. 927 women who were originally contacted, 844 women who were able to complete the menopausal rating scale questionnaire. Result shows that women in the 45-64 age using hormonal therapy a more favourable impact on health related quality of life than non-HT users.

Matsumoto etal (2007) conducted a study to evaluate the impact of combined oral contraceptive pill (OC) use on quality of life among Japanese women, we performed a prospective study using world health organisation quality of life (WHOQOL) questionnaire. Women who consulted chayamachi lady's clinic to get a prescription for OC for the first time, to complete the questionnaire twice before & after taking OC, 217 women responded to our questionnaire. Result indicate oral contraceptive only were found to be unsatisfied with taking oc in a relationship with their partners.

Li RH etal (2004) conducted a study in impact of common contraception methods on quality of life and sexual function in Hong Kong chinese women. Perspective observational study 361 samples are coc pills (n=87) in jectables (n=67) IUCD (n=96) and female sterilization (n=111). Standadiseal WHOQOL tool and Derogation Sexual functioning inventory (DSFT) used before and 3-4 months after adopted the method. We conclude that the COC pills, injectables, IUCD and female Sterilation all do not have significant adverse impact on quality of life and sexual

function. After female sterilization, there is a significant improvement in sexual satisfaction and sexual drove.

Bitzer et al (2003) conducted a study conducted a study effects on the quality of life of a new oral contraceptive containing 30mcg EE and 3mg drospirenone. In a multicenter observation study including 584 women attended b_7 99 participation gynecologists the quality of life changes after 3 month use of oral contraceptive was evaluated through the use of a self developed questionnaire using 20 items with a 5 scale answer scheme. We found a mean positive change of life quality of 7.3% significant changes were observed regarding subjective experiences of weight, skin, hair, cycle attractively, libido and mental well being.

Borenstein etal (2003) conducted a study to evaluate the effect of the oral contraceptive to evaluate the effect of the oral contraception yasmin (drospirenone 3 mg and ethinyl estradiol 30 μg) on premenstrual sysmptomatology and health related quality of wife (HRQOL) in USA. Participating health care providers received 11,260 self administered surveys for distribution to women initiating use of yasmin of these 1932 base line surveys and 1104 follow up surveys were returned with 858 of the returns evaluated as suitable for analysis. Result shows the effectiveness of yasmin in reducing premenstrual symptomatology and improving HRQOL and general sense of well-being.

Melchert et al (2002) conducted a study to describe oral contraceptive use, its determinants and use associated health correlates from 1984 to 1999 in Germany. Cross-sectional comparison was performed for socio-economic factors, personal life style and use-associated health correlates between 1862 oc users and 2625 age – matched non – users identified from five German National health surveys. Regression models were used to obtain the determinants of oc use. Cross sectional comparison and regression analysis. Suggested that

oc users did not differ from non-users in most selected personal socio-economic factors. OC users showed generally a better health profile than age matched non-users.

Ernst et al (2002) conducted a study to assess the influence of an oral contraceptive (OC) containing 20 Mg ethinyl estradiol and 150 Mg desogestrel on quality of life and subjective symptoms. Multicenter observational evaluation performed in Germany, 3679 first time OC users were included that they were treated by 623 physicians. The women completed quality of life questionnaires at baselines and after three treatment cycles. Mean age of users (+/- 7-1 Yrs with 47% of women aged between 15% 20 yrs. Result shows that the OC containing ethinylestradiol and desogestrel. Significantly improved quality of life and subjective symptoms.

Egarter.C et al (1999) conducted this study to investigate the effect of a low dose oral contraceptive on women's satisfaction and quality of life based on a detailed questionnaire. The study was conducted between January 1997 and May 1998 using the quality of life enjoyment and satisfaction questionnaire submitted to 614 first time users of Ocs. Result shows that the total quality of life rating increased significantly with use of OC.

2) Studies related to contraception

Daniel et al (2008) conducted the effect of community based reproductive health interventions on contraceptive use among the young married couples in Bihar, India. The Prachar project an ongoing intervention in Bihar, seeks to increase contraceptive use for delaying and spacing births through communication interventions. Random samples of married women younger than 25 with no more than one child were surveyed in 2002-2003, before Prachar was implemented (N=1995) and

in 2004 after implementation (N=2080) contraceptive demand and user related attitudes and knowledge were assessed in the two surveys in both intervention areas and comparison areas. Logistic regression was used. Result shows that contraceptive use was very low (2-6%) at baseline in both comparison and intervention areas. Women in intervention areas had elevated odds of knowing that fertility varies during the menstrual cycle, and of agreeing early child birth can be harmful and that contraceptive use in necessary and safe for delaying first births. (Odds ratios 1.6-3.0)

Stephenson et al (2008) conducted this study to examine the relationship between male – to female physical domestic violence and unwanted pregnancy among women in three economically and culturally diverse areas of India. Examination of retrospective and prospective measures of pregnancy unwantedness, contrasting their usefulness for specifying levels of unwanted pregnancy and its relationships with domestic violence.

Data from India's 1998-99 NFHS and a 2002-2003 follow up survey for which women in four states were reinter viewed are analysed. Results demonstrate a clean relationship between a woman's experience of physical violence from her husband and her ability to achieve her fertility intentions. The need to improve the measurement of pregnancy inendedness in clean, and a move toward using prospective measures as the standard in necessary.

Stephenson et al (2006) conducted a study domestic violence and contraceptive adoption in Uttarpradesh, India. Matched data on married couples who were not practicing contraception are analyzed from companion surveys of married husbands and is five district of Uttarpraesh. The results highlight the need to address the issue of support for women experiencing domestic violence within existing family planning services and to sensitize service providers to the specific needs of women experiencing such violence.

Bhargava et al (2005) conducted a study in health care infrastructure, contraceptive use and infant mortality in Uttarpradesh, India.

Data on 30,000 women from a survey in Uttarpradesh in 1995 together with the data from surveys of public and private providers of health care and family planning services. The empirical results from logistic regressions for use of female sterilization and IUD showed significant effects of quality of services in Govt. and private hospitals, and of socio economic variables such as education, caste and an index of household possessions. Infant mortality of children born in the proceeding 3 year period showed the significant effects of socioeconomic variables, quality of health care services and birth spacing. Effects of economic development on the quality of services available in public and private facilities.

Takkur N et al (2005) conducted a study on Contraceptive practices and awareness of emergency contraception in educated working women. The study was designed to investigate knowledge and use of contraceptive methods and awareness of emergency or post coital contraception. 258 women consented for interview of 190 married women 154(81.1%) practical contraception. Among them, 73.3% were regular users. Among the available contraceptive methods, condom was the most popular method is 89 (57.8%) followed by copper T in 38 women (24.7%) the use of hormonal contraception was very low 2.6%.

Chandick et al (2003) conducted a study about contraceptive knowledge, practice and utilization of services in the rural areas of India. To obtain information from rural women regarding their contraceptive knowledge, practices and utilization of services across sectional survey of 117,465 eligible women were carried out in 28 districts from January 1996 to Feb 1997. Among the current contraceptive users, all of IUD, OC and acceptors of permanent method in the last one year (14,276) were interviewed. Contraceptive prevalence was 45.2% of which 34% had

used a permanent method. Among the current users, the contraceptive has been availed from either PHC or hospital. The main reason for not using any method was that they didn't like to complete their family upto certain level. There is need to promote spacing methods by policy makers and field workers & motivate couples to accept them.

Agarwal et al (1999) conducted to survey the current contraception use and analyze the sexual patterns in women above 35 yrs of the sexual patterns in women above 35 years of sexual patterns in women above 35 years of age in India. Five hundred women of whom 250 were atleast 35 years old and 250 were less than 35 years old (Control group) were interviewed with the help of a prepared questionnaire permanent surgical method of contraception had been accepted by 40.4% of women > or = 35 years old versus 16.8% of women < 35 years old.

Various temporary method and IUD was used by 5.2% and 22.8% OCS b7 and 1.2% and 9.6% and natural methods by 6.4% and 3.2% in women linked with increased sexual activity and decreased abortion rate.

METHODOLOGY

CHAPTER-III

RESEARCH METHODOLOGY

The methodology of research provides a brief description of the method adopted by the investigator in this study.

This chapter includes the research approach, research design, the setting of the study, sample and sampling technique. It further deals with the development of the tool, procedure for data collection, plan for data analysis and pilot study.

RESEARCH APPROACH:-

The research approach used for this study was quantitative approach.

RESEARCH DESIGN:-

The research design used in this study was a descriptive research design which enable the researcher to determine the quality of life among the permanent contraceptive adopters and non-adopters in a village.

SETTING:-

The study was conducted in selected areas such as Kalpiravu, Milaganoor, Rajakambiram and Annavasal which were situated near Manamadurai, 5-8 Km away from Matha College of Nursing. Total population of each village was 650, 1300, 1150 and 500, total female population in the age group of 15-45 years were 200. In that total population I have selected 50 adopters and 50 non adopters who had fulfilled the inclusion criteria.

POPULATION:-

The target population selected for the study includes mothers in the age group of 15-45yrs and having two children who adopted permanent contraception and not adopted.

SAMPLE SIZE:-

The total size was 100 mothers in the age group of 15-45yrs. Out of 100, 50 mothers having two children who had adopted permanent contraceptive and 50 mothers in the same age group having two children who didn't adopt the permanent contraceptive till their third pregnancy.

SAMPLING TECHNIQUE:-

Purposive sampling technique was used to select the sample for this study.

CRITERIA FOR SAMPLE SELECTION:
Inclusion Criteria:-

- Mothers with 2children, who have adopted contraceptives.
- Mothers who are having more than 2 children in the age group of 15–45 years who have not adopted permanent contraceptive till their third pragnancy.
- Mothers who are willing to participate.
- Mothers in the age group of 15-45yrs
- Mothers who know Tamil or English.

Exclusion criteria:-

- Mothers with more than 3 children who have adopted permanent contraceptive.

- Mothers with less than 2 children who have adopted temporary & permanent contraceptive.

- Mothers who have medical problems.

- Mothers who are in the age group of below 15 and above 45.

- Mothers who don't know Tamil and English.

DEVELOPMENT OF THE TOOL:-

After an intensive library research and experts opinion & suggestions, it has been taken for the development of the tool.

RESEARCH TOOL AND TECHNIQUE:-

The tool used for this study was WHO quality of life modified scale to determine the quality of life among the permanent contraceptive adopters and non adopters in a village.

DESCRIPTION OF THE TOOL:-

The tool consists of three aspects.

Part I   Demographic Profile.

Part II   WHO-QOL-Scale was modified and used in that physical and psychological problems were identified by using the check list. Totally 18 statements were present.

Part III   4 point rating scale was used to determine the quality of life in terms of socio economic status. It consists of 18 statements.

SCORING PROCEDURE

Part I:-

Demographic profile was not scored, but analysed with descriptive statistics .

Part II:-

WHO-QOL modified scale was used to identify the physical and psychological problems by using the check list. Totally 18 statements were present. If the answer is yes the score will be "zero", if the answer is no the score will be "one" was given. The maximum score of the physical & psychological problems are 18. Minimum score was zero.

Part III

Social and economic status was identified by using the 4 point rating scale. It consists of 18 statements. If the mother strongly agreed score given as "four", if agreed score would be "three", if disagreed score would be "two", if the mother strongly disagreed score would be "one". The maximum score was 72, minimum score was 18. The score would be categorized as follows:-

Poor quality of life	-	18- 44
Moderate quality of life	-	45-66
Good quality of life	-	67-90

TESTING OF THE TOOL:-
CONTENT VALIDITY:

Validity of the demographic tool was established by submitting the tool to five experts. The tool was verified regarding the adequacy of the content, sequency and framing the questions.

RELIABILITY:-

The test-re-test method was used to establish the reliability of the tool. The tool was reliable at 0.85. The tool was administered to 10 samples (5 adopters & 5 non adopters) and the same tool was readministered to the same subject after 7 days.

PILOT STUDY:-

In order to find out the feasibility, relevance and practicability of the study was conducted in selected village.10 samples were selected who fulfilled the inclusion criteria. These subjects were not included in the main study. Findings of the pilot study revealed that it was feasible to conduct the study.

DATA COLLECTION:-

Before conducting the study, permission was obtained from the village president. The data collection period was 6 weeks on informed consent from the study subject. Based on inclusion criteria the mothers who adopted the permanent contraception and didn't adopt the contraception were identified and selected. Confidentiality was maintained. Each day 2-3 mothers were interviewed from 9am to 4pm. Each interview lasted for 30 minutes. During the data collection period, the researcher maintained good rapport with women.

DATA ANALYSIS:-

The study subjects were described in terms of their demographic characteristics by percentage. Quality of life among the permanent contraceptive adopters and non adopters was assessed by mean, standard deviation and co efficient variance, independent 't' test was used to

compare the quality of life. The association between the quality of life among the permanent contraceptive adopters & non adopters and selected demographic variables were analysed by chi-square test.

PROTECTION OF HUMAN SUBJECTS:-

The pilot study and main study was conducted after the approval of research committee. Permission was obtained from the study subjects and on informed consent was obtained. Assurance was given to the study subjects about the anonymity and confidentiality of the data collected from them. The oral consent of each sample was obtained before the data collection.

ANALYSIS AND INTERPRETATION

CHAPTER – IV
ANALYSIS AND INTERPRETATION OF DATA

This chapter deals with description of sample, the analysis and interpretation of data collected to determine the quality of life among contraceptive adopters and non-adopters in a selected rural areas. The analysis was done in order to achieve the following objectives of the study.

OBJECTIVES:

- ❖ To assess the quality of life among the permanent contraceptive adopters.
- ❖ To assess the quality of life among the non – adopters.
- ❖ To compare the quality of life among the permanent contraceptive adopters and non – adopters.
- ❖ To find out the association between the quality of life among the permanent contraceptive adopters and selected demographic variables such as age, education (husband and wife), occupation(husband and wife), income, type of family, religion, parity and no. of children, own house latrine facilities, smoke outlet, three times meal /day, prefer non-vegetarian weekly once, TV/radio, vehicle and land.
- ❖ To find out the association between the quality of life among the permanent contraceptive non–adopters and selected demographic variables such as age, education (husband and wife), occupation (husband and wife), income, type of family, religion, parity and no. of children, own house latrine facilities, smoke outlet, three times meal /day, prefer non-vegetarian weekly once, TV/radio, vehicle and land.

Organisation of the study findings:

The data were analysed, tabulated and interpreted using descriptive and inferential statistics. The data findings were organised and presented under the following section.

Section – I

Characteristics of the adopters & non-adopters sample provide a description of sample in terms of age, education, (wife, husband) occupation (wife, husband), monthly income, type of family, religion, parity, no. of children, own house, latrine facilities, smoke outlet, 3 times meal/day. Prefer non vegetarian weekly once, TV/Radio, vehicle and land.

Section – II

To assess the quality of life among the permanent contraceptive adopters.

Section – III

To assess the quality of life among the permanent contraceptive non-adopters.

Section – IV

Compare the quality of life among the permanent contraceptive adopters and non-adopters.

Section – V

Association between quality of life among the permanent contraceptive adopters and selected demographic variables.

Section – VI

Association between the quality of life among the contraceptive non-adopters and selected demographic variables.

SECTION – I
Frequency and percentage distribution of samples on selected demo variables of adopters and non-adopters.

Table – I

S. No	Demographic Variables	Adopters n=50		Non-adopters n=50	
		Frequ-ency	Perce-ntage	Frequ-ency	Perce-ntage
1	Age				
	a) 20-25 Years	9	18.0	5	10.0
	b) 26-30 Years	23	46.0	10	20.0
	c) 31-35 Years	6	12.0	21	42.0
	d) 36-45 Years	12	24.0	14	28.0
2	Education – Wife				
	a) Elementary	19	38.0	31	62.0
	b) Higher Secondary	18	36.0	17	34.0
	c) Graduate & PG	13	26.0	2	4.0
3	Education – Husband				
	a) Elementary	16	32.0	22	44.0
	b) Higher Secondary	19	38.0	27	54.0
	c) Graduate & PG	15	30.0	1	2.0
4	Occupation – Wife				
	a) Govt. or Private	2	4.0	5	10.0
	b) Cooly	27	54.0	29	58.0
	c) House Wife	21	42.0	16	32.0
5	Occupation – Husband	24	48.0	29	58.0
	a) Skilled	24	48.0	20	40.0
	b) Unskilled	2	4.0	1	2.0
	c) Unemployed				

6	Monthly Income				
	a) Less than 2500	16	32.0	43	86.0
	b) 2500-5000	17	34.0	6	12.0
	c) Above 5000	17	34.0	1	2.0
7	Type of Family				
	a) Nuclear Family	34	68.0	23	46.0
	b) Joint Family	16	32.0	27	54.0
8	Religion				
	a) Hindu	35	70.0	15	30.0
	b) Christian	10	20.0	21	42.0
	c) Muslim	5	10.0	14	28.0
	d) Others	0	0	0	0
9	Parity				
	a) Less than two	34	68.0	29	58.0
	b) More than two	16	32.0	21	42.0
10	No. of Children				
	a) 1-2	33	66.0	16	32.0
	b) 3-4	17	34.0	34	68.0
	c) 5 and above	0	0	0	0
11	Own House				
	a) Yes	37	74.0	33	66.0
	b) No	13	26.0	17	34.0
12	Latrine Facilities				
	a) Yes	18	36.0	19	38.0
	b) No	32	64.0	31	62.0
13	Smoke Outlet				
	a) Yes	16	32.0	21	42.0
	b) No	34	68.0	29	58.0

14	Three times meal/day				
	a) Yes	50	100.0	37	74.0
	b) No	0	0	13	26.0
15	Preference of Non-Veg				
	a) Yes	29	58.0	23	46.0
	b) No	21	42.0	27	54.0
16	TV/Radio				
	a) Yes	50	100.0	49	98.0
	b) No	0	0	1	2.0
17	Vehicle				
	a) Yes	35	70.0	22	44.0
	b) No	15	30.0	28	56.0
18	Land				
	a) Yes	23	46.0	22	44.0
	b) No	27	54.0	28	56.0

The data presented in the above table shows that 23 (46.0%) adopters were between 26-30 years, 12 (24.0%) in the age group of 36-45 years, 9 (18.0%) in the age group of 20-25 years, 6 (12.0%) in the age group of 31-35 years.

21 (42.0%) Non adopters were between 31-35 years, 14 (28.0%) in the age group of 36-45 years, 10 (20.0%) in the age group of 26-30 years, 5 (10.0%) in the age group of 20-25 years.

Regarding wife education, maximum 19 (38.0%) adopters were in elementary, 18 (36.0%) were in higher secondary, 13 (26.0%) adopters as graduate & PG.

Maximum 31 (62.0%) non-adopters were elementary, 17 (34.0%) were higher secondary, 2 (4.0%) were graduate & PG.

Regarding educational status of husband, maximum 19 (38.0%) adopter's husband were higher secondary, 16 (32.0%) husbands were elementary, 15 (30.0%) husbands were graduate & PG.

Non-adopters husband 27 (54.0%) were higher secondary, 22 (44.0%) were elementary 1 (2.0%) were graduate & PG.

Regarding wife occupation 27 (54.0%) adopters were cooly worker, 21 (42.0%) were house wife, 2 (4.0%) were govt. or private.

29 (58.0%) non – adopters were cooly worker, 16 (32.0%) were house wife, 5 (10.0%) were govt. or private.

Regarding adopter's husband occupation, 24 (48.0%) were skilled, 24 (48.0%) were unskilled and 2 (4.0%) were unemployed.

Non-adopters husband occupation, 29 (58.0%) were skilled, 20 (40.0%) were unskilled and 1 (2.0%) were unemployed.

Regarding family monthly income, 17 (34.0%) adopters were from Rs.2500-5000, 17 (34.0%) were above Rs.5000, 16 (32.0%) were less than Rs.2500.

Non-adopters monthly income 43 (86.0%) were less than Rs.2500, 6 (12.0%) were from Rs.2500-5000, 1 (2.0%) was above Rs.5000.

Regarding type of family, maximum 34 (68.0%) adopters were from Nuclear family 16 (32.0%) were from joint family.

Maximum 27 (54.0%) non-adopters from joint family, 23 (46.0%) from nuclear family.

Regarding religion maximum 35 (70.0%) adopters from Hindu, 10 (20.0%) from Christian, 5 (10.0%) from Muslim and 0% from others.

Maximum 21 (42.0%) non-adopters from Christian, 14 (28.0%) from Muslim, 15 (30.0%) from Hindu and 0% from others.

Regarding parity maximum 34 (68.0%) adopters were less than two, 16 (32.0%) were more than two deliveries.

Maximum 29 (58.0%) non-adopters were less than two, 21 (42.0%) were more than two deliveries.

Regarding number of children maximum 33 (66.0%) adopters had 1-2 children and 17 (34.0%) had 3-4 children.

Maximum 34 (68.0%) non-adopters had 3-4 children and 16 (32.0%) had 1-2 children.

Regarding own house maximum 37 (74.0%) adopters had own house, 13 (26.0%) had rented house.

Maximum 17 (34.0%) non-adopters had rented house, and 33 (66.0%) had own house.

Regarding latrine facilities 32 (64.0%) adopters had no latrine facilities, and 18 (36.0%) had latrine facilities.

Maximum 29 (58.0%) non-adopters had no smoke outlet and 21 (42.0%) had smoke outlet.

Maximum 50 (100.0%) adopters had three times meal/day.

Maximum 37 (74.0%) non-adopters had 3 times meal/day and 13 (26.0%) had not three times meal/day.

Regarding preference of non-vegetarian maximum 29 (58.0%) adopters had prefer non-vegetarian and 21 (42.0%) had not prefer non-vegetarian

Maximum 27 (54.0%) non adopters had not prefer non-vegetarian weekly once and 23 (46.0%) had prefer non-vegetarian weekly once.

Maximum 50 (100.0%) adopters had TV/Radio and 49 (98.0%) non-adopters had TV/Radio and 1 (2.0%) had not TV/Radio.

Regarding vehicle maximum 35 (70.0%) adopters had vehicle and 15 (30.0%) had no vehicle.

Maximum 28 (56.0%) non adopters had no vehicle and 22 (44.0%) had vehicle.

Regarding land maximum 27 (54.0%) adopters had no land and 23 (46.0%) had land.

Maximum 28 (56.0%) non-adopters had no land and 22 (44.0%) had land.

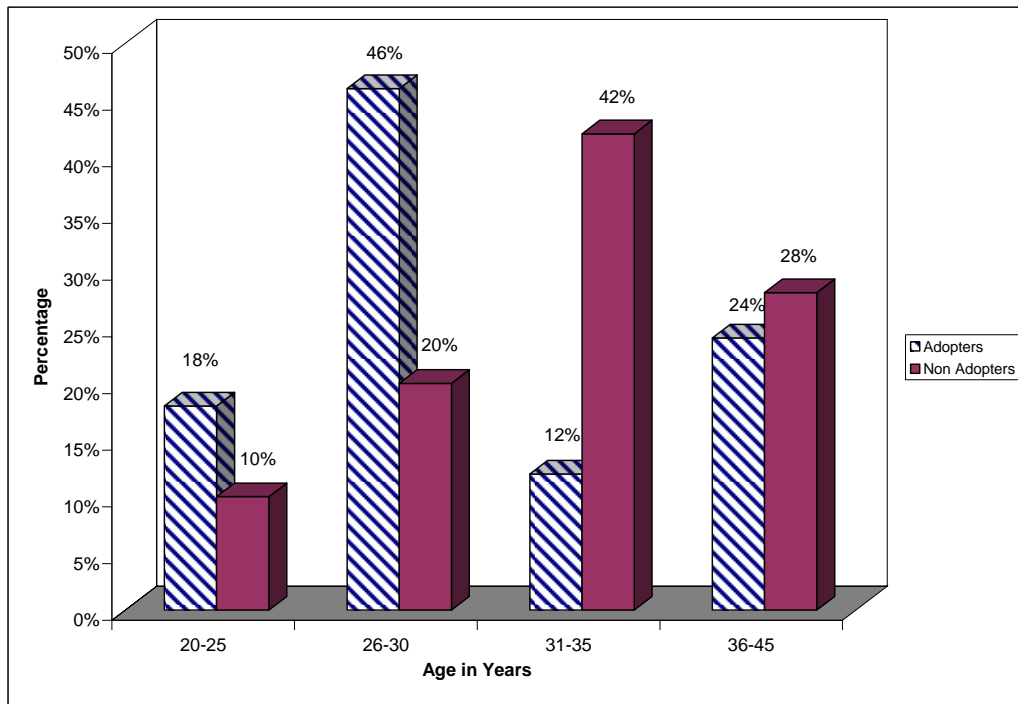# Figure 2 : Distribution of samples according to Age in years

Figure 3 : Distribution of samples according to Education of Wife

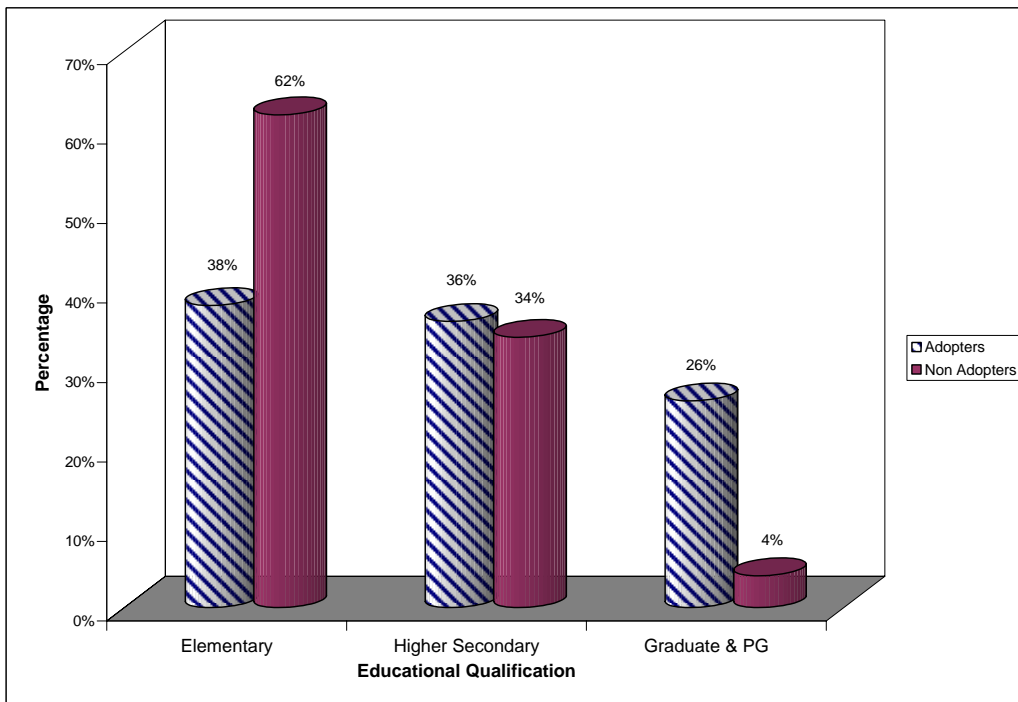# Figure 4 : Distribution of samples according to Education of Husband
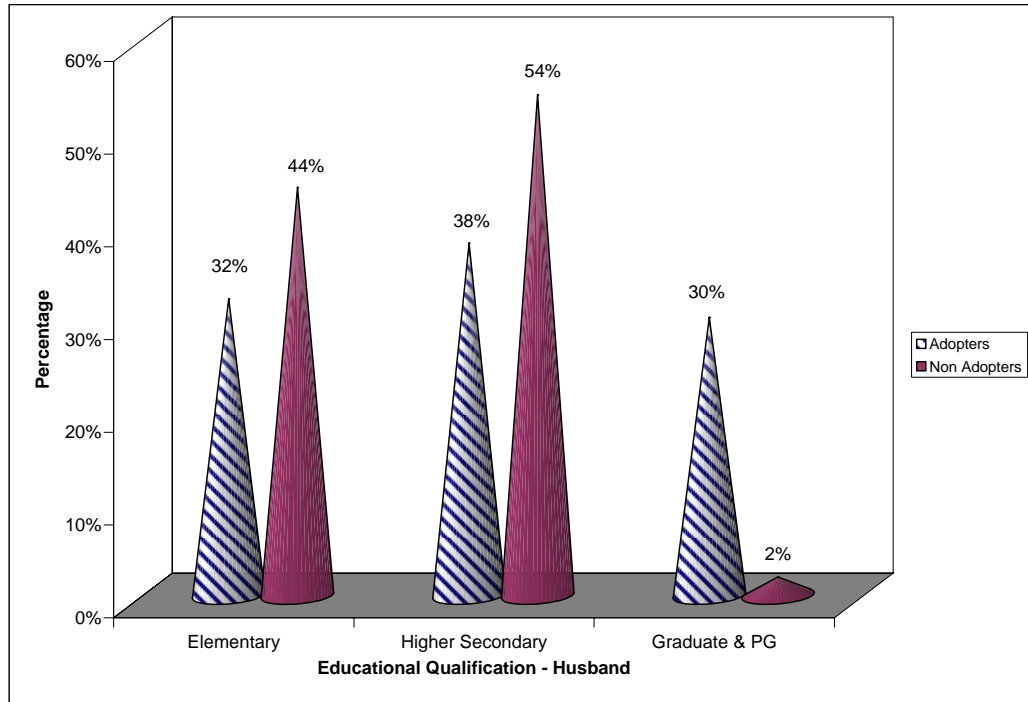
Figure 5 : Distribution of samples according to Occupation of Wife
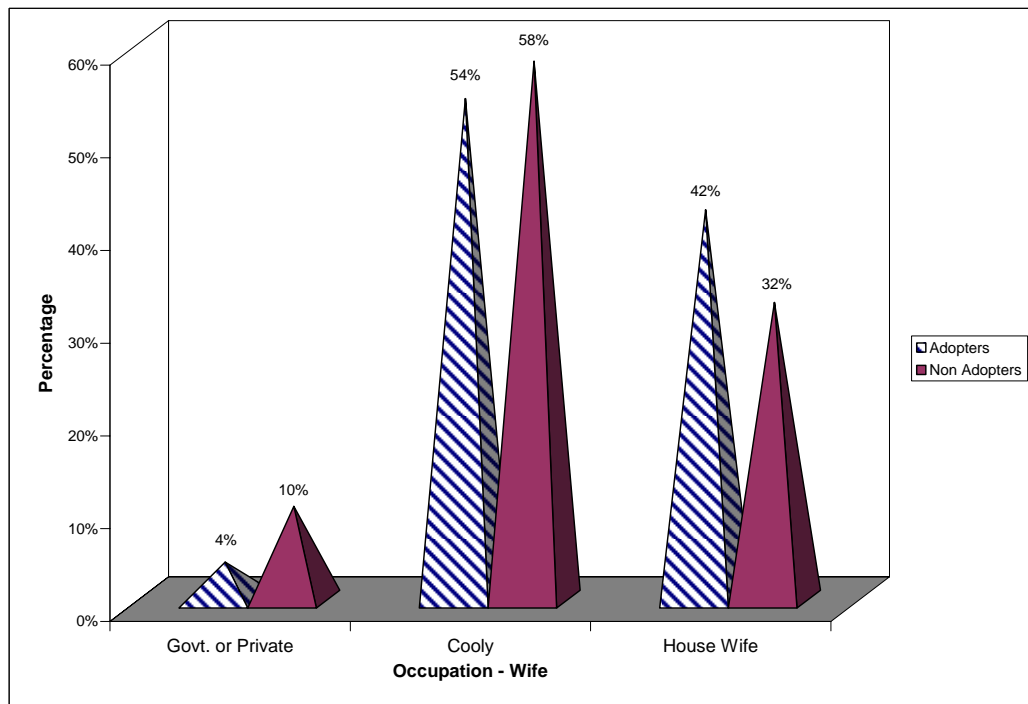
Figure 6 : Distribution of samples according to Occupation of Husband

Figure 7 : Distribution of samples according to Monthly Income

Figure 8 : Distribution of samples according to Type of Family

Figure 9 : Distribution of samples according to Religion
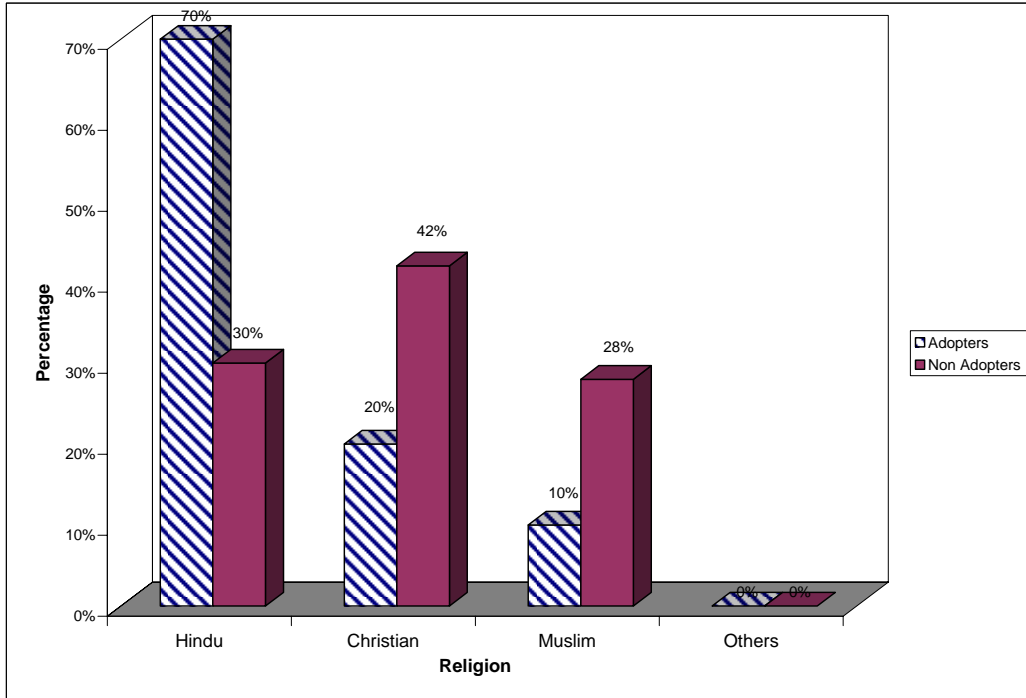
Figure 10 : Distribution of samples according to Parity
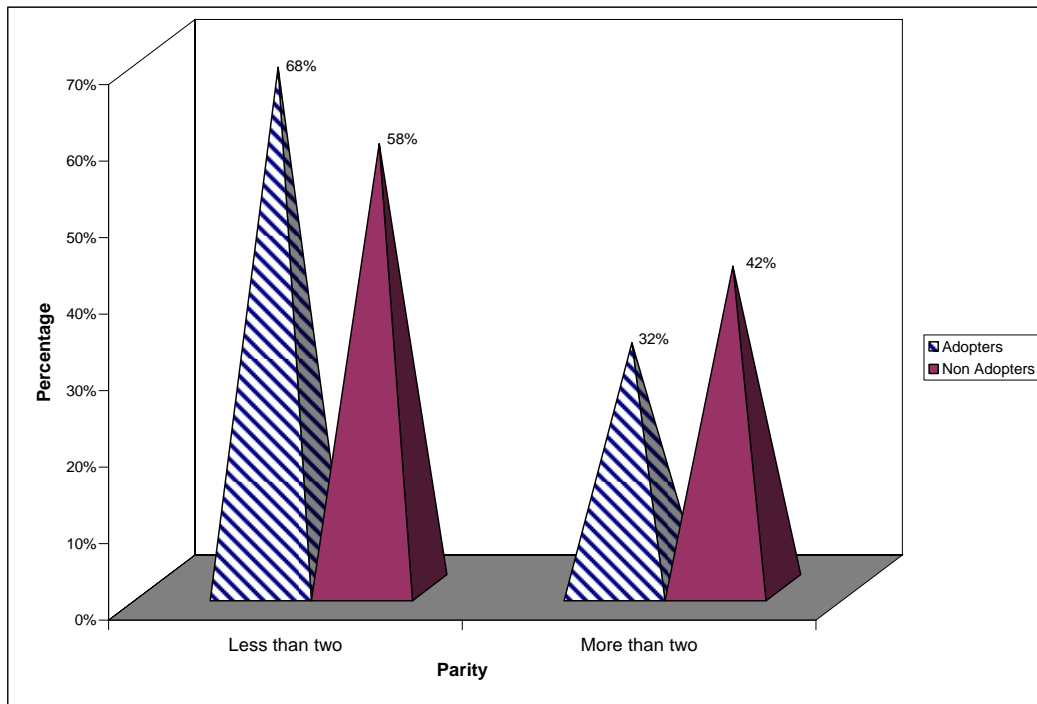
Figure 11 : Distribution of samples according to Number of Children
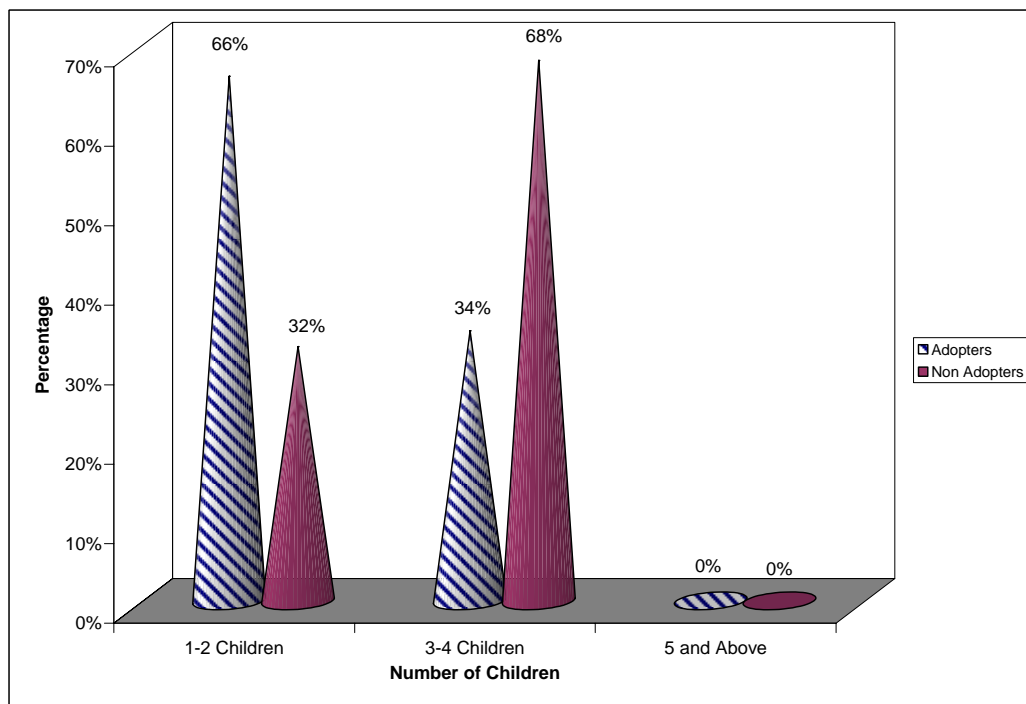
Figure 12 : Distribution of samples according to Own House
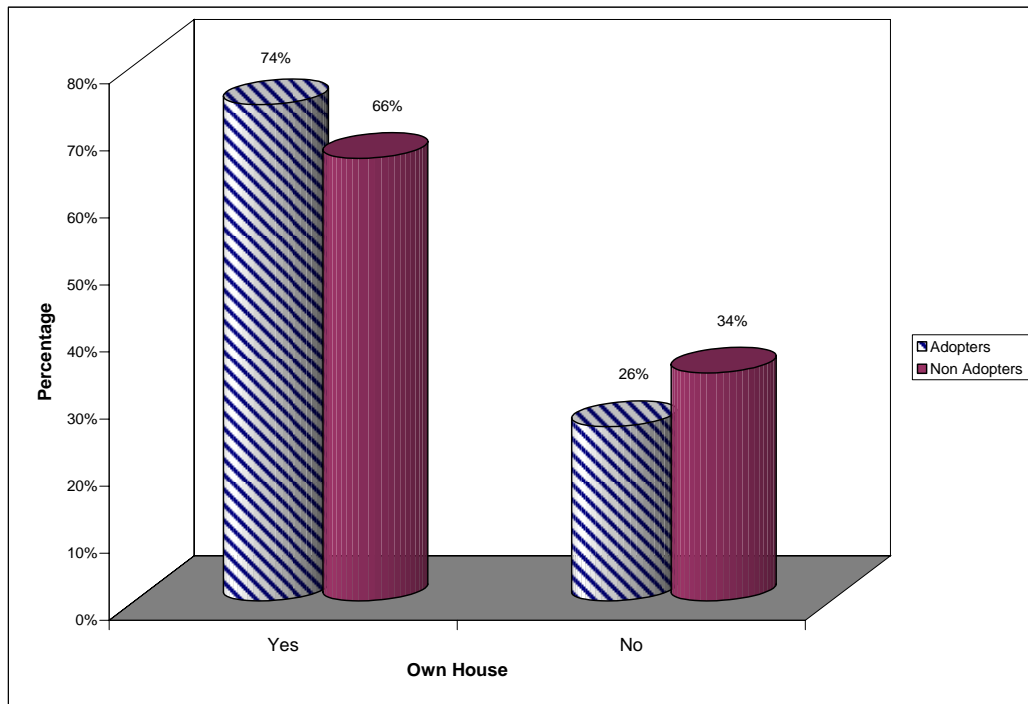
Figure 13 : Distribution of samples according to Latrine Facilities
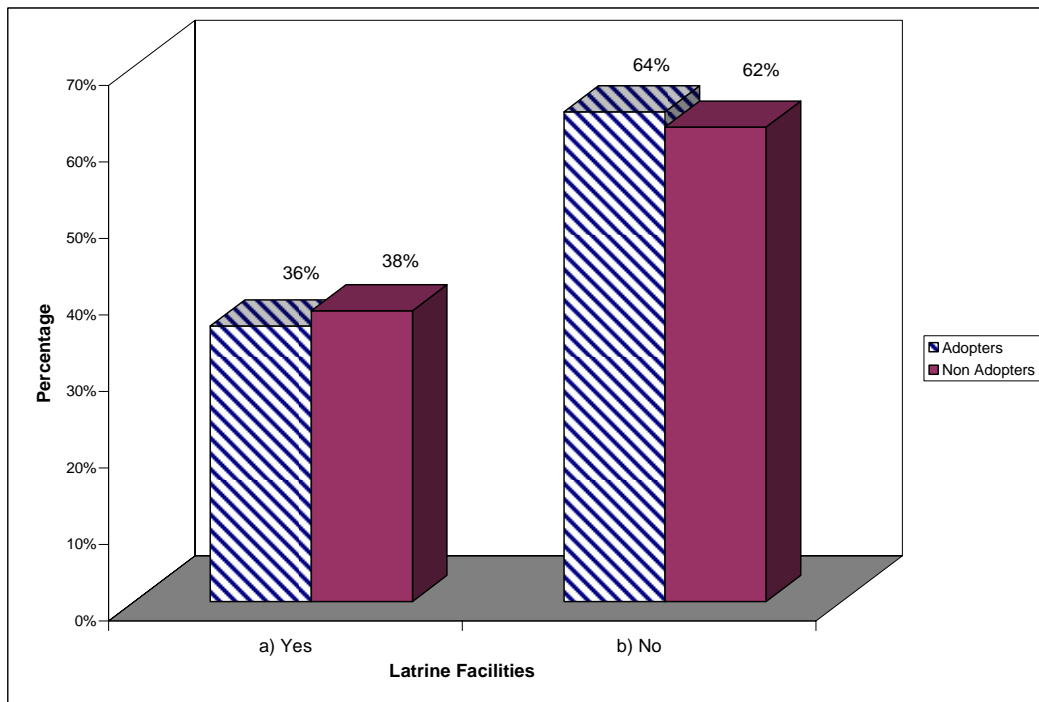
Figure 14 : Distribution of samples according to Smoke Outlet
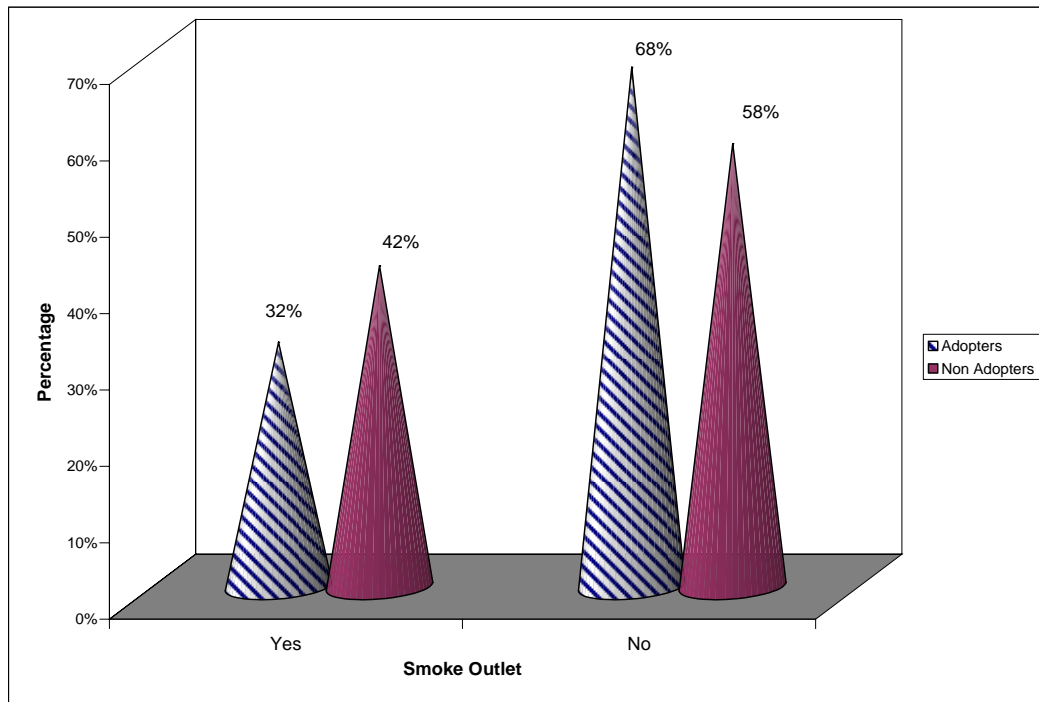
Figure 15 : Distribution of samples according to Three times meal/day
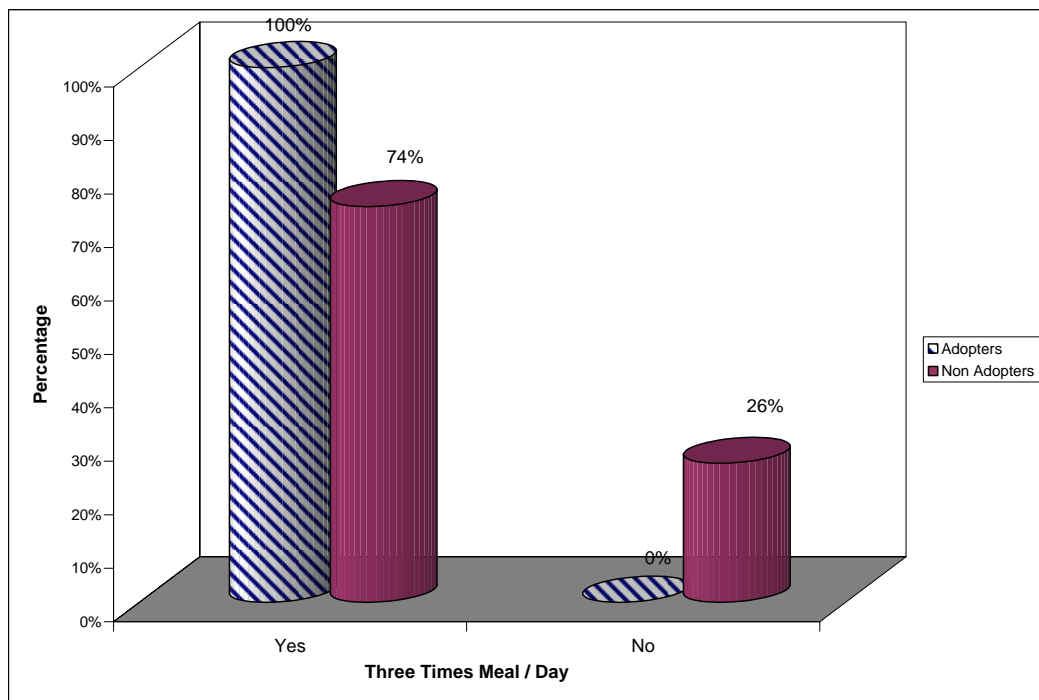
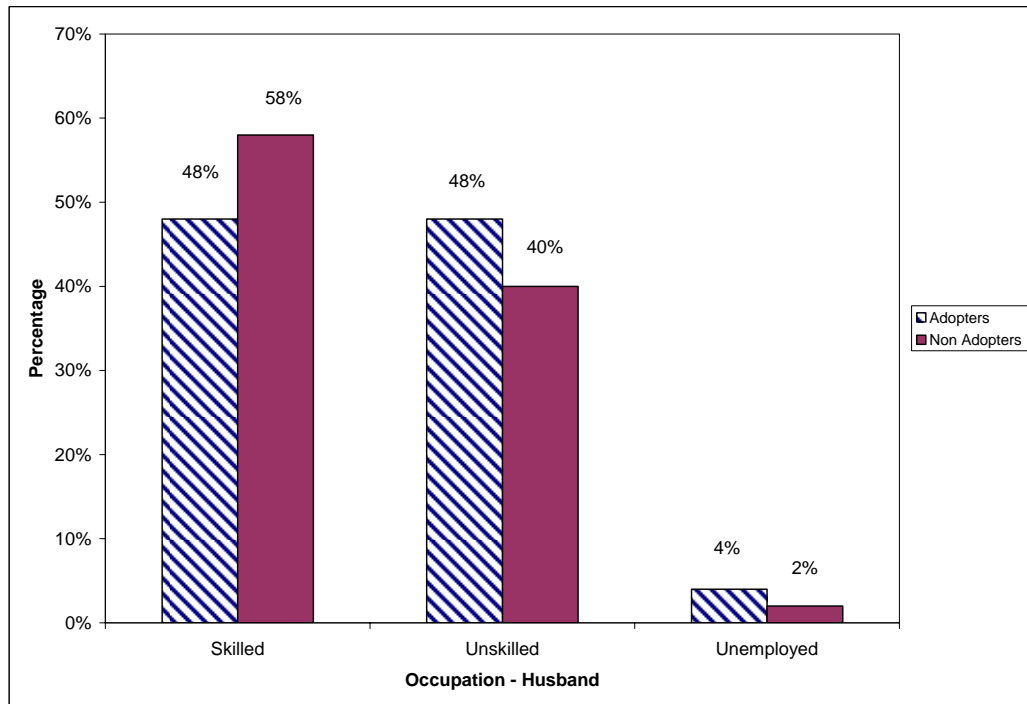# Figure 16 : Distribution of samples according to Preference of Non-Vegetarian
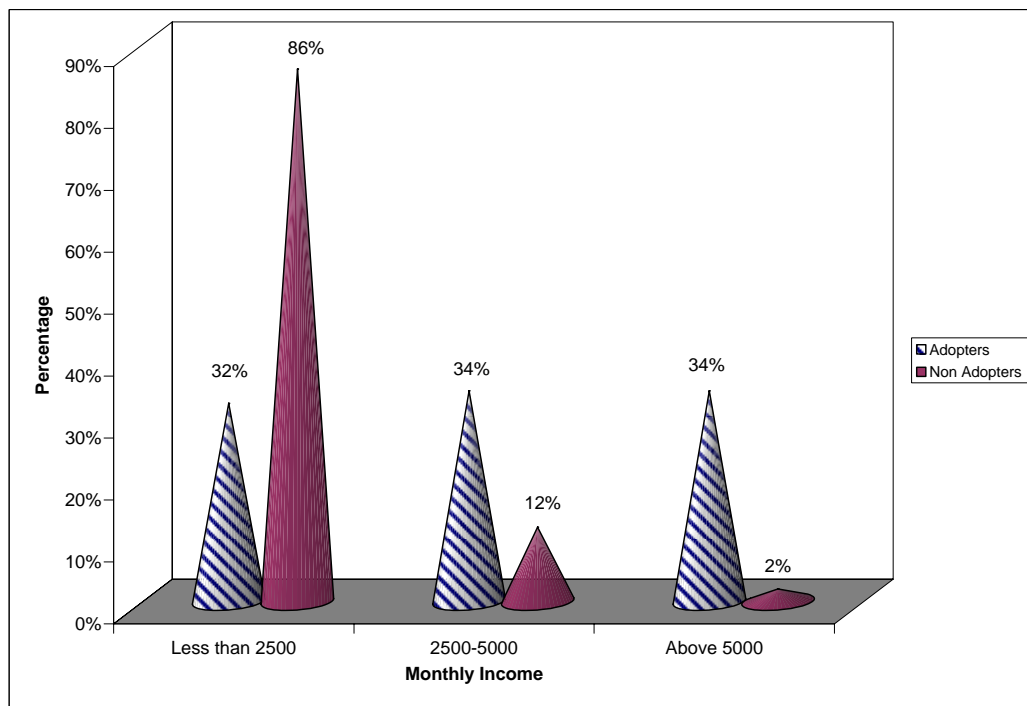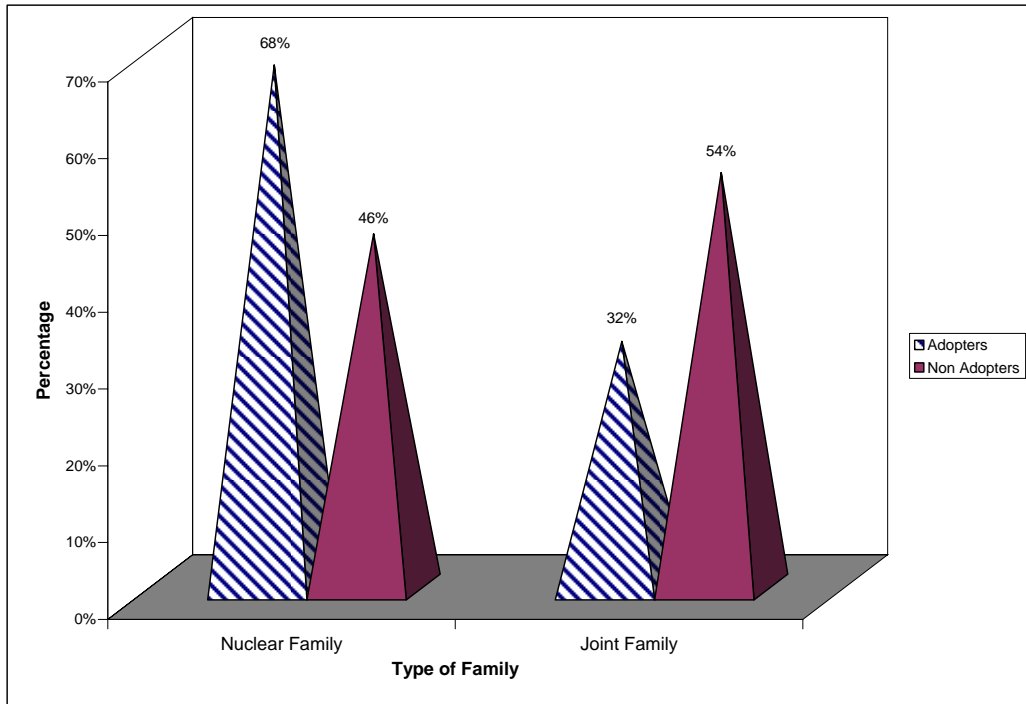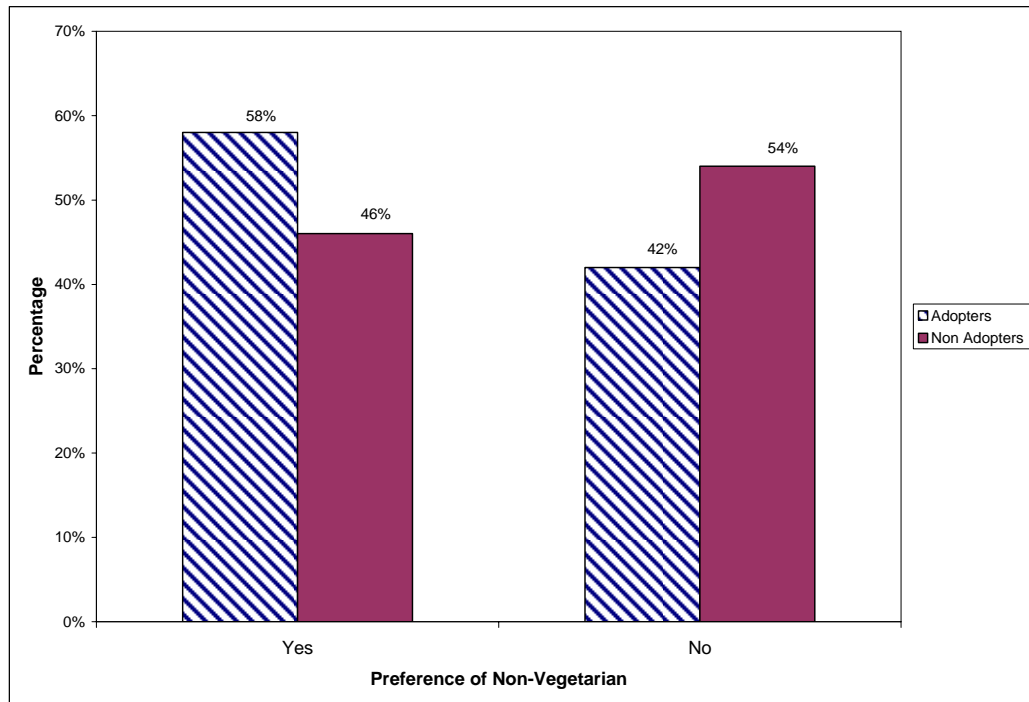

Figure 17 : Distribution of samples according to TV / Radio
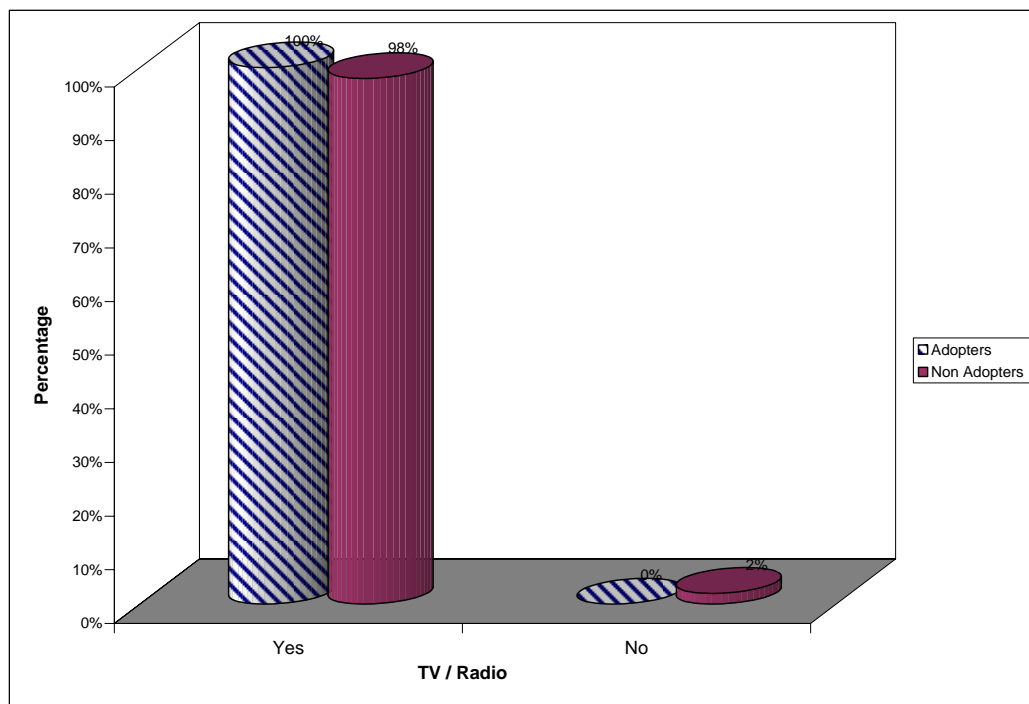
Figure 18 : Distribution of samples according to Vehicle
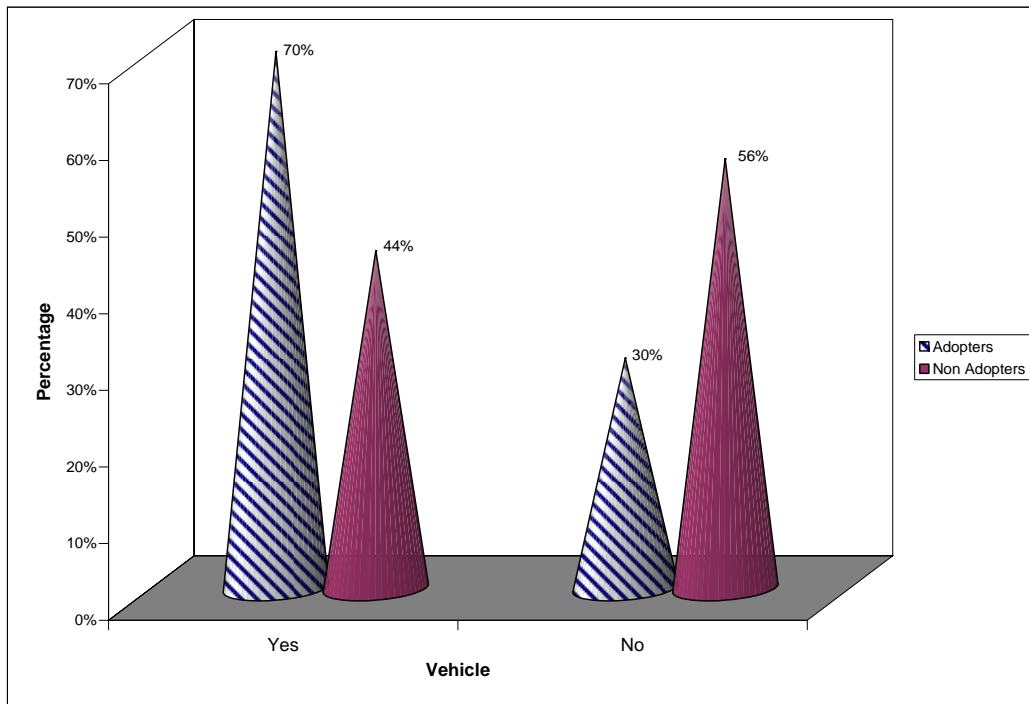
Figure 19 : Distribution of samples according to Land
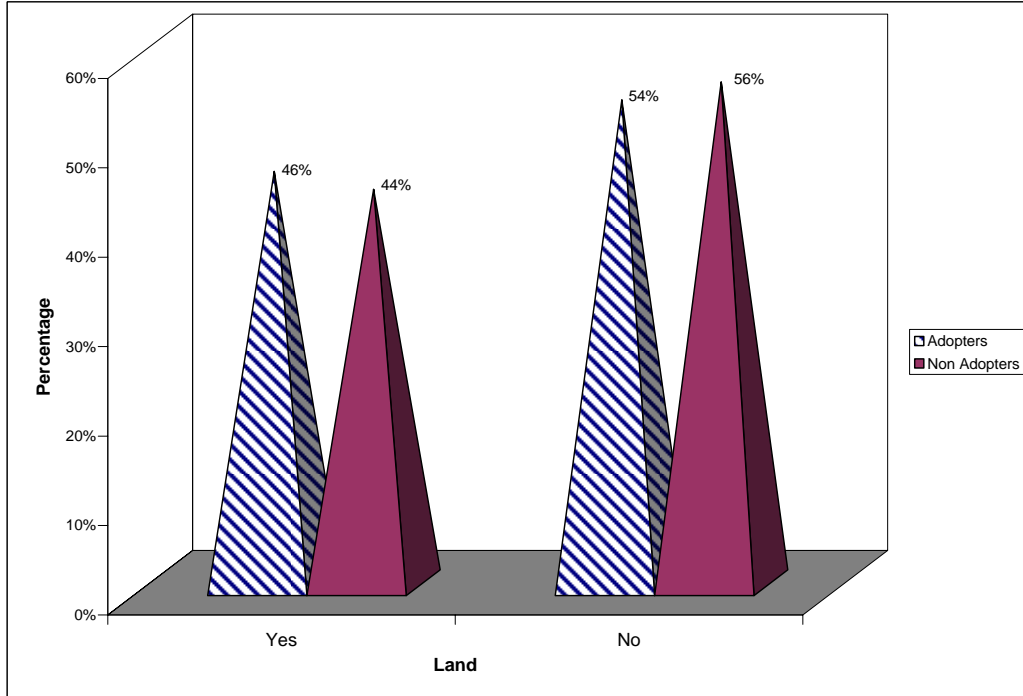
SECTION – II

Table – II

Frequency and percentage distribution of quality of life among the permanent contraceptive adopters

S. No	Level	Frequency n=50	Percentage
1	Poor	0	0%
2	Moderate	31	62%
3	Good	19	38%

The above table shows that the frequency and percentage distribution of samples according to the quality of life of contraceptive adopters. It reveals that none of the adopters had poor quality of life, 31 (62.0%) had moderate quality of life and 19 (38.0%) had good quality of life.

Figure 20 : Percentage Distribution of Level of Quality of life among the adopters

Level of Quality

Table – III

Frequency and percentage distribution of quality of life among the contraceptive non-adopters

S.No	Level	Frequency n=50	Percentage
1	Poor	24	48%
2	Moderate	26	52%
3	Good	0	0%

The above table shows that the frequency and percentage distribution of samples according to the quality of life of contraceptive non-adopters. It reveals that 24 (48.0%) non adopters had poor quality of life, 26 (52.0%) had moderate quality of life and none of the non-adopters had good quality of life.

Figure 21 : Percentage Distribution of Level of Quality of life among the Non-Adopters
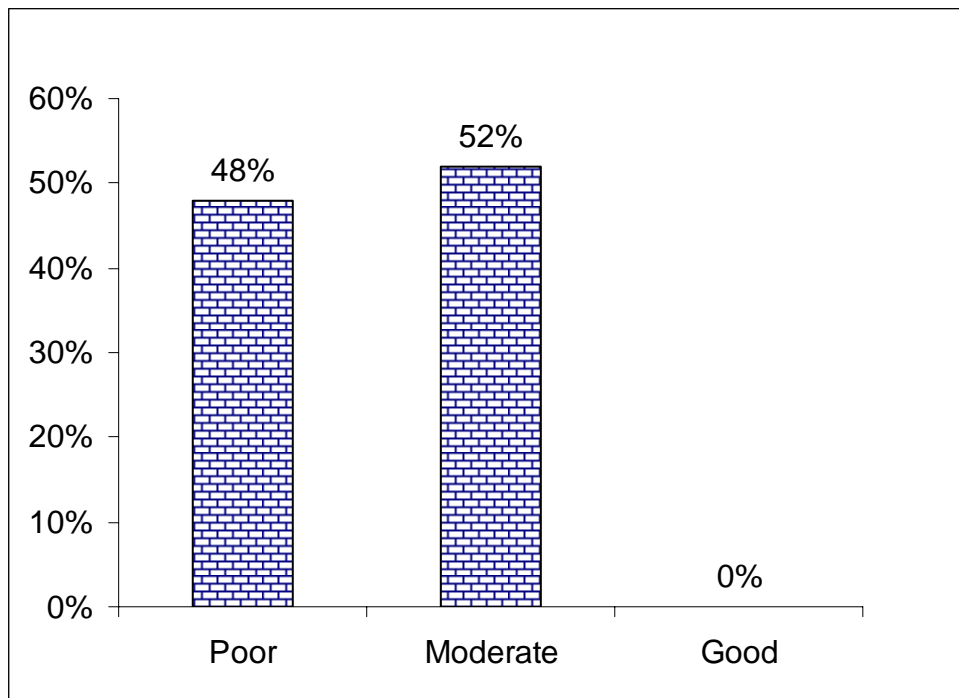
Level of Quality

SECTION – IV

Comparison of quality of life among the permanent contraceptive adopters and non-adopters

Hypothesis – 1

There is a significant difference between the quality of life among the permanent contraceptive adopters and non-adopters.

Table IV

Independent 't' Test

Group	Mean	SD	"t" Value
Adopters	65.0800	4.61072	26.569
Non-adopters	44.2200	3.09239	

The above table shows that the adopters mean value was 65.08 and the standard deviation was 4.6 non-adopters mean value was 44.22 and the standard deviation was 3.09 't' value was 26.569, higher than the table value. So there was a highly significant difference between quality of life among the permanent contraceptive adopters and non-adopters.

Association between the quality of life among the permanent contraceptive adopters and selected demographic variables.

To identify the association between the quality of life among the permanent contraceptive adopters and selected demographic variables. The following hypothesis was stated.

Hypothesis 2

There is a significant association between quality of life among the permanent contraceptive adopters and selected demographic variables.

Table V

Demographic Variables	Fre	Poor	Moderate	Good	χ^2
1) Age					
a) 20-25 Yrs	96	0	3	1	3.396
b) 26-30 Yrs	23	0	12	9	NS
c) 31-35 Yrs	6	0	14	5	
d) 36-45 Yrs	12	0	2	4	
2) Education – Wife					
a) Elementary	19	0	13	6	.651
b) Higher Secondary	18	0	10	8	NS
c) Graduate & PG	13	0	8	5	
3) Education- Husband					
a) Elementary	16	0	11	5	2.139
b) Higher Secondary	19	0	13	6	NS
c) Graduate & PG	15	0	7	8	

4) Occupation-Wife					
a) Govt. or Private	2	0	0	2	4.276
b) Cooly	27	0	19	8	NS
c) House wife	21	0	12	9	
5) Occupation-Husband					
a) Skilled	24	0	14	10	1.365
b) Unskilled	24	0	15	9	NS
c) Unemployed	2	0	2	0	
6) Monthly Income					
a) Less than 2500	16	0	29	11	9.548
b) 2500-5000	17	0	2	7	**
c) above 5000	17	0	0	1	
7) Type of family					
a) Nuclear Family	34	0	18	16	3.701
b) Joint Family	16	0	13	3	*
8) Religion					
a) Hindu	35	0	18	17	6.100
b) Christian	10	0	8	2	*
c) Muslim	5	0	5	0	
d) Others	0	0	0	0	
9) Parity					
a) Less than2	34	0	22	12	.330
b) More than 2	16	0	9	7	NS
10) No.of children					
a) 1-2	33	0	23	10	
b) 3-4	17	0	8	9	2.441
c) 5 and above	0	0	0	0	NS

11) Own house					
a) Yes	37	0	24	13	.496
b) No	13	0	7	6	NS
12) Latrine facility					
a) Yes	18	0	9	9	1.719
b) No	32	0	22	10	NS
13) Smoke outlet					
a) Yes	16	0	11	5	.455
b) No	34	0	20	14	NS
14) Prefer non-veg weekly once					
a) Yes	29	0	15	14	3.095
b) No	21	0	16	5	NS
15) Vehicle					
a) Yes	35	0	21	14	.198
b) No	15	0	10	5	NS
16) Land					
a) Yes	23	0	16	7	1.035
b) No	27	0	15	12	NS

*- Significant at 0.05 level

**- Highly Significant at 0.01 level

NS- Non Significant

To find out the association between the quality of life among the permanent contraceptive adopters and demographic variables used by chi-square.

The result shows that there was a highly significant association in monthly income and significant association in religion and type of family.

But there was no association between age, education of husband and wife, occupation of husband and wife, parity, number of children. own house, latrine facility, smoke outlet, prefer non-vegetarian weekly once, vehicle and land.

Association between the quality of life among the permanent contraceptive non-adopters and selected demographic variables.

To identify the association between the quality of life among the permanent contraceptive non-adopters and selected demographic variables. The following hypothesis was stated.

Hypothesis-3

There was a significant association between quality of life among the permanent contraceptive non-adopters and selected demographic variables.

Table VI

Demographic Variables	Fre	Poor	Moderate	Good	χ^2
1) Age					
a) 20-25 Yrs	5	0	4	0	14.254
b) 26-30 Yrs	10	10	11	0	**
c) 31-35 Yrs	21	14	5	0	
d) 36-45 Yrs	14	0	6	0	
2) Education – Wife					
a) Elementary	31	10	9	0	.272
b) Higher Secondary	17	8	10	0	NS
c) Graduate & PG	2	6	7	0	
3) Education- Husband					
a) Elementary	22	8	8	0	4.510
b) Higher Secondary	27	12	7	0	NS
c) Graduate & PG	1	4	11	0	

4) Occupation-Wife					
a) Govt. or Private	5	1	1	0	3.184
b) Cooly	29	16	11	0	NS
c) House wife	16	7	14	0	
5) Occupation-Husband					
a) Skilled	29	12	12	0	0.087
b) Unskilled	20	11	13	0	NS
c) Unemployed	1	1	1	0	
6) Monthly Income					
a) Less than 2500	43	19	21	0	1.133
b) 2500-5000	6	5	4	0	NS
c) above 5000	1	0	1	0	
7) Type of family					
a) Nuclear Family	23	16	18	0	3.570
b) Joint Family	27	8	8	0	*
8) Religion					
a) Hindu	15	16	19	0	
b) Christian	21	6	4	0	.778
c) Muslim	14	2	3	0	NS
d) Others	0	0	0	0	
9) Parity					
a) Less than2	29	16	18	0	.038
b) More than 2	21	8	8	0	NS
10) Number of children					
a) 1-2	16	17	16	0	.480
b)3-4	34	7	10	0	NS
c) 5 and above	0	0	0	0	
11) Own house					
a) Yes	33	16	21	0	1.290
b) No	17	8	5	0	NS

12) Latrine facility					
a) Yes	19	6	12	0	2.424
b) No	31	18	14	0	NS
13) Smoke outlet					
a) Yes	21	8	8	0	.038
b) No	29	16	18	0	NS
14) Prefer non-vegetarian weekly once					
a) Yes	23	14	15	0	0.002
b) No	27	10	11	0	NS
15) Vehicle					
a) Yes	22	15	20	0	1.236
b) No	28	9	6	0	NS
16) Land					
a) Yes	22	13	10	0	1.239
b) No	28	11	16	0	NS

**- Highly Significant at 0.01 level

*- Significant at 0.05 level

NS- Non significant

To find out the association between the quality of life among the permanent contraceptive non-adopters with demographic variables used by chi-square.

The result shows that there was a highly significant association in age and significant association in type of family. But there was no association between the education of wife and husband, occupation of wife and husband, monthly income, religion, parity, number of children, own house, latrine facilities, smoke outlet, prefer non-vegetarian weekly once, vehicle and land.

DISCUSSION

CHAPTER – V
DISCUSSIONS

This study was done to determine the quality of life among the permanent contraceptive adopters and non-adopters. Descriptive research design was used to conduct the study. WHO quality of life modified scale was used to assess the quality of life among the permanent contraceptive adopters and non-adopters. The purposive sampling technique was used for selecting the sample to conduct the study. This study consists of 50 samples of adopters and 50 samples of non-adopters. The study findings were discussed in the chapter with reference to the objectives.

OBJECTIVES

➢ To assess the quality of life among the permanent contraceptive adopters.

➢ To assess the quality of life among the non-adopters.

➢ To compare the quality of life among the permanent contraceptive adopters and non – adopters.

➢ To find out the association between the quality of life among the permanent contraceptive adopters and selected demographic variables such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity and number of children, own house, Latrine facilities smoke outlet, 3 times meal/day. Prefer non vegetarian weekly once. TV/Radio, Vehicle and Land.

➢ To find out the association between the quality of life among the permanent contraceptive non-adopters and selected demo variables such as age, wife's education and occupation, husband's education and occupation, monthly income, type of family, religion, parity,

number of children, own house, Latrine facilities. Smoke outlet, 3 times meal/day. prefer non vegetarian weekly once, TV/Radio, Vehicle and Land.

The first objective was to assess the quality of life among the contraceptive adopters.

The analysis table II shows that the frequency and percentage distribution of samples according to the quality of life among the permanent contraceptive adopters. It reveals that none of the adopters had poor quality of life, 31 (62.0%) had moderate quality of life and 19 (38.0%) had good quality of life.

Kameshwaranrao Avasarala (March 2009) conducted a study on "quality of life" assessment of family planning adopters through the user perspectives at Andhra Pradesh in India. A cross sectional descriptive study was carried out by using random sampling, proportions and chi-square test among 50 FP adopting families and 50 non-FP adopting families. Program perspectives revealed a better standard of living for FP adopters because they had amenities like housing, television and vehicles and less mortality and morbidity (P<0.001) while assessing the impact of a health program on quality of life multiple methods of assessments including user perspectives are better than program indicators alone. This study supports the present study.

Adopters could maintain the quality of life due to planning of the children as well as finance like spending the money equally with the limited children and for family.

Educated families always plan monthly expenses and expect for unexpected expenditure. This planned system also helps them to maintain the life with quality.

The second objective was to assess the quality of life among the permanent contraceptive non-adopters.

The table III shows that the frequency and percentage distribution of samples according to the quality of life among the permanent contraceptive non-adopters. It shows that 24 (48.0%) non-adopters had poor quality of life, 26 (52.0%) had moderate quality of life and none of the non-adopters had good quality of life.

The mother quote that their in laws restrains them not to do operation. Favouring / missing of to have male child is another reason. The women felt that they lost their strength because of permanent method of family planning.

Joshi et al (2001) conducted a comparative study to assess the knowledge and attitude of the acceptors and non acceptors of contraception in a tribal areas in Thane district, Maharashtra. A sample of 254 eligible women (age, 15-36 Yrs) a randomly selected and interviewed by trained social workers. The findings revealed that 88% of them were below 30 yrs of age, out of the total sample of 254 women 38% were illiterate, and 18% were tribal. The monthly per capital income was below Rs.500/month in 68% of cases. All respondents were Hindus and 69% of them were house wives, 54 women had accepted temporary (27) and permanent (27) methods of contraception, whilst 200 women did not use any method. This study also supports the present study.

The third objective was to compare the quality of life among the permanent contraceptive adopters and non-adopters.

The corresponding hypothesis was a significant difference between quality of life among the permanent contraceptive adopters and non-adopters

The analysis table IV shows that there was a highly significant association between the adopters quality of life with monthly income that the adopters mean value was 65.08 and the non-adopters mean value was 44.22. There was a difference between adopters and non-adopters mean value. It was highly significant at 0.01 level 't' value was (26.569) higher than the table value. The research hypothesis was accepted the null hypothesis was rejected. So the researcher concluded that adopters had good quality of life and the non-adopters had poor quality of life.

Melchert et al (2002) conducted a study to describe oral contraceptive use, its determinants and use associated health correlates from 1984 to 1999 in Germany. Cross-sectional comparison was performed for socio-economic factors, personal life style and use-associated health correlates between 1862 oc users and 2625 age – matched non – users identified from five German National health surveys. Regression models were used to obtain the determinants of oc use. Cross sectional comparison and regression analysis. Suggested that oc users did not differ from non-users in most selected personal socio-economic factors. OC users showed generally a better health profile than age matched non-users. This study supports the present study.

The fourth objective was to determine the association between the quality of life among the permanent contraceptive adopters and selected demo variables such as age, education-wife, husband, occupation-wife, husband, monthly income, type of family, religion, parity, number of children, own house, latrine facilities, smoke outlet, prefer non-vegetarian weekly once, vehicle and land.

The corresponding hypothesis was that there was a significant association between adopters quality of life with selected demographic variables. The analysis table V shows that there was a highly significant association between the adopters quality of life with monthly income (chi-square=9.548) and significant association in religion (6.100) and type of family (3.701). So the research hypothesis was partially accepted.

But there was no association between adopters quality of life with age, education (wife & husband), occupation (wife & husband), number of children, parity, own house, latrine facility, smoke outlet, prefer non-vegetarian weekly once, vehicle and land. So the null hypothesis was partially rejected.

Soni and Sachar (2000) conducted a comparative study of sterilization acceptors. The study was conducted retrospectualy at family welfare and post partum centre dayard medical college, Ludhiana. The performance data of the sterilization acceptors for the previous 4 yrs were utilised for carrying out the analysis. The findings revealed that majority of women accepted stabilization with 3 living children. The difference among acceptors & non acceptors was found to be highly significant ($\gamma^2 = 34.38$, P<0.001). There were 78.20% acceptors & 21.80% non-acceptors, co-relation was observed between the age of mother and number of living

children (r = 0.95) Its influence for accepting a permanent family planning. This study also supports the present study.

The fifth objective was to find out the association between the quality of life among the permanent contraceptive non-adopters and demo variables such as age, education-wife, husband, occupation-wife, husband, monthly income, type of family, religion, parity, number of children, own house, latrine facilities, smoke outlet, 3 times meal/day, prefer non-vegetarian weekly once, TV/Radio, vehicle and land.

The corresponding hypothesis was that there was a significant association between non-adopters quality of life with demo variables.

The table VI shows that there was a highly significant association between the permanent contraceptive non-adopters quality of life with age and significant association in type of family. So the investigator found that the research hypothesis was partially accepted.

But there was no association between non-adopters quality of life with education (wife & husband), occupation (wife & husband), monthly income, religion, parity, number of children, own house, latrine facility, smoke outlet, prefer non-vegetarian weekly once, vehicle and land. So the researcher found that partially reject the null hypothesis.

Savitha (2000) conducted a study in demographic features of tubectomy acceptors at Goa. An attempt was made to investigate the acceptance of family planning among Hindus, Christians and Muslims. It was observed that Hindu acceptors were 76% of the total sample followed by Christians were 13% and Muslim was 1%. This study indicates that the religion also influenced the permanent methods of contraception. This study also supports the present study.

SUMMARY, FINDINGS, CONCLUSION, IMPLICATION AND RECOMMENDATION

CHAPTER – VI

SUMMARY, IMPLICATION, RECOMMENDATION AND CONCLUSION

This chapter deals with the summary of the study and conclusion. It clarifies the implications for nursing practice and recommendation for further research in the field.

Summary:

The purpose of the study was to determine the quality of life among the permanent contraceptive adopters and non-adopters. Descriptive research design was used in this study. The objectives and hypothesis of the study are given below.

The following **objectives** were set for this study.

★ To assess the quality of life among the permanent contraceptive adopters.

★ To assess the quality of life among the non – adopters.

★ To compare the quality of life among the permanent contraceptive adopters and non – adopters.

★ To find out the association between the quality of life among the permanent contraceptive adopters and selected demographic variables such as age, education (husband and wife), occupation (husband and wife), income, type of family, religion, parity and no. of children, own house latrine facilities, smoke outlet, three times meal /day, prefer non-vegetarian weekly once, TV/radio, vehicle and land.

★ To find out the association between the quality of life among contraceptive non – adopters and selected demographic variables such as age, education (husband and wife), occupation (husband and wife), income, type of family, religion, parity and no. of children, own house latrine facilities, smoke outlet, three times meal /day, prefer non-vegetarian weekly once, TV/radio, vehicle and land.

The following **hypotheses** were set to the study and tested at 0.05 level of significance.

➢ There is a significant difference between the quality of life among the permanent contraceptive adopters and non – adopters.

➢ There is a significant association between the quality of life among the permanent contraceptive adopters and selected demographic variables such as age, education (husband and wife), occupation, income, type of family, religion, parity and no. of children, own house latrine facilities, smoke outlet, three times meal /day, prefer non-vegetarian weekly once, TV/radio, vehicle and land.

➢ There is a significant association between the quality of life among contraceptive non – adopters and selected demographic variables such as age, education (husband and wife), occupation, income, type of family, religion, parity and no. of children, own house latrine facilities, smoke outlet, three times meal /day, prefer non-veg weekly once, TV/radio, vehicle and land.

The conceptual framework of the study was based upon.

Rosenstocke's and **Becker** 1974, health belief model. The instrument used for data collection was a interview schedule on WHO quality of life scale (modified tool) physical and psychological problems used by checklist and socio economic status used by rating scale.

The purposive sampling technique was used for selecting the sample.

Descriptive statistical (frequency, percentage, mean, standard deviation) and inferentual statistics (chi-square, independent "t" test) were used to analyse the data and to test the hypothesis.

Major findings of the study:

➢ Majority of the samples of adopters were 46% in the age group from 26 to 30 years and non-adopters were 42% in the age group from 31 to 45 years.

➢ Regarding wife education, majority adopters were 38% and non adopters were 62% in elementary education.

➢ Spouse education of adopters were 38% and non-adopters were 54% in higher secondary education.

➢ Regarding occupation, most of the adopters were 54% and non-adopters were 58% as cooly workers.

➢ Husband occupation, majority of the adopters were 48% and non-adopters husband's occupation were 58% as the skilled workers.

➢ Regarding monthly income, majority adopters were 34% from Rs.2500-5000 and non-adopters were 86% less than Rs.2500.

➢ Type of family, adopters were 68% from nuclear family and non-adopters were 54% from joint family.

- Regarding religion, maximum adopters were 70% from Hindu and non-adopters were 42% from Christian.
- Regarding parity, maximum adopters were 68% less than two and non-adopters were 58% less than two deliveries.
- Regarding number of children, 33 (66%) of adopters had 1-2 children and maximum 34 (68%) of non-adopters had 3-4 children.
- Regarding own house, maximum adopters were 74% and non-adopters were 66%.
- Regarding latrine facilities, maximum adopters were 64% and non-adopters were 62% who had no latrine facilities.
- Regarding smoke outlet, majority adopters were 68% and non-adopters were 58% who had no smoke outlet.
- Regarding three times meal/day, maximum adopters were 100% and non-adopters were 74% who had three times meal/day.
- Regarding preference of non-vegetarian, majority adopters were 58% who preferred non-vegetarian once in a week and non-adopters were 54% who didn't prefer non-vegetarian.
- Regarding TV/Radio, maximum adopters were 100% and non-adopters were 98% who had TV and radio.
- Regarding vehicle, majority adopters were 70% who had vehicle and non-adopters were 56% who had no vehicle.
- Regarding land, maximum adopters were 54% and non-adopters were 56% had no land.
- The adopters mean score was 65.08 and non-adopters mean score was 44.22 and adopters standard deviation was 4.61 and non-adopters standard deviation was 3.09.
- Regarding level of quality, maximum adopters were 62% and non-adopters were 52% who had moderate quality of life.

➢ There is a highly significant difference between quality of life among the adopters and non-adopters.

➢ There is a highly significant association between the adopters quality of life with monthly income and significant association in religion and type of family. But there was no association between adopters quality of life with age, education (wife & husband), occupation (wife & husband), number of children, parity, own house, latrine facility, smoke outlet, prefer non-vegetarian weekly once, vehicle and land.

➢ There is a highly significant association between permanent contraceptive non-adopters quality of life with age, and significant association in type of family. But there was no association between education (wife & husband), occupation (wife & husband), monthly income, parity, number of children, own house, latrine facilities, smoke outlet, prefer non-vegetarian weekly once, vehicle and land.

Implications:

The implications from the study is vital concern to the health care team including the professional nurse practitioners, nurse educators and nurse administrator and nurse researchers.

Implications for Nursing Practice:

The responsibility of educating the multi para mothers on permanent family planning method lies in the hands of the nurses as health care professionals can considerably influence the practice of tubectomy.

Practicing nurses have the opportunities where they can teach the multi para mothers regarding permanent family planning methods and there by help the mother to select the method and adopt the same successfully.

Implications for nursing education:

As nurse educators all the students should be provided opportunities to gain skill in teaching the multi para mothers on the family planning methods.

Not only for completing their individual procedures but every students should be encouraged to teach all the multi para mothers on permanent family planning methods (tubectomy) and motivate them to practice it.

The study topic should be included in the GNM & Bsc syllabus which helps the nurse student to develop the concept of combining contraception adopting and quality of life.

Implication for nursing administration:

Nurse administrators should provide the necessary physical facilities in the post natal wards and out patient clinics for counseling and teaching the multipara mothers regularly on the family planning methods.

A regular health education program on family planning methods can be included in the maternity ward activities.

Implication for Nursing research:

Nursing research adds to nursing scientific knowledge base and improves the practice of nursing for the ultimate improvement of patient care.

The findings of the study serve as the guide and provide a base to develop a sense of enquiry among the professional nurses and nursing students.

The generalization of the study result can be made by further replication of the study in different settings with more samples.

Recommendation:

- ☯ The study can be replicated on larger samples in different settings to validate and generalise results.
- ☯ A similar study can be conducted with a true experimental research approach.
- ☯ A comparative study can be done between urban and rural mothers.
- ☯ A similar study can be carried out by using different teaching strategies.
- ☯ A case study may be conducted as a quality of life among the acceptors of family planning.
- ☯ An experimental study can be done to find out the improvement of knowledge.
- ☯ A comparative study among different religion about contraceptive method can be performed.

CONCLUSION:

The researcher found out that the couples who adopt the permanent contraceptive can maintain the quality of life by sharing of wealth among small family whereas by non adopters who have poor planning and unnecessary suffering end their life without health and happy.

Providing teaching module is an effective means to increase the knowledge and promote practice of contraceptive methods.

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APPENDICES

APPENDIX – I

Prof : Jebamani Augustine, M.Sc., (N)
Principal

To

   The President,
   Manamadurai Union,
   Sivagangai District.

Respected Sir / Madam,

   Sub: Project work of M.Sc., Nursing student in rural area
   around Manamadurai.

   I am to state that Mrs. Karthiha one of our final year M.Sc., Nursing students has to conduct a project, which is to be a partial fulfilment of university requirement for the degree of Master of Science in Nursing.

   The topic of research is "A study to determine the quality of life among the permanent contraceptive adopters and non adopters at selected rural areas in Sivagangai district "

   Kindly permit her to do the research work in your rural area.

   Thanking you.

Place: Yours faithfully,
Date :   Prof. Mrs. Jebamani Augustine
                                              (PRINCIPAL)

APPENDIX - II

Letter seeking experts opinion for content validity of the tool

From

      Mrs. Karthiha
      M.Sc.Nursing , II Year,
      Matha College of nursing, Manamadurai.

To

Through : The Principal, Matha College of Nursing , Manamadurai.

Respected madam,

      Sub: Requisition for getting expert opinion and suggestion for content validity of the tool.

      I am a second year master degree student in Matha College of Nursing, Manamadurai. In partial fulfilment of Master Degree in Nursing. I have selected the topic mentioned below for the research project to be submitted to the Dr. MGR Medical university, Chennai.

Problem statement:

      "A study to determine the quality of life among the permanent contraceptive adopters and non adopters at selected rural areas in Sivagangai district "

      I request you to kindly validate the tool and give your expert opinion for necessary modification and also I will be very grateful if you refine the problem statement and objectives.

ENCL :

      Statement of the Problem
      Objectives
      Hypothesis
      Research Tool
            Demographic profile
            WHO quality of life modified scale
            Checklist & Rating Scale

Thanking you

Place : Manamadurai

Date :   Yours faithfully

                                       Mrs. Karthiha

APPENDIX – III

List of Experts Consulted for the Content Validity of Research Tools

1. **Dr. Chalice Raja, M.S., D.G.O.,**
   Infant Jesus Hospital,
   Madurai.

2. **Jebamani Augustine, M.Sc.,(N), RN., RM.,**
   Principal cum HOD, Medical Surgical Nursing,
   Matha College of Nursing,
   Manamadurai.

3. **Mrs. Sabeera Banu, M.Sc.,(N), Ph.D.,**
   Vice Principal,
   Matha College of Nursing,
   Manamadurai.

4. **Mrs. Helan Rajamanickam, M.Sc.,(N),**
   HOD of Community Health Nursing,
   Matha College of Nursing,
   Manamadurai.

5. **Mrs. Juliet, M.Sc.,(N), Ph.D.,**
   Professor, HOD of Community Health Nursing,
   Sacred Heart Nursing College,
   Anna Nagar, Madurai.

6. **Mrs. Thamarai Selvi, M.Sc.,(N)**
   Professor,
   Matha College of Nursing,
   Manamadurai.

APPENDIX IV

SECTION –I
DEMOGRAPHIC DATA

Sample No:

Date:

1. Age   (   )

   a) 20 – 25 yrs

   b) 26 - 30 yrs

   c) 31 - 35 yrs

   d) 36 - 45 yrs

2. Education : Wife   (   )

   a) Elementary Education

   b) Higher Secondary Education

   c) Graduate & Post Graduate

3. Education : Husband   (   )

   a) Elementary Education

   b) Higher Secondary Education

   c) Graduate & Post Graduate

4. Occupation- wife   (   )

   a) Government or private

   b) cooly

   c) House wife

5. Occupation – husband   (   )

   a) Skilled Worker

   b) Un skilled Worker

   c) Unemployed

6. Monthly Income   (   )

    a) Less than 2500

    b) 2500 – 5000

    c) Above 5000

7. Type of Family   (   )

    a) Nuclear Family

    b) Joint Family

8. Religion   (   )

    a) Hindu

    b) Christian

    c) Muslim

    d) Others

9. Parity   (   )

    a) Less than two

    b) More than two

10. No of Children   (   )

    a) 1 – 2

    b) 3 – 4

    c) 5 and above

11. Own House   (   )

    a) Yes

    b) No

12. Latrine facilities   (   )

    a) Yes

    b) No

13. Smoke outlet   (   )

   a) Yes

   b) No

14. Three times meal per day   (   )

   a) Yes

   b) No

15. Prefer Non-Veg weekly once   (   )

   a) Yes

   b) No

16. TV/ Radio   (   )

   a) Yes

   b) No

17. Vehicle   (   )

   a) Yes

   b) No

18. Land   (   )

   a) Yes

   b) No

SECTION II

Read the Question carefully and choose the correct and appropriate answer

	Yes	No
Physical problems:		
1. Backache & Body Pain		
2. Irregular Bleeding		
3. Prolapse uterus		
4. white discharge		
5. weight gain		
6. Fatigue / Tiredness		
7. Undernourishment		
8. Anaemia		
9. Sleep pattern disturbances		
10. Sexual disturbances		
Psychological Problems:		
11. Anger		
12. Irritation		
13. Excitement		
14. Depression		
15. Anxiety about future		
16. Blaming		
17. Lack of Co-operation from family members		
18. Dis-satisfaction from Partners		

SECTION III

Read the statement carefully and choose the appropriate answer.

Key : Strongly Agree – SA   Agree – A   Disagree – D   Strongly Disagree - SD

	SA	A	D	SD
Scio-economic status:				
1. Enjoy your life.				
2. Able to accept physical appearance which is changed after giving many births.				
3. Your medical expense is high.				
4. Able to satisfy basic needs of your family. (food clothes etc)				
5. You are satisfied with health status.				
6. You are satisfied with your personal relationship				
7. You spend more time with Children.				
8. You feel that you are exhausted with child care activities.				
9. You feel that you are overloaded with household work				
10. You are able to meet educational need of your children				
11. You are able to meet nutritional needs of your family				
12. You feel that your quality of life is good				
13. You are able to maintain healthy environment				
14. You are able to concentrate all the family member's health				
15. You are afford to meet recreational /entertainment need of your family.				
16. You are able to involve/participate in social gatherings.				
17. You are able to celebrate festivals with adequate facilities.				
18. You have the opportunity for leisure activities.				

SCORE KEY

Part : II   No – 1   Yes – 0

Part : III   SA – 4, A – 3, D – 2, SD - 1

gpupT - I

jdp egu; tpguk;

gq;Fjhuupd; FwpaPL :

Njjp :

1   taJ
   a)   20 - 25 Mz;Lfs;
   b)   26 - 30 Mz;Lfs;
   c)   31 - 35 Mz;Lfs;
   d)   36 - 45 Mz;Lfs;

2   kidtpapd; fy;tp
   a)   Muk;gf; fy;tp
   b)   Nkdpiyf; fy;tp
   c)   gl;lk;> gl;l Nkw;gbg;G

3   kidtpapd; njhopy;
   a)   murhq;fk;/jdpahu;
   b) $yp
   c)   FLk;gj;jiytp

4   fztdpd; fy;tp
   a)   Muk;gf; fy;tp
   b)   Nkdpiyf; fy;tp
   c)   gl;lk;> gl;l Nkw;gbg;G

5   fztdpd; njhopy;
   a)   gbj;j Ntiy
   b)   gbf;fhj Ntiy
   c)   Ntiyapy;yhjtu;

6   khj tUkhdk;
   a)   &.2500/-f;Ff; fPo;
   b)   &.2500/- - &.5000/-
   c)   &.5000/-f;F Nky;

7   FLk;g tif
   a)   jdpf; FLk;gk;
   b) $l;Lf;FLk;gk;

8   kjk;
   a)   ,e;J
   b)   fpwp];jtu;
   c)   K];yPk;
   d)   kw;wit

9   gpurtq;fspd; vz;zpf;if
   a)   ,uz;Lf;Ff; fPo;
   b)   ,uz;Lf;F Nky;

10 Foe;ijfspd; vz;zpf;if
   a)   1 - 2
   b)   3 - 4
   c)   5f;F Nky;

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11 nrhe;j tPL

   a) Mk;

   b) ,y;iy

12 fopg;gpl trjp

   a) Mk;

   b) ,y;iy

13 Gifg;Nghf;fp

   a) Mk;

   b) ,y;iy

14 xU ehisf;F %d;W Ntis czT

   a) Mk;

   b) ,y;iy

15 thuj;jpw;F xUKiw mirt czT

   a) Mk;

   b) ,y;iy

16 njhiyf;fhl;rp / thndhyp

   a) Mk;

   b) ,y;iy

17 thfdk;

   a) Mk;

   b) ,y;iy

18 ed;nra; / Gd;nra;

   a) Mk;

   b) ,y;iy

gpupT - II

thf;fpaj;ij thrpj;J Mk;/,y;iy vd bf; nra;aTk;

t. vz;	tpguk;	Mk;	,y;iy
	cly; uPjpahf		
1	KJF typ / clk;G typ		
2	khjtplha; xOq;fpd;ik		
3	fUg;ig ,wq;Fjy;		
4	nts;isg;gLjy;		
5	cly; gUkd;		
6	Nrhu;T		
7	Cl;lr; rj;J gw;whf;Fiw		
8	,uj;j Nrhif		
9	J}f;fkpd;ik		
10	clYwT njhe;juT		
	kd uPjpahf		
11	Nfhgk;		
12	vupr;ry;		
13	mjpf czu;r;rp trg;gLjy;		
14	kd mOj;jk;		
15	vjpu;fhyj;ijf; Fwpj;j gak;		
16	mLj;jtiuf; Fiw $Wjy;		
17	FLk;g egu;fspilNa xw;Wikapd;ik		
18	fztdplk; jpUg;jpapapd;ik		

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gpupT - lll

thf;fpaj;ij thrpj;J rupahd tpilia bf; nra;aTk;

t. vz;	tpguk;	SA*	A*	DA*	SDA*
	r%fg; nghUshjhu epiy				
1.	re;Njh\khd tho;f;if				
2.	gy gpurtq;fSf;Fg; gpwF cly; khw;wj;ij xj;Jf; nfhs;Sjy;				
3.	mjpf kUj;Jt nryT				
4.	mbg;gil trjpfis G+u;j;jp nra;jy;				
5.	MNuhf;fpak; epiwT				
6.	epiwthd cwT Kiw				
7.	gps;isfsplk; mjpf Neuk; nrytpLjy;				
8.	gps;isfisf; ftdpf;Fk; Kiwfshy; Nrhu;T milAk; czu;T				
9.	mjpf tPl;L Ntiyg; gSthy; czu;T				
10.	fy;tp Njitfis G+u;j;jp nra;a Kbjy;				
11.	Cl;l rj;J Njitfis G+u;j;jp nra;a Kbjy;				
12.	vd; tho;f;ifj; juk; ed;whf cs;sJ				
13.	Rfhjhu #oiy ghJfhf;f KbAk;				
14.	FLk;gj;jpy; vy;NyhUila eyidAk; fUj;jpy; nfhs;s KbAk;				
15.	gps;isspd; nghOJNghf;fpw;F nryT nra;a KbAk;				
16.	r%f epfo;Tfspy; gq;F nfhs;s KbAk;				
17.	tpohf;fis NghJkhd trpfSld; nfhz;lhl KbAk;				
18.	vdf;F ,isg;ghw Neuk; cz;L				

Fwpg;G :

* (SA – cWjpahf xj;Jf; nfhs;sy; A – xj;Jf; nfhs;sy; DA – kWj;jy; SDA – cWjpahf kWj;jy;**;)**

TEACHING MODULE

Topic	:	Permanent family planning methods
Group	:	Multipara Mothers (Non-adopters)
Place	:	Village
Time	:	30 Minutes
Method of Teaching	:	Lecture cum Discussion
Teaching Aid	:	Charts & Flash Cards
General Objective permanent	:	The teacher will be able to provide adequate information on family planning methods to the multipara mothers individually.
Specific Objectives	:	The mother will be able to

> ➢ define permanent family planning

> ➢ list out the methods of permanent family planning.

> ➢ describe female sterilization.

> ➢ enumerate the guidelines for sterilization

> ➢ mention the selection criteria of serilization.

➢ explain complications, advantages & post operative advice.

Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation
Introduction of the topic to the mother	**Introduction (Vanakkam)** Pregnancy and giving birth to a child is one of the happiest moment in the life of a women and her family, it is very essential to presence this happiness throughout the life. You have given birth to a healthy baby and it is your responsibility to maintain and promote the health of your child and also your health. Planning and decide the family size is very important to promote the health of the family as well as our nation. By becoming aware of the permanent method of family planning, its	Wishes the mother and introduce herself and the topic	Listening		

Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation
	advantages and disadvantages you will be able to select the best method that suits you and practice it successfully.				

Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation

	Permanent Family Planning
	
	It is a well established contraceptive procedure for couples desiring no more children.
	
	Methods of Family Planning
	
	1. Natural Methods
	
	   a) Rhythm method
	
	   b) Lactational amenorrhoea
	
	2. Temporary Methods or spacing
	
	   a) Copper T
		Explaining	Listening	Chart & Flash Card	

Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation
	b) Oral Pill c) Injectable Contraceptive d) Condom				

	3. Permanent Methods
	
	    a) Laproscopy
	
	    b) Female Sterilization or tubectomy
	
	    c) Male sterilization or non scalpel
	
	      vasectomy
	
	Laproscopy
	
	    This is a technique of female sterilization
	
	through abdominal approach with a no				

associated medical disorders

eg: Heart disease, Hyper tension

Specialised instrument is called

"laproscopy" used for visualize the tubes.

Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation
	Female Sterilization (Tubectomy) It can be done as an internal procedure during post partum or at the time of abortion. **Vasectomy** is a simple operation, to remove a piece of vas atleast 1cm after clamping & sutured in position.	Explaining	Listening	Flash Card	List down the methods?

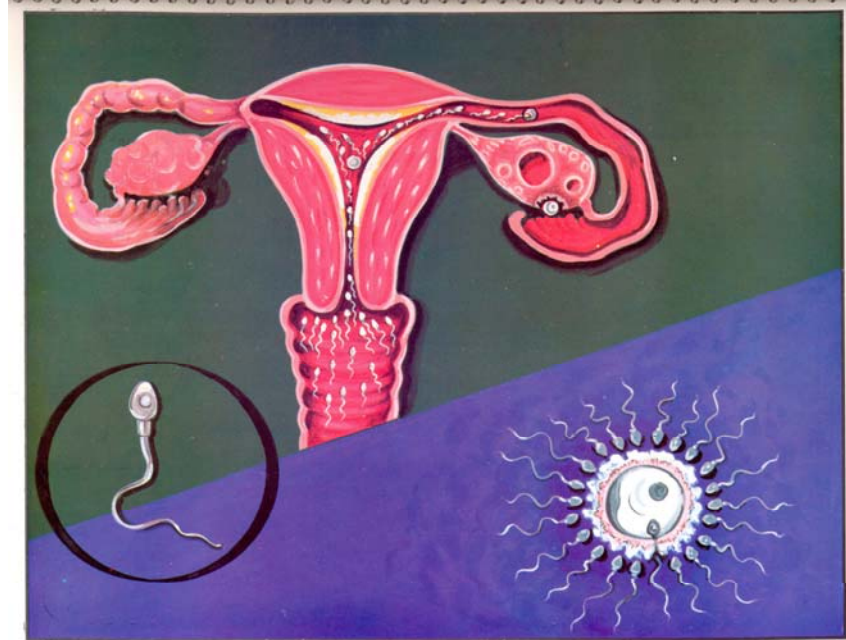| Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation
	Guidelines for sterilization: ➤ The age of the wife should not be less than 20 years or more than 45 years. ➤ The motivated couple must have 2 living children at the time of operation. ➤ Obtained the consent of her spouse to undergo sterilization.	Explaining	Listening & asking questions	Chart	What are the guidelines for sterlization ?
	Patient Selection: During the post partum period after delivery, Haemoglobin level should be less than 8 and no medical disorders. eg: hypertension, diabetes, heart disease & respiratory diseases. Complications:	Explaining	Listening	Chart	What are

Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation
	Although complications are uncommon when they do occur they may be of a serious nature requiring experienced surgical intervention. Puncture of large blood vessels and other potential complications have been reported an major hazards of laprascopy. Laproscopic sterilizations have become very popular in India. Rarely pregnancy can occur.				the complicati-ons?
	Advantages of permanent family planning: ➢ Improve the health of the mother & family. ➢ It gives more sexual satisfaction in life. **Post operative advice:** ➢ To avoid bath for atleast 24 hrs after				

	operation.				
	➢ To avoid lifting heavy weights for 6 months, no need for complete bedrest.				
	➢ Remove the stitches on the 7th day after the operation.				
	➢ Advice to take nutritious diet.				
Specific Objectives	Content	Teachers Activity	Learners Activity	Avaids	Evaluation
	Advantages of small family norm: ➢ Small family size plays a very important role in the health & welfare of not only the individual family & community but also the				

	nation. ➢ To control population ➢ To reduce Infant mortality & maternal mortality rate.				
	Conclusion: So far we have discussed about the permanent family planning method, definition. Types and guidelines for sterilization, complications, advantages and post operative advice.				

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fU¤jil KiwfŸ _‹W tif¥gL«:

1. Ïa‰if KiwfŸ:

(m) g¤Âukhd gUt Kiw,

(M) jhŒ¥ghš bfhL¥gj‹ _y« fUÎWjiy¤ jL¤jš

2. j‰fhèf KiwfŸ:

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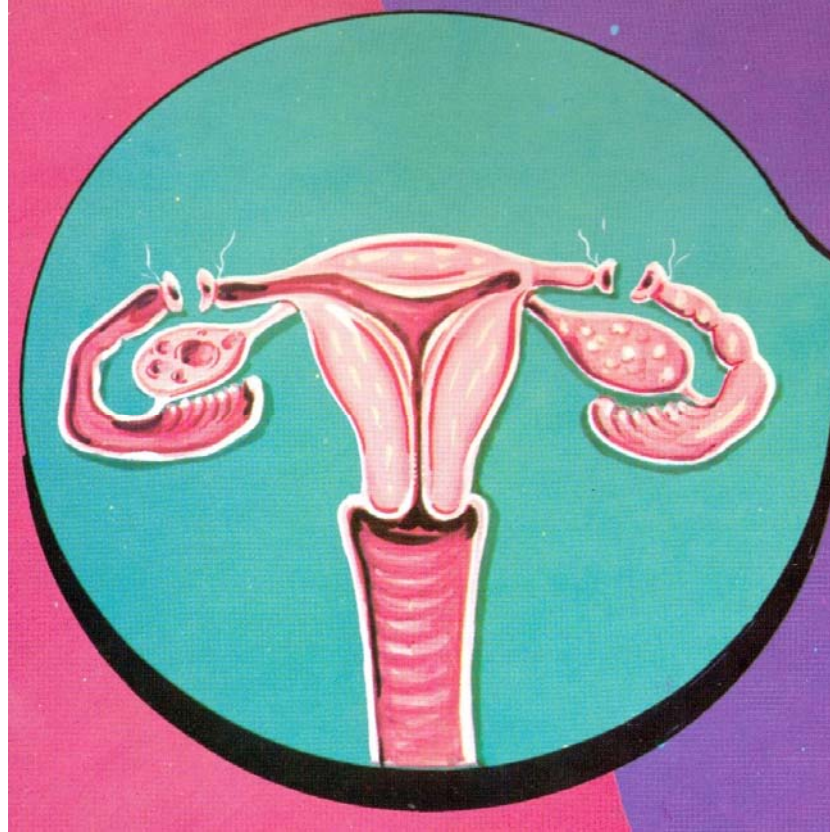
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3. ãuªju KiwfŸ:

(m) bg©fS¡fhd eÅd mWit Á»¢ir (yh¥uh°

nfh¥Ã), (M) bg©fS¡fhd rhjhuz mWit Á»¢ir,

(Ï) M©fS¡fhd jG«Ãšyhj mWit Á»¢ir (thr¡lä)

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motæ‰W¥ gFÂæYŸs Áid¡ FHhŒfis mWit
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ãuªju fU¤jil KiwahF«.

Tamil Font: VANAVIL-Avvaiyar

- rpWFLk;gk; vd;gJ tPl;bw;Fk;>

  rKjhaj;jpw;Fk; kl;Lkpd;wp ehl;bw;Fk;

  ngUk; gydhf ,Uf;Fk;.

- kf;fs; njhifia fl;Lg;gLj;j cjTfpwJ.

- jha;> Nra; ,wg;G tpfpjj;ijf; Fiwf;fpwJ.

  "Á¿a FL«g«,
  Óuhd thœÎ"