

## ANNEXURE – I

Phone : 04256 - 247321



### SRI ADICHUNCHANAGIRI SHIKSHANA TRUST

DHARMARATHNAKARA DR. MAHALINGAM INSTITUTE OF PARAMEDICAL SCIENCES & RESEARCH

(Kannada Linguistic Minority Institution)

Sakth Nagar - 638 315. Bhavani Taluk, Erode District, Tamilnadu.

Ref. No. **LETTER SEEKING PERMISSION ON CONDUCT PILOT STUDY**.....

From

Mr. Alex K George, M.Sc., (N) II Year,  
(Speciality – Community Health Nursing),  
Dr. Mahalingam College of Nursing,  
Sakthi Nagar (Po),  
Bhavani (TK), Erode (DT),  
Tamilnadu.

To


CHAIRMAN  
APPAKUDAL TOWN PANCHAYAT,  
SAKTHI NAGAR (PO),  
BHAVANI

Through,

The Principal,  
Dr. Mahalingam College of Nursing,  
Sakthi Nagar (Po),  
Bhavani (TK), Erode (DT).

Respected Sir / Madam,

SUB : Request for the Validation of the tool. .

  
PRINCIPAL  
COLLEGE OF NURSING  
DHARMARATHNAKARA DR MAHALINGAM INSTITUTE  
OF PARAMEDICAL SCIENCES AND RESEARCH  
SRI ADICHUNCHANAGIRI SHIKSHANA TRUST

I the II year M.Sc., Nursing student of Dr. Mahalingam College of Nursing, Sakthi Nagar. As a partial fulfillment of Master of Science in Nursing, I have undertaken the following research study, which has to be submitted to The Tamilnadu Dr.M.G.R. Medical University, Chennai.

#### RESEARCH STUDY :

“A STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAM REGARDING KNOWLEDGE AND ATTITUDE OF FAMILY PLANNING METHODS AMONG THE SELECTED RURAL MALE POPULATION LIVING IN PARUVACHI VILLAGE AT ERODE DIST”



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Sakthinagar - 638 315. Bhavani Taluk, Erode District, Tamilnadu.

Ref. No.

Date : .....

... 2 ...

To achieve the objective of dissertation, I have prepared the following tools:

- I. Demographic data and
- II. Standard Questionnaire

With regard to this, I kindly request you to go through the tools and validate it against the given criteria and render your valuable suggestions that will keep in improving the study at an earliest.


Thanking you in anticipation,

Yours Sincerely,

(Alex K George)

**Enclosures:**

1. Demographic data
2. Blueprint and Standard Questionnaire
3. Criteria check list for evaluation of tool
4. Content validity certificate for tool.
5. Self addressed cover.

  
**CHAIRMAN,**  
Appakkudal Town Panchayat,  
Sakthi Nagar-638 315  
ERODE DISTRICT.



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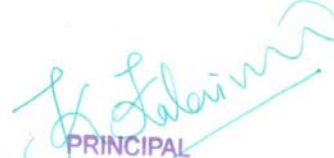
The President,  
Paruvachi Village,  
Bhavani Tk,  
Erode dist

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P. S. Rajagopal  
ಶಾಖಾಧಿಕಾರಿ  
ಪ್ರಾಥಮಿಕ ಶಿಕ್ಷಣ



## ANNEXURE – III

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Topic entitled:

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His content for the study is validated and was found reliable.

Date:

Place:

Signature of guide with seal

MRS. K. LAKSHMI DEVI, M.Sc (N),

READER

SRI VIJAY VIDYALAYA COLLEGE OF

NURSING

DHARMAPURI.

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Place:

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M. AROCKIA MARY, MSc (N)

READER

SRI SAKTHIMAYEIL INSTITUTE OF

NURSING & RESEARCH

KOMARA PALAYAM.



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Date:

Place:

Signature of guide with seal

N. S.  
[Dr. N. Sumanth]



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**His content for the study is validated and was found reliable.**

Date:

Place:

*K. Duraim*  
Signature of guide with seal

*K. DURAIM*  
Professor of Statistics



**CERTIFICATE BY THE MANUSCRIPT EDITOR**

This is to certify that the dissertation entitled **“A study to assess the effectiveness of the structured teaching programme on knowledge and attitude regarding family planning methods among the selected rural male population living in Paruvachi Village, Bhavani Taluk, Erode District”** is a bonafide research work done by **Mr.Alex K. George**, II Year M.Sc., (Nursing) student of Dharmarathnakara Dr.Mahalingam Institute of Paramedical Sciences & Research, Sakthi Nagar, Bhavani Taluk, Erode District. Mrs.T.S.Sumithra Devi., M.A., M.Phil edited this manuscript on behalf of the partial fulfillment of the prerequisite for the degree of **Master of Science in Nursing** (Specialty: Branch – IV, Community Health Nursing).

**Date:**

**Signature of the Editor**

**Place: Sakthi Nagar.**

## **LIST OF EXPERTS :**

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4. Mrs.K.Lakshmi Devi,M.Sc(N)  
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Dharmapuri.
5. Prof.M.Dhanapal,M.Sc,Ph.D,  
Professor,  
Dr.Mahalingam College of Nursing,  
Sakthi Nagar(po),  
Bhavani.
6. Mrs.Sumithra,M.A,M.Phil.,  
Lecturer in English,  
DMIPSR,  
Erode.

# CHAPTER I

## INTRODUCTION

### CURRENT DEMOGRAPHIC SCENARIO

India, currently the second most populated country in 17% world's population is less, than three percent of earth's land area. India began the 20<sup>th</sup> century with the population about 238 million and doubled in 60 year to 439 million (1961) doubled aagain, this time in only 30 years to reach 846 million by: 1991 it crossed 1.210 billion in 2011. While the global population has increased three times during the last century in the same period. India's population is excepted to exceed that of china before 2030 to become the most popular countey in the world.

**[www.google.com](http://www.google.com)**

The high growth rate in India is a threat to its developmental plans and the unlimited urbanization has cause various problem like unemployment over crowding and environmental pollution. If the gains of economic development are not to be effect by a rapid increase in the population there is no escape from family planning. Family planning is defined by WHO as a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitude and responsible decision by individuals and couples in order to promote the health and welfare of the family groups and thus contribute effectively to the social development of country. It is seen that the socio economic and demographic influences are factors which are important for the acceptance and actual practice of family planning. An adequate knowledge about the various contraceptives available is also a pre-requisite. An understand of the knowledge and attitudes of people is necessary for the success of any family planning programme.

India in the middle of demographic transition. Both fertility and mortality have started declining throughout the country, though the pace and magnitude of the decline varies considerably across the states. Like many countries of the world, the onset of mortality decline preceded the onset of fertility decline by few decades. The country has witnessed significant improvements in demographic and health indicators since independence. But an accurate assessment of India's demographic achievements is estimates of fertility and mortality levels at the time of independence are believed to be gross under estimates. None the less, even the suggest significant achievements in this fluid. The crude birth rate, which was officially put at 42 per 1,000 in 1951-61, has declined to 22.8 in 2008, as per the estimates available from the sample registration system (SRS). The life expectancy at birth, which was about 32 years at the time of independence, has doubled, infant mortality rate has come down from about 150 in 1951 to 21 by 2013.

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Considering the size and diversity of India's population, the decline in both fertility and mortality is a significant achievement. Nearly one-third of India's population has lowered its fertility to replacement level. Fertility in India has come down under a wide range of socio-economic and cultural conditions. Despite this achievement many are concerned with the pace of fertility decline, particularly in the large, north Indian states. To overcome this, the northern region of India will need much more focused programmes and more investment not only in the provision of family welfare services but also for the overall socio-economic development.

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In the 1990s, Government of India began to reorient the programme in the light of recommendations made by a subcommittee of the National Development



Council, an expert group headed by Dr.M.S.Swaminathan, and more specifically to address the concerns expressed at the International Conference on population and Development held at Cairo in 1994.

Following a major review under taken with the support of the world bank and other agencies in 1994-95, method, specific contraceptives targets were abolished and the emphasis shifted a decentralized planning at district level based on community needs assessment and implementation of programmes aimed at fulfilling in met needs. The first phase of the reproductive the child health programme was launched in 1997 as a flagship programme that covered the entire gamut of safe motherhood, child health and RTI/STI diagnosis and care. The National Population Policy (NPP) articulated the new broad-based approach towards population stabilization and set long-term policy goals. A National Population Commission was also set up under the chairmanship of the Prime Minister of India to review monitor and give directions for the implementation of the NPP and to promote inter-sectoral coordination.

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## NEED FOR THE STUDY

### World Population Trends

At the beginning of the Christian era, nearly 2,000 year age world population was estimated to be around 250 million.

**Table 1**

#### WORLD POPULATION

<b>Year</b>	<b>Population (million)</b>	<b>Average annual growth rate (percent)</b>
1750	791	-
1800	798	0.4
1850	1262	0.5
1900	1650	0.5
1950	2526	1.1
1960	3037	1.79
1970	3969	1.92
1975	4066	1.89
1980	4432	1.72
1987	5000	1.63
1991	5385	1.7
1998	5884	1.6
2000	6054	1.7
2002	6225	1.1
2003	6313	1.1
2007	6655	1.4
2008	6734	1.2
2010	6908	1.23
2013	7.142billion	3.2

**Table 2****POPULATION SIZE AND GROWTH, INDIA, 2001-2011**

Census year	Population (in Million)	Growth over decade		Multiple of 1001
		Number (in	Percent	
1901	238,396	-	-	1.0
1911	252,093	13,697	5.7	1.1
1921	251,321	-772	-0.3	1.1
1931	278,977	27,656	11.0	1.2
1941	318,661	39,683	14.2	1.3
1951	361,088	42,428	13.3	1.5
1961	439,235	78,147	21.6	1.8
1971	548,160	108,925	24.8	2.3
1981	683,329	135,169	24.7	2.9
1991	846,421	163,092	23.9	3.6
2001	1,028,737	182,316	21.5	4.3
2011	1210.1	198.214	17.6	4.8

**Table 3**

**RANKING OF MOST POPULOUS STATES IN INDIA BY POPULATION  
SIZE 2011**

Rank	State	Population 01.03.2011 (in Million)	Percent to total population of India 31.03.2011
1	Utter Pradesh	199.581	16.49
2	Maharashtra	111.372	9.29
3	Bihar	103.804	8.58
4	West Bengal	91.347	7.55
5	Andhra Pradesh	84.665	7.00
6	Tamil Nadu	72.597	6.00
7	Madhya Pradesh	72.138	5.96
8	.	68.621	5.67
9	Karnataka	61.130	5.05
10	Gujarat	60.383	4.99

**Table 4**

**TOTAL FERTILITY RATES IN SELECTED DEVELOPED AND  
DEVELOPING COUNTRIES 1994 AND 2013**

<b>COUNTRY</b>	<b>1994</b>	<b>2010</b>	<b>2013</b>
India	3.7	2.6	2.4
Bangladesh	3.9	2.2	2.1
Nepal	4.8	2.7	2.5
Sri Lanka	2.3	2.3	2.2
Myanmar	3.6	2.0	2.1
China	1.9	1.6	1.7
Pakistan	5.5	3.4	3.2
UK	1.8	1.9	1.7
USA	2.0	2.1	2.0
Japan	1.5	1.4	1.5
Switzerland	1.5	1.5	1.2

**K. Park 22<sup>th</sup> Edition**

**Table 5**

**TOTAL FERTILITY RATE AROUND 2000 AND THE EXPECTED  
NUMBER OF YEARS IT WOULD TAKE TO REACH REPLACEMENT  
LEVEL FERTILITY, MAJOR INDIAN STATES**

<b>State</b>	<b>Total fertility rate (TFR) 2000</b>	<b>Expected (TFR) Total Fertility Rate 2013</b>
Andhra Pradesh	2.5	1.66
Assam	3.2	2.24
Bihar	4.3	3.43
Gujarat	3.0	2.25
Haryana	3.0	2.15
Himachal Pradesh	2.4	1.64
Karnataka	2.4	1.79
Kerala	1.9	1.65



Madhya Pradesh	3.9	2.95
Maharashtra	2.7	1.72
Orissa	2.9	2.27
Punjab	2.6	1.64
.Himachal pradesh	4.1	1.64
<b>Tamil Nadu</b>	2.0	1.64
Uttar Pradesh	4.6	3.21
West Bengal	2.4	1.71
All India	3.3	2.32

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**Table 6**

**USE OF CONTRACEPTIVE METHODS IN INDIA 1998-99 TO 2011-2013**

Methods	Percentage of married women ages 15-49 using contraception		
	1998-99	2002-08	2011-13
	Any method	48.2	53.0
Any modern method	42.8	45.7	47.3
Pill	2.1	3.5	12.1
IUD	1.6	1.9	23.7
Condom	3.1	4.8	38.1
Female Sterilization	34.2	34.3	53.9
Male Sterilization	1.9	0.9	0.7
Any traditional method	5.0	7.3	19.1
Periodic Abstinence	3.0	4.1	11.0
Withdrawal	2.0	2.7	3.8
Others	0.4	0.5	2.1
Not using a method	51.8	47.0	26.9

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**Table 7**

**INDIA IN COMPARISON WITH OTHER COUNTRIES**

Indicator	India	China	US A	Sri Lanka	Thailand
-----------	-------	-------	---------	-----------	----------

IMR/1000 live births	47	15.2	5.6	9.24	41
Under 5 mortality / 1000 live births	56	15	8	12	12
Fully immunized (%)	67	84	93	99	94
Births by skilled attendants	59	98	99	99	100
Health expenditure as% of GDP	7.3	5.2	17.7	3.2	3.9
Government share of Total expenditure (%)	53	40	51.2	56.1	72.3
Government health spending to total government spending (%)	5.2	14.9	26.2	8	23.1
Per capital spending in international dollars	59	278	860	97	202
			8		

**Source:** World health Report 2013, World health organization, General.

There are different ways of improving the responsiveness of health and family welfare system. Just increasing the budgetary provision will not yield the desired results unless it is accompanied by strategic reforms and programmes to involve communities in population stabilization. Health outcomes can be improved if local communities have a greater say in the provision of basic health care. To improve efficiency, based on the experience so far the following recommendations have been made.

1. Despite five decades of effort to promote the use of family planning methods, a large percentage of couples report unmet need for contraception. ANMs and ASHAs could be asked to identify the couples with unmet need in their area and address their concerns. As more than half of the unmet need is for limiting family size. Meeting the unmet need would call for significant expansion of sterilization services, especially in the large north Indian states

although the NRHM launched by the government of India acknowledged this issue.

2. India's family welfare programme placed heavy emphasis on sterilization as the major method of family planning. Many other Asian countries started their family planning programmes with spacing methods and then gradually introduced sterilization services requires well-trained medical personnel and well equipped facilities. A permanent method may not be preferred when levels of infant and child mortality are high, or because of religious beliefs. Therefore, sterilization should be the last resort than the first one in the contraceptive choices given to the public. So there is a need to expand the range of choices of contraceptives as well as to improve the quality of services provided to couples, both in rural and urban areas.
3. There is an urgent need to restructure the existing PHCs and SCs does it make sense to have the same number of ANMs per population in every state, given that birth –rates differ considerably from state to state, whether the government has the capacity and funds to adequately maintain and to operate the current level of infrastructure. How best we can attract qualified doctors to government health care institutions in rural areas. Answers to such persisting questions should be immediately found within the frame work of NRHM. Some successful experiments made to address these concerns should be carefully looked into for implementation at a wider scale.
4. There is a need for specially focusing on poorly performing districts based on the available data from the DGHS and facility surveys. To bridge the gap in essential health infrastructure and man power, state should have a more flexible approach. Care should be taken to ensure the uninterrupted supply of

essential drugs, vaccines and contraceptives of required quality and quantity to all the CHCs, PHCs and SCs.

5. The Panchayat Raj Institutions should play a bigger role in the supervision and monitoring of PHCs. In most states the PRI involvement is not very effective mainly because the health management committees are not functioning or not representing the poor. Even when the health committees are active they have no authority over medical and paramedical personnel. In many cases there is the need to develop better co-ordination mechanism between local self government's and health care institutions.
6. Consented efforts are necessary to improve the coverage and quality of registration of births, deaths, marriages and pregnancies. A motivated ANM, Anganwadi worker or ASHA can play an important role in this regard.
7. Strict enforcement of the child marriage restraint Act, 1976 implying prevention of marriages of girls and boys below the legally permissible ages of 10 and 21 respectively would facilitate not only reduction of high risk teenage pregnancies but also help in human resource development amongst these younger girls and boys during their formative years towards improvement in the quality of life in the long run. The group recommends a national campaign against child marriage, sex selection against the girl child and for promoting institutional delivery by the central and state governments.
8. Focused attention on antenatal and institutional delivery care would help towards reduction in neo-natal component of infant mortality as well as maternal mortality, which in turn has externalities towards better acceptance of the family welfare program interventions and thus accelerate the process of fertility transition and population stabilization.



9. To improve the operational efficiency of the programmes. The health management information system (HMIS) needs to be strengthened. The timely and accurate information gives the health managers the ability to monitor inputs and outputs of the system and help them to assess the costs and returns from various procedures. In many cases, measuring performance and distributing that information will automatically provide certain incentives for the service providers to problem.
10. The success of the family welfare programme depends to a great extent on the personnel working in various institution regular in service training to enhance their knowledge and skills and to familiars them with the new programmes should becomes a part of regular activity of the health department. They should also be in a position to develop local level healthy plans taking into account the health condition of the people and their requirements.
11. It is important to periodically assess the utilization of health services and customer satisfaction. Regular surveys both for clients as well as for health care providers, to be undertaken. The findings from these periodic surveys should provide feed back to the health department as well as to the local bodies.

The respondents of family planning surveys included women only focused on determinants of their contraceptive use but knowledge and attitude of male partners are seldom reported. But strengthening communication between partners about reproductive health will be rewarding. Thus recently the importance of male participation in promotion of reproductive health matters have received increasing attention first step towards increasing men's participation in reproductive health is

thus understanding knowledge, attitudes and practices of the male partners about a range of reproductive issues.

But in many developing countries males often dominate in taking important decisions in the family including with reproduction family size and contraceptive use. Participation of male not only helps in accepting appropriate contraception, but also in its effective use. So there is a need to understand the level of knowledge and attitudes of males towards family planning and the extent to which they perceive their responsibilities in family formation and reproductive health.

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### **STATEMENT OF THE PROBLEM**

“A STUDY TO ASSESS THE EFFECTIVENESS OF THE STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE AND ATTITUDE REGARDING FAMILY PLANNING METHODS AMONG THE SELECTED RURAL MALE POPULATION LIVING IN PARUVACHI VILLAGE, BHAVANI TALUK, ERODE DISTRICT”.

### **OBJECTIVES OF THE STUDY**

1. To assess the pre-test and post test knowledge and attitude of experimental and control group regarding family planning method.
2. To compare the pre-test and post test knowledge and attitude of experimental and control group.

3. To find out the correlation between knowledge and attitude of experimental and control group.
4. To find out the association between demographic variable with knowledge and attitude.

## **HYPOTHESIS**

**H<sub>1</sub>:** There will be significant difference between pretest and post-test knowledge and attitude of experimental group.

**H<sub>2</sub>:** There will be significant relation between knowledge and attitude in control and experimental group.

**H<sub>3</sub>:** There will be a significant association between knowledge, attitude and selected demographic variables.

## **ASSUMPTIONS**

- ❖ Structured teaching programme improves knowledge of rural men about family planning methods.
- ❖ Structured teaching programme improves the attitudes of rural men about family planning methods.
- ❖ It promote positive health behaviours of rural men that is practice of family planning methods.
- ❖ Population explosion can be decreased significantly if the men practice family planning methods.

## **OPERATIONAL DEFINITIONS**

### **Assess**

Measurement of knowledge of rural men as observed from the score based on interview schedule.

### **Effectiveness**

It refers to determine the extent to which the teaching programme has achieved the desired effect and is measured in terms of significant gain the post test knowledge of rural men.

### **Structured Teaching Program**

It is systematically developed instruction and teaching aids designed for a group of rural men to provide information regarding population explosion and family planning methods.

### **Knowledge**

Defined as the correct responses of rural men to the items in the structured interview schedule regarding family planning methods or information and skills acquired through experience or education.

### **Attitude**

Feeling a belief about something or some one or way of behaving.

### **Family Planning**

A way of thinking and living that is adopted voluntarily upon the basis of knowledge attitudes and responsible decision by individuals and couples in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country.

### **Rural Male Population**

It refers to the married men residing in Paruvachi area with their families.

### **LIMITATIONS**

- ❖ The result of the study could not be generalized. The study is conducted only in Paruvachi areas.
- ❖ The data was collected only from rural men those who were present in the study area and who have not adopted family planning methods.

- ❖ The study was limited to eligible couples who are residing in study areas at the time of data collection.

## **CHAPTER II**

### **REVIEW OF LITERATURE**

Review of literature is a key step in research process. Review of literature refers to an extensive, exhaustive and systematic examination of publications relevant to the research project. Nursing research may be considered a continuing process in which knowledge gained from earlier studies is an integral part of research in general. Before and research can be started whether it is a single study or an extended project, a literature review of previous studies and experiences related to the proposed investigations should be done. One of the most satisfying aspect of the literature review is the contribution it makes to the new knowledge, in sight and general scholarship of the researches. A researcher analyzes existing knowledge before delving into a new area of study while conducting a study, when interpreting the results of the study, and when making judgements about applications of a new knowledge in nursing practice.

A review of literature is a compilation of resources that provides the ground work for further study. It helps with the conceptualization of research problems and the determination of specific problems and the determination of specific methodology to be used for further exploration of the problems

Thus, review of literature is an essential step in the development of a research project. It helps the researcher to design the proposed study in a scientific manner. So as to achieve the desired result. It helps to determine the gaps, consistencies and inconsistencies in the available literature about a particular subject under the study.

This chapter attempts to present a review of studies done, methodology adopted and conclusion assured by earlier investigators which helps to study the problem in depth. The sources to obtain more information on the selected topic were

internet search, text book, published journal, editorials, conference proceeding published and unpublished thesis. In this chapter, the researcher presents the review of literature under the following headings:

1. Literature related to family planning methods.
2. Studies related to family planning methods.

## **I. LITERATURE RELATED TO FAMILY PLANNING METHODS**

### **1. Definition of Family Planning:**

“Family Planning is a way of thinking and living that it is adopted voluntarily, upon the basis of knowledge, attitude and responsible decisions by individuals and couples in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country (WHO 1971).

### **OBJECTIVES OF THE FAMILY PLANNING**

1. To avoid unwanted births.
2. To bring about wanted births.
3. To regulate about intervals between pregnancies.
4. To control the time at which birth occurs in relation to the age of the parents.
5. To determine the number of children in the family.

## **CONTRACEPTIVE METHODS**

### **Mainly two types:**

1. Spacing methods or temporary
2. Terminal methods or permanent.

### **1. CLASSIFICATION OF THE SPACING OR TEMPORARY METHODS.**

#### **1. Barrier methods**

- a) Physical methods.
- b) Chemical Methods



c) Combined methods

2. Intra uterine devices.
3. Hormonal methods
4. Post conceptional methods
5. Miscellaneous

## **2. CLASSIFICATION OF THE TERMINAL OR PERMANENT METHODS**

1. Male sterilization.
2. Female sterilization

### **1. TEMPORARY METHODS**

#### **1) Barrier Methods**

- a. Physical Methods:
  - i. Condom (Nirodh)
  - ii. Female Condom
  - iii. Diaphragm (Douch cap)
  - iv. Vaginal sponge
- b. Chemical methods:
  - i. Foams: Foams tablets, foam aerosols
  - ii. Cream jellies and pates – squeezed from a tube
  - iii. Suppositories- Inserted manually
  - iv. Soluble films – C – film , inserted manually.

#### **2) Intra- uterine devices**

- a. copper – T
- b. Lippes Loop

### **3) Hormonal contraceptives**

- a. Oral pills
- b. Injectables
- c. Subdermal implants

#### **a. Oral pills**

- i. Mala – N
- ii. Mala – D

#### **b. Injectables**

- ii. DMPA (Depot-medroxyprogesterone acetate)
- iii. NET – EN (Nor ethisterone emanate)

#### **c. Subdermal implants**

- “Norplant” is a highly effective, reversible, oestrogenfree long acting contraceptive it contains only progesterone.

### **4) Post conceptional methods**

- Abortion (MTP) Medical termination of pregnancy

### **5) Miscellaneous**

- ii. Abstinence
- iii. Coitus interruptus or withdrawal
- iv. Safe period (rhythm method)
- v. Breast feeding.

## **2. TERMINAL METHODS OF PERMANENT METHODS**

- i) Female Sterilization
- ii) Male Sterilization

## II. STUDIES RELATED TO FAMILY PLANNING METHODS

**Sep 2013**, Stantny yoder of ICF. Macro with the help of USAID. The topic was the use of family planning methods in mali.

The findings of this study point to four key conclusions about users and non-users of family planning among married women in three regions first women and men undustand the dangers posted by short birth intervals for the health of the mother and her children. Second they understand the benefits of contraceptive use, and few are opposed to family planning on priniciple, third women's experience in becoming socialized, finding a husband, and having children associated with the practice of family planning and women's ability to use contraception. Fourth; both women and men, often fail to apply their knowledge of the sphiazzy of births to their own situation.

**Kazerooni R., 2013, Takizwa Nigeria**The objective was to identify predictors of adherence to hormonal contraceptives in female vetran population. They concluded that hormonal contraceptive adherence in the vetran population in below optimal, providing 3 – month supplies of high – value therapies such as hormonal contraceptives is on straterg that may improve adherence. Initiatives to target lower socio economic status or new start populations to increase contraceptive adherence should also be considered.

**J. Biomed (2013)** study investigated on knowledge and accaptance of “vasectomy as a method of contraception amogst literate married men in Nigeria.

They concluded that vasectomy to an extent is unknown and even to those with knowledge; it is unacceptable owing to lack of information's failure of health workers to make male contraceptives information available and accesible. They recommend that health workers make available accurate and understandable

information's on vasectomy and also discuss family planning with patients irrespective of their main purpose for visiting the clinic.

**Igor Volsky, 2013 Feb, UK International,** Despite the claims of anti-abortion activists, the largest study ever conducted on the issue finding that abortion does not increase a women chance of developing mental health problems. Among women with un wanted pregnancies, those who had abortions were no more likely to suffer from problems including anxiety or depression than women who gave birth the research review by UK'S National collabrating centre for mental health foundation.

**Adam sonfield, 2013** studied about clinical clients in USA. They concluded that majority of the clients say that use of birth control to prevent pregnancy has helped them meet emotional, career, finacial and family goals and women with incomes below the federal poverty level have more than five times the unitendied pregnancy rate of women at 200% of poverty and greater.

**Marchi NM, (2012),** conducted study on contraceptive methods with male participation of Brazilian couples. They concluded that specific actions are necessary for men to achieve integral participation in relation to reproductive sexual health. These include education and discussions on gender roles, leading to great awareness in men of the realities of sexual and reproductive health.

**Bunce A, etal., (2011),** conducted studies on factors affectiing vasectomy acceptablity in Janzania. They concluded that spousal discussions are important in the decision to get a vasectomy but these discussions should be initiated by the male partner. programs need to educate men about contraceptive options, including vasectomies. Detailed, culturally relevant knowledge of the barriers and facilitators individuals experience during their decision making process will enable vasectomy promotion programs to more successfully target appropriate populations.

**Ziyane IS, Ehlers Vy(2011)**, Study investigated Swazi men's contraceptive knowledge, attitudes and practices, and Swazi men indicated that men were the sole decision makers about sexual and reproductive issues. This finding holds some promise for enabling more Swazi women to use contraceptives at least until they have completed their schooling contraceptive services were not readily accessible women in Swaziland.

**Costantino. A. et al, (2010)**, Study conducted on current status and future perspective on male contraception first clinic of objectives and Gynaecology S. Orsola Hospital, University of Olonga, Italy, Antonietta, Costantino evidences contraception is a crucial human right for its role on health, development and quality of life since the introduction of hormonal female contraception the burden of family planning has fallen mostly on women. The few methods of family planning available for men namely condom, vasectomy, periodic abstinence and withdrawal are hundred year old in concept are based on preindustrial practices and have low effectiveness or are difficult to reverse.

**Kaza. Rc, (2010)**, study investigated on No scalpel vasectomy among Maulana Azad Medical College, New Delhi, Male sterilization is less popular because of fear of loss of virility and loss of physical strength. No scalpel vasectomy is a surgical attempt to reduce complication and thereby allays the fear in the minds of the couples. Despite the introduction of the advanced technique the acceptance of male sterilization has not gone up. Though with aggressive IEC campaign has failed to produce the desired result, but a camp based approach was successfully adopted in some states of India. Technique of no scalpel vasectomy has been summarized in the article with diagrams. Some postoperative instructions should be given to the client after discharge. No scalpel vasectomy is the gold standard for vasectomy today.

Training is mandatory for experienced surgeons. Government of India funds and supports both training and service activity.

**Sadeghipoor Roudsari HR. et al, (2010)**, comparative study conducted on Reproductive health knowledge, attitudes and practices of Iranian and Afghan men in Tehran province. A questionnaire was used for the assessment means cores for knowledge, attitudes and practices for Iranians were 4.38/30, 13.89/20 and 12.99/31 respectively for Afghans the scores were 3.79/30, 11.66/20 and 11.88/31. Although the scores in both groups were low, Afghans showed significantly lower scores for attitudes and practices. Access to reproductive health services was the same for both groups further scrutiny of men's role in reproductive health, particularly social and cultural factors, is strongly recommended.

**Nuguyen. HN, et al, (2009)**, study conducted on knowledge of contraceptives and sexually transmitted diseases and contraceptive practices amongst young people in Ho Chi Minh City, Vietnam. They examine knowledge of contraceptives and sexually transmitted diseases (STDs) and contraceptives practices amongst young vietnamese people. They conducted a qualitative study on sexuality and abortion with young people in Ho Chi Minh city, Vietnam. Twelve female and 4 male young people were individually interviewed using an in depth interview technique. They found the condoms and pills were contraceptives known by almost all young people but their knowledge of condom and pills was still inadequate. Sexual education provided by educational institutions and within families was very basic.

**Tavakoli. R. Rashidi – Jahan. H, (2009)**, Cross sectional study was carried out on knowledge of and attitudes to family planning in male teachers working in the education system in Teheran. They found that 65% of the study population had acceptable knowledge regarding the issue, more than 95% of respondents reported

having a favourable attitude towards the implementation of family planning programmes and about 90% believed that decision making regarding use of contraceptives should be a joint process. To improve the planning and administration of family planning programmes. The main variables identified in this study should be further investigated in different population groups. Addressing men in family planning programmes may improve their success and lead to increased contraceptive use.

**Manhoso. FR, Hoga. LA, (2008)**, study conducted on men's experiences of vasectomy in the Brazilian public health service. An integrated public policy is required to promote male involvement in reproductive health family planning programmes must be meaningful socio culturally and the inclusion of men in these programmes is recommended. The use of anonymized video taped narratives or the recruitment of the men themselves during counselling about this method would be helpful for the resolution of reservations related to vasectomy. All the interviewed men expressed satisfaction with vasectomy and this feeling was mainly based on the certainty of the preservation of sexual performance.

**Espirito Santo. DC, (2007)**, study conducted on male views of contraceptive methods in a rural community in Bahia state. Brazil family planning programs have traditionally concentrated on women. This study aimed to determine men's knowledge of contraceptive methods in a rural community in Bahia state Brazil. Mean age of interviews was 40.0 (+1-17.6) years avoiding unwanted pregnancy was reported as a responsibility of the couple by 39.7% of the male interviewers (n=71) and as the men's responsibility by 26.8% (n=48). The most widely known methods were condoms (98.9%) and the pill (96.6%) condom (22.9%) female sterilization (21.2%) and the pill (12.8%) were the most widely used method. The majority of the

interviews (56.4%) reported that they 'always' use some method. The men chose the method in 45.6% of the couple.

**Durate. GA, et al, (2006)**, study conducted on male participation in contraceptive methods use. This study aimed to evaluate male participation in the use of contraceptive methods and to identify relevant variables. A secondary data analysis was conducted and the sample size was estimated at 175 men using contraceptive methods that require male participation. The study used the chi-square test to evaluate differences between groups, as well as multiple logistic regression analysis. Some 38% of interviewees used some birth control method that required male participation.

**Ndiaye. CA, et al, (2006)**, study conducted on knowledge and use of contraceptive methods in rural Senegal. This study presents results from a representative survey carried out in a rural setting in Senegal (on 804 20 to 69 year old men and 1,039 15 to 54 year old women) and aims at improving the understanding of contraceptive knowledge and practice. Contraceptive knowledge was measured through spontaneous and recognized contraceptive methods. Contraceptive practice was measured through the gap between spontaneously cited methods and recognized methods is important while about 80% of men and 70% of women had even heard about any contraceptive method only 46% of men and 23% of women could spontaneously mention a specific contraceptive method.

**Jenson. YT, (2005)**, study conducted on male contraception. Department of obstetrics and gynecology and division of reproductive sciences Oregon Health and Science University from a public health perspective the need for contraception has never been greater. Although the existing male specific methods (withdrawal, condoms and vasectomy) are safe and effective,



increasing male options for fertility control could improve family planning for new male contraceptive methods to have an impact. They must be acceptable to both men and women as well as effective. A male hormonal method will likely come to market within the next 5 years other strategies such as contraceptive vaccines and inhibitors of spermatogenesis and sperm motility provide a potential for nonhormonal male contraceptives.

**Ghazal – Aswad. S, (2004)**, study conducted on the knowledge and practice of contraception among men in the United Arab Emirates. They found that the level of awareness of contraception among men attending primary care in UAE is moderate. Two-thirds of the study subjects objected to the use of contraception by their wives and less than 20% practice contraception themselves. This is partly due to socio cultural traditions religious beliefs and poor knowledge.

## **CONCEPTUAL FRAME WORK**

The conceptual frame work is based on the general system theory of learning. A system is made up of separate components. The parts rely on one another, are interrelated share a common purpose and together form a whole. In systems model there is input, through put, output and feedback. The aims of the study was increased knowledge and attitude of rural men regarding family planning methods and improve the acceptance, Ludwig von Betterlanffy's consists of three components.

### **Input**

Input is a assessing the knowledge and attitude on family planning methods of the rural men by using interview schedule on various aspects such as definition of family planning, meaning, objectives, effects of population explosion, small family norms and its importance, hazards of the large and unplanned family and contraceptive methods (both temporary and permanent methods of family planning) family planning.

### **Throughput**

Throughput is the teaching programme regarding definition, meaning, objectives and effects of population explosion. Small family norms and its importance, hazards of the large and unplanned family and contraceptive methods (both temporary and permanent methods of family planning).

### **Output**

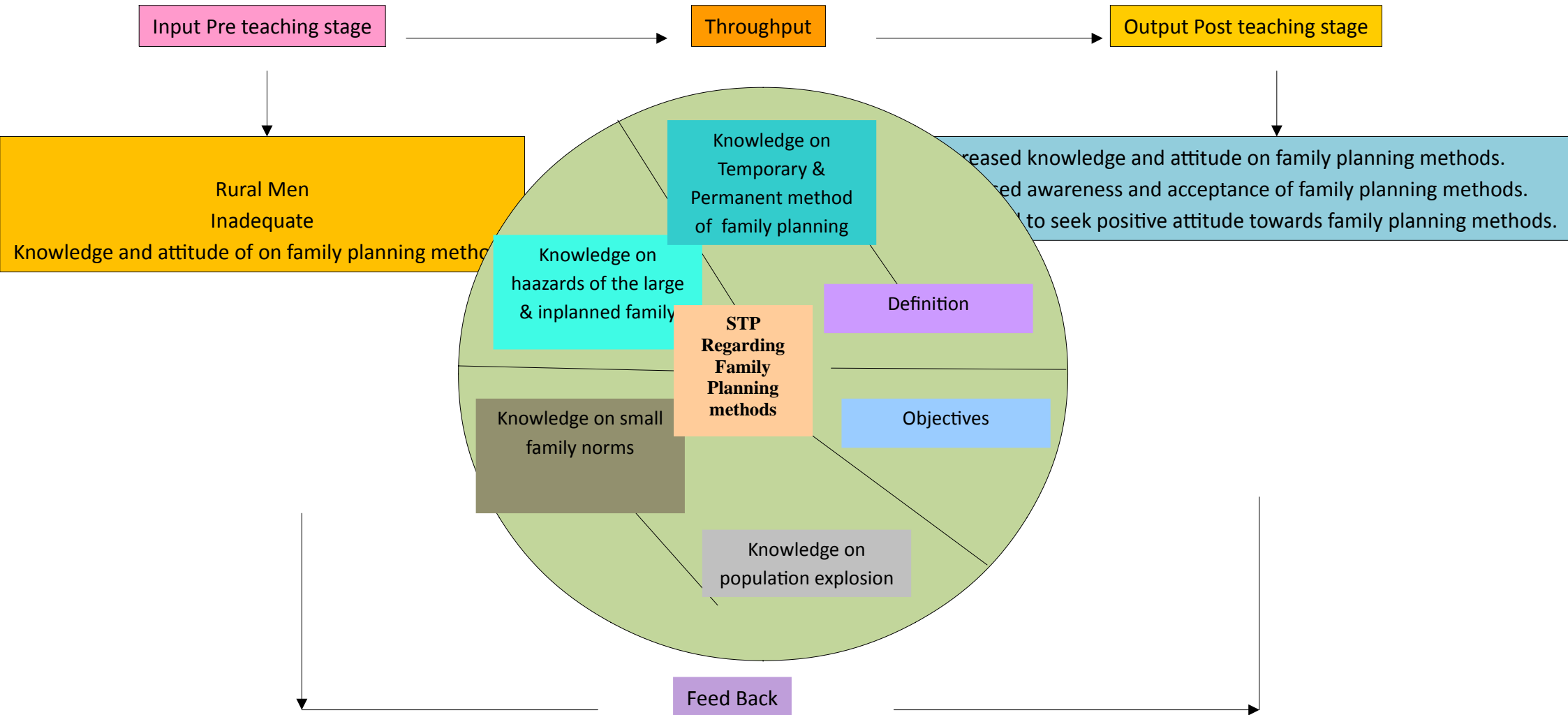
Output is increased knowledge and attitude on family planning methods and acceptance of family planning methods.

### **Feed Back**

Feed back is the evaluation of teaching programme by using the same pretest questionnaires.

**FIGURE: 1, CONCEPTUAL FRAME WORK BASED ON GENERAL SYSTEM THEORY (MODIFIED)**

**LUDWING WON BERTALANTTY'S GENERAL SYSTEM THEORY**



## **CHAPTER III**

### **METHODOLOGY**

Research Methodology is the systematic way to solve a research problem. Pearson (1992) stated that there is no shortcut to truth. There is no way to gain knowledge of universe except through the gate way of scientific method. Methodology is one, which enables the researcher to project a blue print of the research undertaken.

This chapter explains the methodology followed to assess the effectiveness of structured teaching programme on knowledge and attitude regarding family planning methods among the selected rural men residing in Paruvachiarea.

The research methodology presents the research approach and the research design. The design of the study describes about the setting of the study, population, the sample and sampling technique. The data collection technique, content validity and reliability of tools, pilot study and the method of data analysis based on the statement.

#### **RESEARCH APPROACH**

Experimental approach was used for this study.

#### **RESEARCH DESIGN**

“The research design refers to the researcher’s overall plan for obtaining answers to the research questions and for testing the research hypothesis. The research design spells out the strategies that the researcher adopts to develop information that is accurate, objective and interpretable”.

For this study the research design chosen is true experimental design, which includes.

M - Manipulation

C - Control

R - Randomization

The design chosen is pretest and post-test with control group. The design was used for assessing the level of knowledge and attitude of men regarding the family planning methods. It will be achieved through the comparison between two groups. The groups are experimental group and control group.

### **SCHEMATIC REPRESENTATION OF THE RESEARCH DESIGN**

A true experimental design, which include manipulation, control and randomization

Key

O<sub>1</sub> – Pre assessment

X – Structured Teaching Programme

O<sub>2</sub> – Post assessment

It is represented in figure.

### **VARIABLES**

Variables are the qualities, properties of characteristic of person. Things or situation that change or vary. The variables mainly included in this study are independent and dependent variables. Dependent variables explain the effect of independent variables.

#### **A) Independent Variable**

Independent variables are the variable that stand alive and is not dependent on any other. In this study, the independent variable refers to structured teaching programme, on knowledge and attitude of family planning methods.

## **B) Dependent Variables**

The dependent variable is the variable that the researcher is interested in understanding, explaining or predicting. In this study the dependent variable refers to knowledge and attitude of men in population at Paruvachi village, Bhavani Taluk, Erode District.

## **SAMPLING AND SAMPLING TECHNIQUES:**

### **POPULATION**

Men residing with in the Paruvachi area were the populations for the study who fulfill the criteria are selected as sample. Ethical clearance was obtained to conduct the study.

### **SAMPLE**

Married men whose wives are in the reproductive age or eligible for adopting methods of family planning.

### **SAMPLE SIZE**

The sample comprises 60 rural men who met the inclusion criteria and residing in Paruvachi area.

### **SAMPLING TECHNIQUE**

The investigator selected subjects by simple random sampling technique.

## **CRITERIA FOR SAMPLE SELECTION**

### **a) Inclusion Criteria**

- ❖ Men who are willing to participate in the study.
- ❖ Married men whose wives are in the reproductive age or eligible for adopting methods of family planning.
- ❖ Men who had not undergone permanent method of family planning.
- ❖ Men who were present during the data collection

### **b) Exclusion Criteria**

- ❖ Men with Psychiatric disorders
- ❖ Men who underwent vasectomy surgery
- ❖ Men who do not understand Tamil and English.

## **SITE**

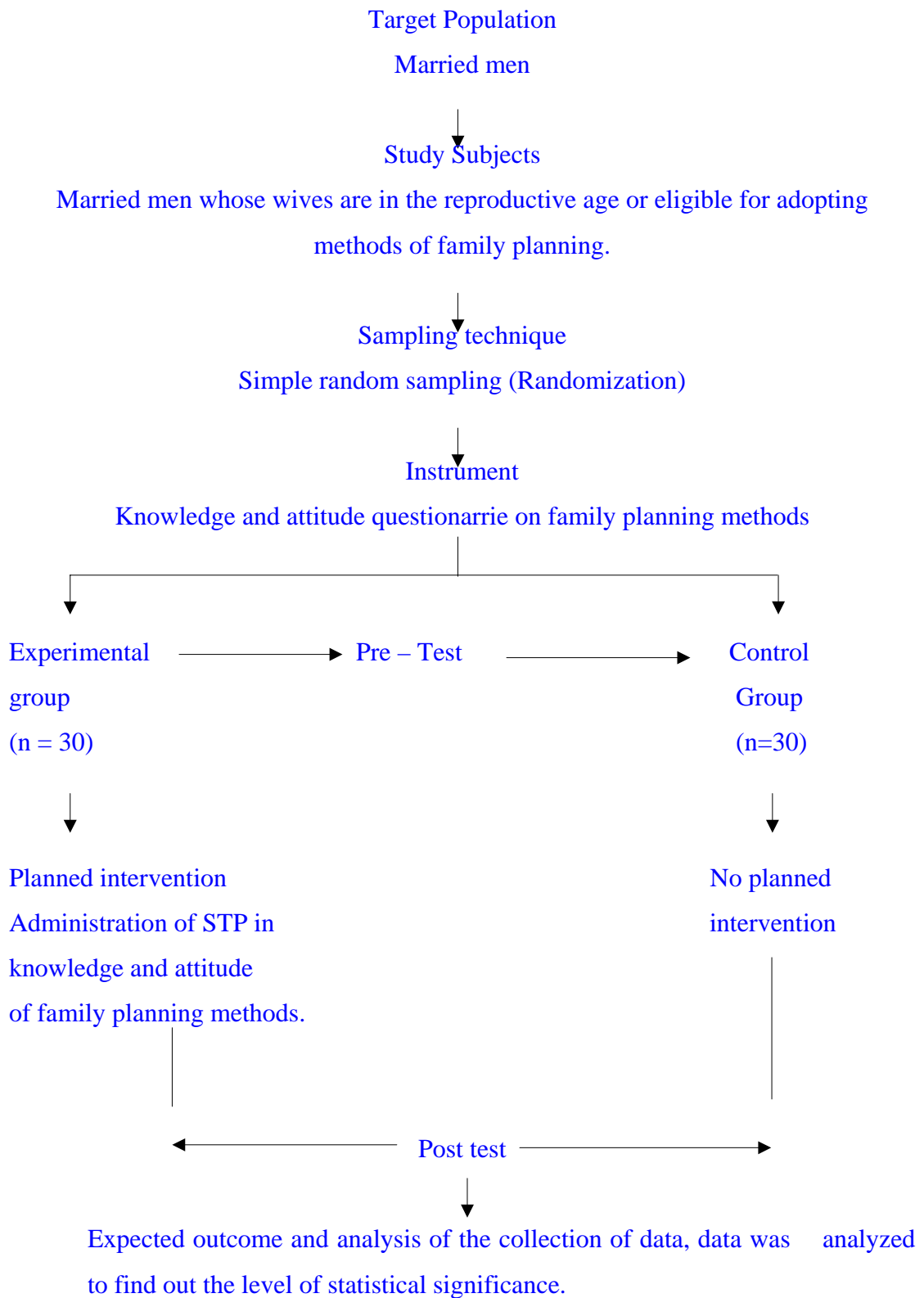
Bhavani Taluk, Erode District.

## **SETTING**

Setting is the physical location and condition in which data collections take place in a study.

The present study was conducted at Paruvachiarea, This comes under Bhavani Taluk, Erode District.

**FIGURE: 2, SCHEMATIC REPRESENTATION OF THE STUDY DESIGN**





## **DEVELOPMENT OF DATA COLLECTION INSTRUMENT**

The instruments selected in the research should be as far as possible the vehicle that would best obtain data for drawing conclusions, which are pertinent for the study.

The major task of the researcher is to develop instruments that accurately and precisely measure the variables of interest questioning allows gathering of large amount of information from a large sample, relatively quickly and responsively. It avoids interviewer bias offers anonymity and is cost effective.

To assess the knowledge and attitude of rural men a questionnaire was prepared based on objectives of the study by the investigator, after reviewing literature on family planning methods and considering the opinion of the nursing subject experts.

## **DATA COLLECTION INSTRUMENT**

- ❖ Structured Questionnaire (Pre test and Post Test)
- ❖ Structured teaching programme.

## **DESCRIPTION OF DATA COLLECTION INSTRUMENT**

The instrument used for data collection was structured questionnaire which consists of 4 sections.

- Section I - Demographic variables
- Section II - Structured questionnaires on knowledge
- Section III - Structured questionnaires on attitude
- Section IV - Structured Teaching Programme

## **SECTION I – DEMOGRAPHIC VARIABLES**

It consists of selected demographic, variables like age of eligible couple, number of children in family, educational status, occupational status, socio-economic status, religion.

## **SECTION II – STRUCTURED KNOWLEDGE QUESTIONNAIRE**

Structured questionnaire to assess the level of knowledge of the subjects on family planning methods.

It consisted of 20 items divided into 3 areas. They are

- ❖ Knowledge regarding the meaning of family planning – 7 items.
- ❖ Knowledge regarding temporary methods of family planning – 9 items.
- ❖ Knowledge regarding permanent methods of family planning – 4 items.

All the items were multiple choice questions, which had 3 alternative responses. A score value of 1 (one) was allotted to each correct response and for wrong response 0 (zero) was awarded. Thus there were 20 maximum obtainable scores.

### **KNOWLEDGE**

76 – 100%	-	Adequate
51 – 75%	-	Moderately Adequate
50% and below	-	Inadequate

## **SECTION III**

Attitude scale was used to assess that attitude of the subject on family planning methods.

It contains 20 questions related to men attitudes on family planning methods which should be responded as agree, uncertain and disagree.

Agree	-	3 marks
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Uncertain - 2 Marks

Disagree - 1 Marks

#### **SECTION IV**

##### **Structured teaching Programme on family planning methods**

The structured teaching programme was titled as “Structured teaching programme on family planning methods”.

The structured teaching programme was organized into various headings.

- a) Introduction related to family planning methods and population explosion.
- b) Objectives of family planning.
- c) Causes of population explosion.
- d) Temporary methods of family planning
- e) Permanent methods of family planning.

##### **CONTENT VALIDITY**

The content validity of the instrument was assessed by obtaining opinion from five experts in the field of nursing and medicine. The experts suggested simplification in language and reorganization and addition of certain items. Appropriate modifications were made accordingly and the tool was finalized.

##### **RELIABILITY**

The reliability is the degree of consistency or accuracy with which an instrument measures on attribute it is supposed to measure.

In order to establish reliability of the tool, it was administered to 6 men those are not in sample area. Reliability of the structured teaching programme was established through test – retest method knowledge and attitude questionnaire.

## **PILOT STUDY**

A pilot study is a small preliminary investigation of the same general character as the major study. It is designed to acquaint the researcher with the problems to be corrected in preparation for the larger research project and try out the problems for collecting the data". Pilot study was conducted to ensure validity and reliability of the tool and feasibility for giving intervention.

The pilot study was conducted in Appakodal, Bhavani Taluk, Erode District, Tamilnadu. After getting formal permission from through principal 6 sample were taken during the pilot study. They were selected by using simple random sampling method. 3 Sample in experimental group and 3 in control group who fulfilled the inclusion criteria other than the main study sample area. A Structured pretest and post test questions was used to collect data from the men during pilot study.

## **DATA COLLECTION PROCEDURE**

The study was conducted in Paruvachi village, Bhavani Taluk, Erode District. The period of data collection was from 10.09.2013 to 22.10.2013. A written permission was obtained from the president of Paruvachi area was made aware of the nature of the study and was assured that the study would not affect their daily routine. Men's who fulfilled the criteria were selected using simple random sampling technique method. The researcher introduced himself to the men and developed a good rapport with the men. The researcher assured the participants for the confidentiality of their responses.

The purpose of the study was explained to every sample. So as to get their full cooperation. Adequate privacy was provided and consent was taken.

A pre test questionnaire on knowledge and attitude of men on family planning method was administered for 15 to 20 minutes. The structured teaching programme

on family planning methods using chart, hand made flash cards, which was prepared by the researcher consulting the specialists. The structured teaching programme consisted of the information regarding definition, objectives, temporary and permanent methods of family planning. The teaching and the discussion lasted for period of 45 minutes. Certain points were repeated for better understanding and doubts were cleared and given a self instructional module to each men. After seven days the post test was administered to the same sample for 15 to 20 minutes regarding the knowledge and attitude on family planning methods using the same questionnaire. It took one month for the researcher to complete the process of this data collection involving 60 minutes.

#### **PLAN FOR STATISTICAL ANALYSIS**

The data were analyzed based on the objectives of the study using descriptive and inferential statistics.

1. Frequencies and percentages for the analysis of the demographic data.
2. Mean score, percentage and standard deviation for the knowledge score.
3. Computing ANOVA and Paired test association between the selected demographic variables, knowledge and attitude score.

## **CHAPTER IV**

### **ANALYSIS AND INTERPRETATION**

The data analysis is described as “categorizing, ordering, manipulating and summarizing the data to obtain answer to research questions.

The purpose of analysis is to reduce the data to an intelligible and interpretable form so that the relation of research problems can be studied.” The term analysis refers to a number of closely related operations, which are performed with the purpose of summarizing the collected data, organizing the data in such a manner that they answer the research questions.

The data was analyzed based on the objectives of the study. The objectives of the study were to:

- To assess the pre-test and post test knowledge and attitude of experimental group regarding family planning method.
- To assess the pre-test and post test knowledge and attitude of control group regarding family planning method.
- To compare the pre-test and post test knowledge and attitude of experimental and control group.
- To find out the correlation between knowledge and attitude of experimental and control group.
- To find out the association between demographic variable with knowledge and attitude.

### **ORGANIZATION OF FINDINGS**

The data have organized, tabulated, analyzed and interpreted by means of statistical tables and graphs. The data have presented under the following headings.

## **SECTION I**

Description of frequency and percentage distribution of selected demographic variables.

## **SECTION II**

Assessment of pre-test and post-test knowledge of experimental and control group regarding family planning method.

## **SECTION III**

Assessment of pre-test and post test attitude of experimental and control group regarding family planning method.

## **SECTION IV**

Comparison of pre-test and post test knowledge of experimental and control group regarding family planning method.

## **SECTION V**

Comparison of the pre-test and post test and attitude of experimental and control group regarding family planning method.

## **SECTION VI**

Correlation between knowledge and attitude of experimental and control group regarding family planning method.

## **SECTION VII**

Association between level of knowledge on family planning method with selected demographic variables in control and experimental group.

## **SECTION VIII**

Association between level of attitude on family planning method with selected demographic variables in control and experimental group.

## SECTION I

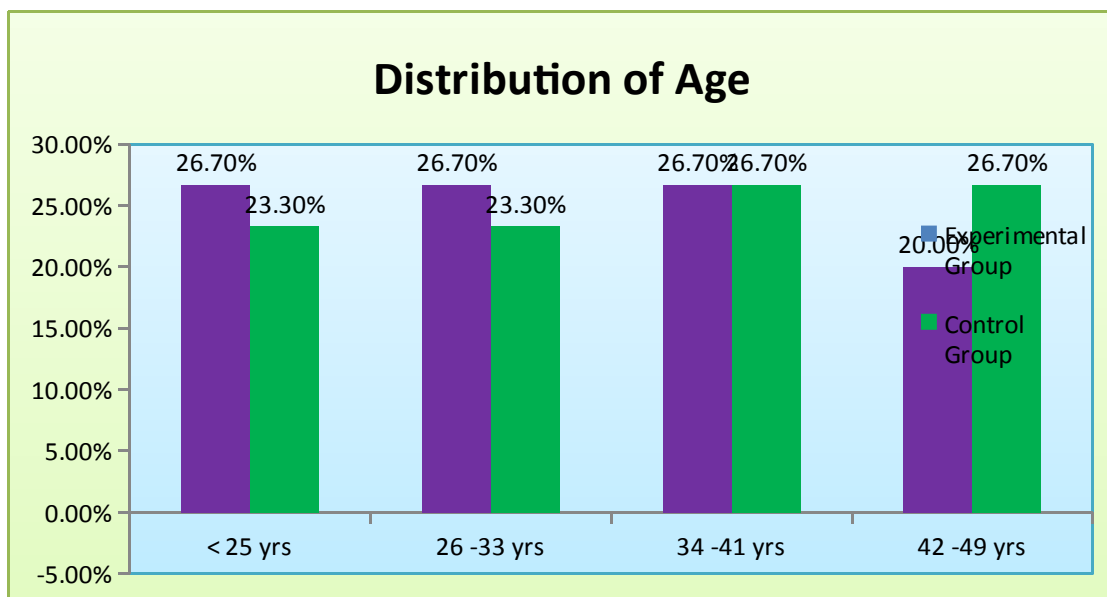
### DESCRIPTION OF FREQUENCY AND PERCENTAGE DISTRIBUTION OF SELECTED DEMOGRAPHIC VARIABLES

**Table 8.a**

#### DEMOGRAPHIC PROFILE AGE OF THE ELIGIBLE COUPLE

Demographic variables		Group			
		Experiment		Control	
		n	%	n	%
Age of eligible couple	< 25 yrs	8	26.7%	7	23.3%
	26 -33 yrs	8	26.7%	7	23.3%
	34 -41 yrs	8	26.7%	8	26.7%
	42 -49 yrs	6	20.0%	8	26.7%

The above table shows in relation to the age of male in experimental group 8(26.7%) of the respondents were in the age group of less than 25 years, 8(26.7%) of the respondents were in the age group of 26-33 years, 8(26.7%) of the respondents were in the age group 34-41 years, 6(20%) of the respondents were in the age group of 42-49 years. In control group 7(23.3%) of the respondents were in the age group of less than 25 years, 7(23.3%) of the respondents were in the age group of 26-33 years, 8(26.7%) of the respondents were in the age group of 34-41 years, 8(26.7%) of the respondents were in the age group of 42-49 years.



**Figure 3.a**



**Table 8.b**

**DEMOGRAPHIC PROFILE NUMBER OF CHILDREN IN FAMILY**

Demographic variables		Group			
		Experiment		Control	
		n	%	n	%
Number of children in family	No children	6	20.0%	5	16.7%
	One child	10	33.3%	9	30.0%
	Two children	7	23.3%	8	26.7%
	> Two children	7	23.3%	8	26.7%

Above table shows in relation to the number of children in experimental group 6(20%) of the respondents were not having children, 10(33.3%) of the respondents were having one child, 7(23.3%) of the respondents were having two children, 7(23.3%) of the respondents were having more than two children. In control group 5(16.7%) of the respondents were not having children, 9(30.0%) of the respondents were having one child, 8(26.7%) of the respondents were having two children, 8(26.7%) of the respondents were having more than two children.

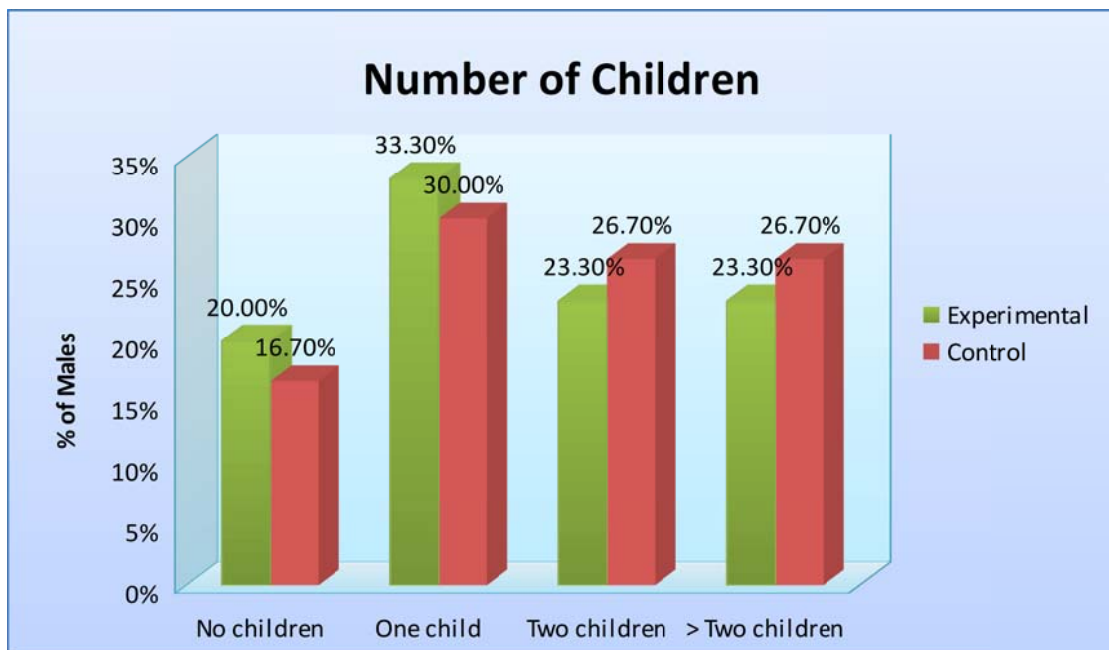


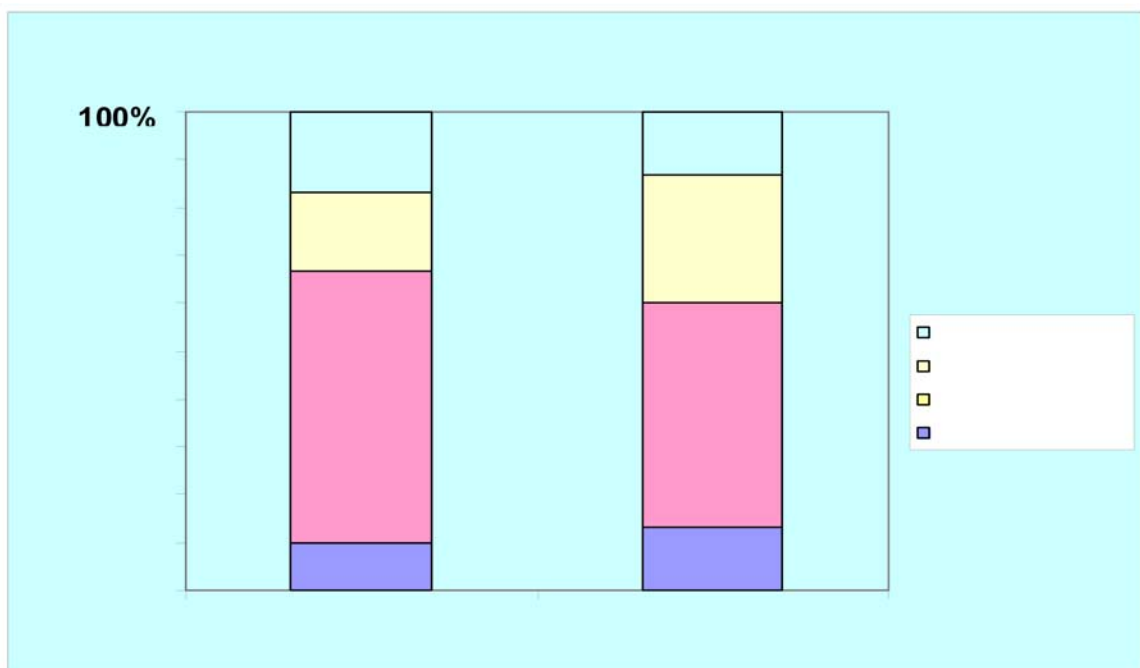
Figure3.b

Table 8.c

**DEMOGRAPHIC PROFILE OF EDUCATIONAL STATUS**

Demographic variables		Group			
		Experiment		Control	
		n	%	n	%
Educational Status	Illiterate	3	10.0%	4	13.3%
	Primary school	17	56.7%	14	46.7%
	Secondary school	5	16.7%	8	26.7%
	Graduate	5	16.7%	4	13.3%

The above table shows in relation the educational status in the experimental group 3(10.0%) of the respondents were illiterate, 17(56.7%) of the respondents had primary school education, 5(16.7%) of the respondents had secondary school education, 5(16.7%) of the respondents were graduate. In control group 4(13.3%) of the respondents were illiterate, 14(46.7%) of the respondents had primary school education, 8(26.7%) of the respondents had secondary school education, whereas 4(13.3%) of the respondents were graduate.



**Figure 3.c**

**Table 8.d**

**DEMOGRAPHIC PROFILE OF MONTHLY INCOME**

Demographic variables		group			
		Experiment		Control	
		n	%	n	%
Monthly income	Rs.2000 -5000	7	23.3%	11	36.7%
	Rs.5001 -8000	15	50.0%	11	36.7%
	Rs.8001 -10000	5	16.7%	6	20.0%
	> Rs.10000	3	10.0%	2	6.7%

The above table shows in relation to the monthly income in the experimental group 7(23.3%) of the respondents were earning Rs.2000-5000 per month, 15(50.0%) of the respondents were earning Rs.5001-8000 per month, 5(16.7%) of the respondents were earning Rs.8001-10000 per month, 3(10.0%) of the respondents were earning is more than Rs.10000/- per month. In the control group 11(36.7%) of the respondents were earning Rs.2000-5000 per month, 11(36.7%) of the respondents were earning Rs.5001-8000 per month, 6(20.0%) of the respondents were earning Rs.8001-10000 per month, 2(6.7%) of the respondents were earning is more than Rs.10000/- per month.

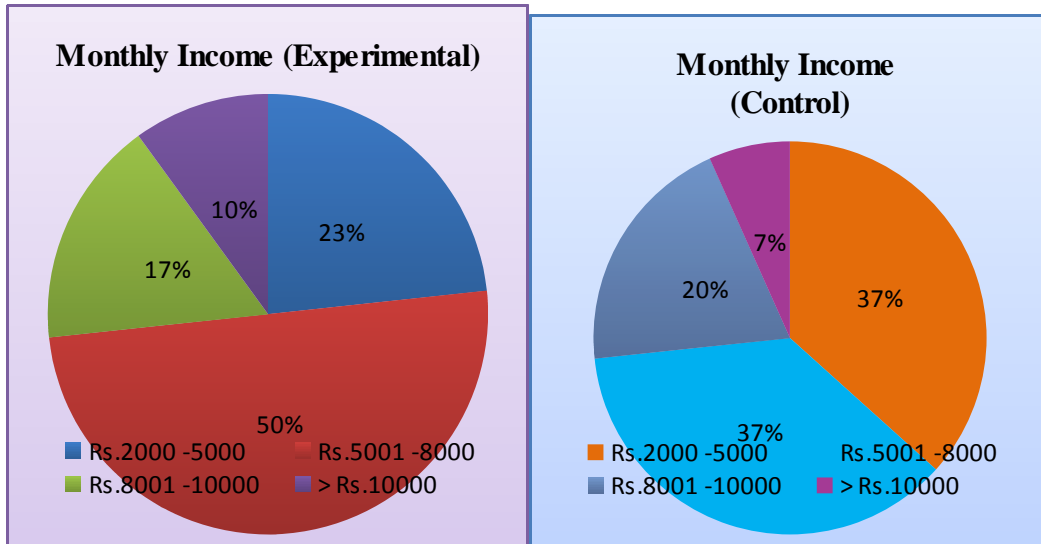
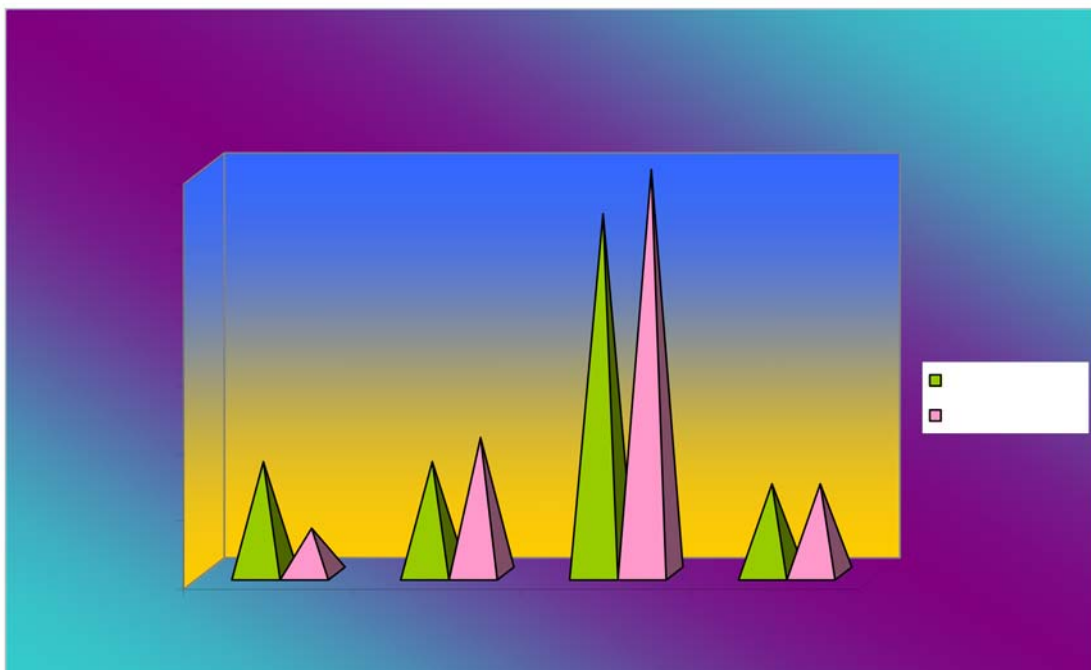


Figure 3.d

Table 8.e

**DEMOGRAPHIC PROFILE OF OCCUPATION**

Demographic variables		group			
		Experiment		Control	
		n	%	n	%
The Occupation	Professional	5	16.7%	2	6.7%
	Coolie	5	16.7%	6	20.0%
	Farmer	16	53.3%	18	60.0%
	Others	4	13.3%	4	13.3%



**Figure 3.e**

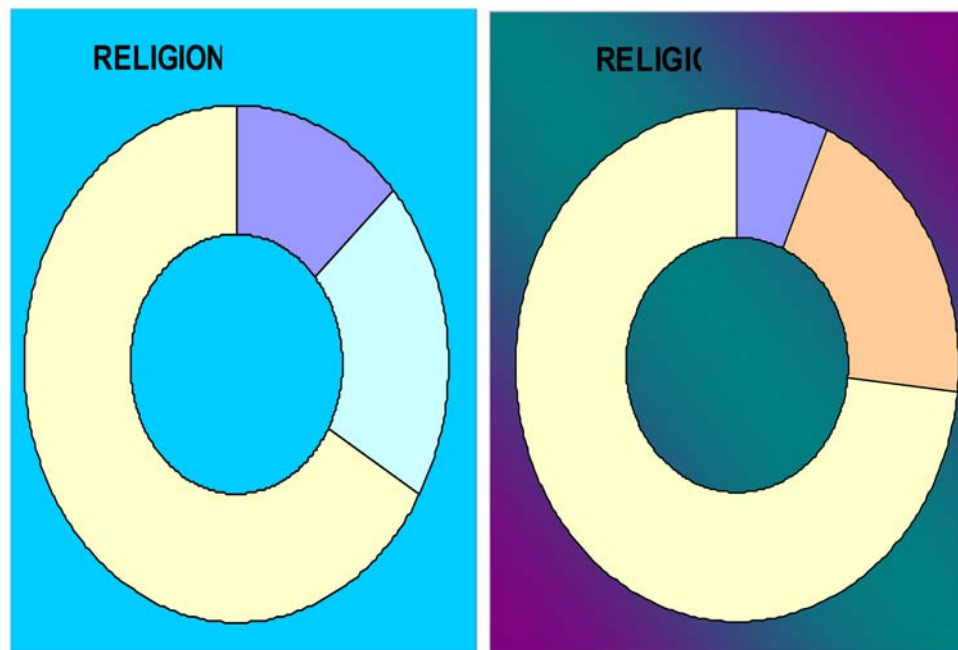
**Table 8.f**

**DEMOGRAPHIC PROFILE OF RELIGION**

Demographic variables		group			
		Experiment		Control	
		n	%	n	%
Religion	Muslim	4	13.3%	2	6.7%
	Christian	6	20.0%	6	20.0%
	Hindu	20	66.7%	22	73.3%

The above table shows in relation to the religion in the experimental group 4(13.3%) of the respondents were Muslim, 6(20.0%) of the respondents were Christian, 20(66.7%) of the respondents were Hindu.

In control group 2(6.7%) of the respondents were Muslim, 6(20.0%) of the respondents were Christian, whereas 22(73.3%) of the respondents were Hindu.



**Figure 3.f**

## SECTION II

### ASSESSMENT OF PRE-TEST AND POST TEST KNOWLEDGE OF EXPERIMENTAL AND CONTROL GROUP REGARDING FAMILY PLANNING METHOD

Table 9.a

#### LEVEL OF KNOWLEDGE IN EXPERIMENTAL GROUP

Level of knowledge	Pre-test	Post-test
Inadequate	26(86.7%)	0(0.0%)
Moderately Adequate	4(13.3%)	9(30.0%)
Adequate	0(0.0%)	21(70.0%)

Above table shows the pre-test and post-test overall level of knowledge for experiment group males. In pre-test 86.7% of males are having inadequate knowledge regarding family planning methods. In post-test none of the staff nurses are having inadequate knowledge regarding family planning methods.

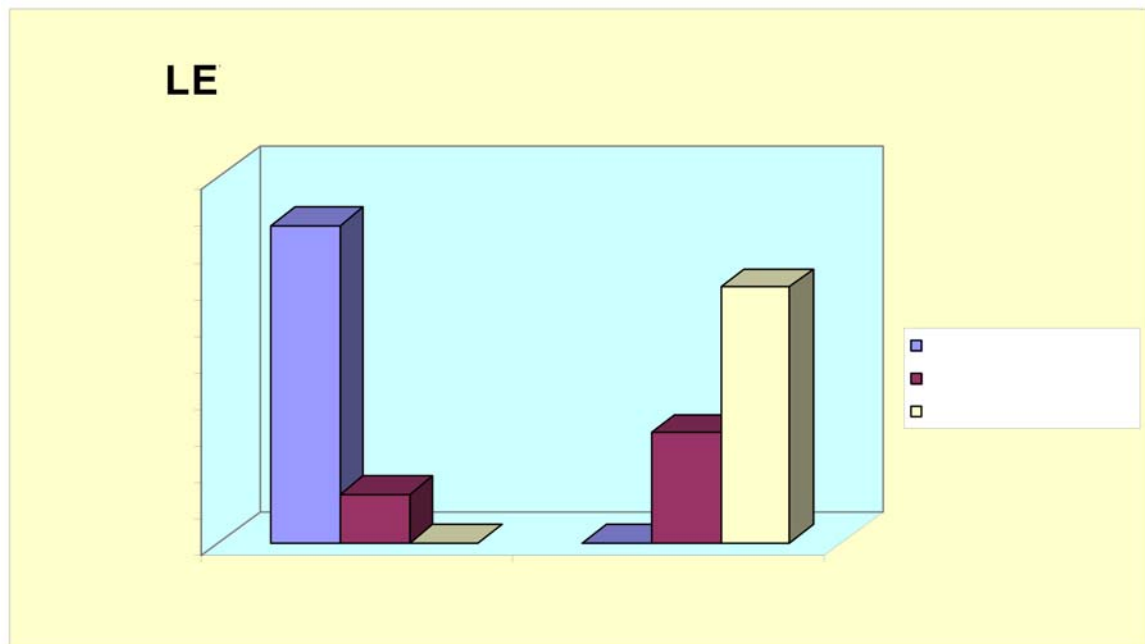


Figure 4.a

**Table 9.b**

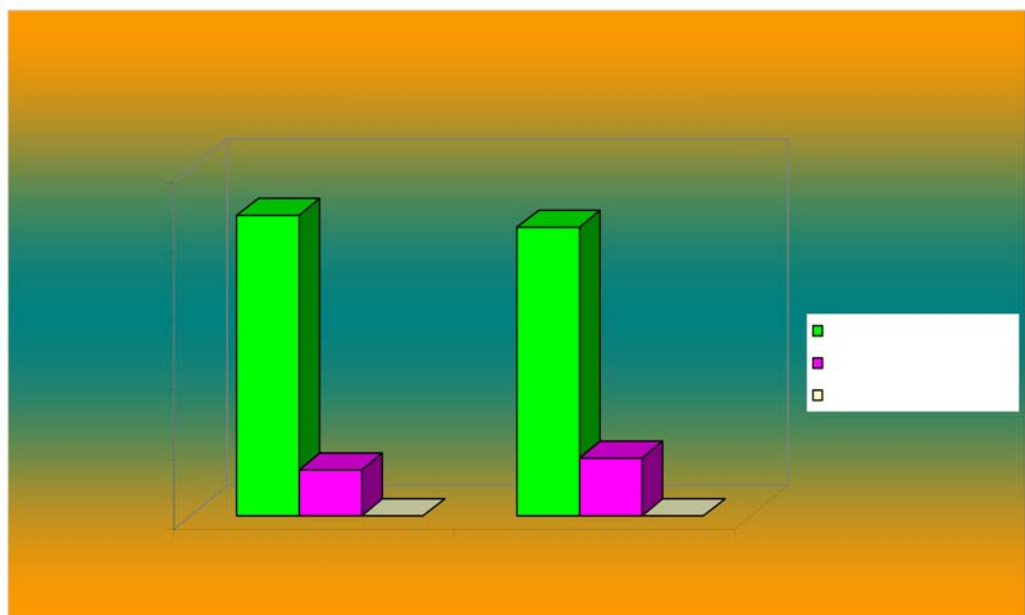
**LEVEL OF KNOWLEDGE IN CONTROL GROUP**

<b>Level of knowledge</b>	<b>Pre-test</b>	<b>Post-test</b>
Inadequate	26(86.7%)	25(83.3%)
Moderately Adequate	4(13.3%)	5(16.7%)
Adequate	0(0.0%)	0(0.0%)

Above table shows the pretest and posttest overall level of knowledge for control group males. In pretest 86.7% of males are having inadequate knowledge regarding family planning methods. In post-test none of them are having inadequate knowledge regarding family planning methods.

**Score 0 – 20**

- < 50% inadequate knowledge = 0 – 10 score
- 51 -75% moderately adequate knowledge = 11 -15 score
- 76 -100% adequate knowledge = 16 – 20 score





**Figure 4.b**  
**SECTION III**

**ASSESSMENT OF PRE-TEST AND POST TEST ATTITUDE OF  
EXPERIMENTAL & CONTROL GROUP REGARDING FAMILY  
PLANNING METHOD**

**Table 10.a**

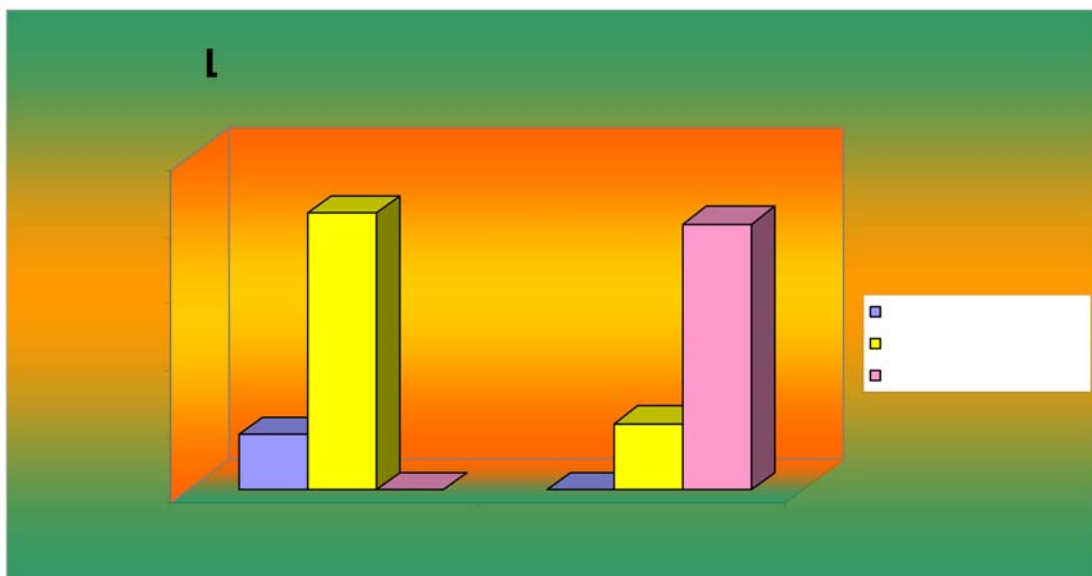
**LEVEL OF ATTITUDE IN EXPERIMENTAL GROUP**

<b>Level of attitude</b>	<b>Pre-test</b>	<b>Post-test</b>
Inadequate	5 (16.7%)	0 (0.0%)
Moderately Adequate	25 (83.3%)	6 (20.0%)
Adequate	0 (0.0%)	24 (80.0%)

Above table shows the pre-test and post-test overall level of attitude for experimental group. In Pre-test 16.7% are having inadequate attitude regarding family planning methods. In Post-test none of them are having inadequate attitude.

**Score 10 - 60**

- |                                      |                |
|--------------------------------------|----------------|
| < 50% inadequate attitude            | = < =30 score  |
| 51 -75% moderately adequate attitude | = 31- 45 score |
| 76 -100% adequate attitude           | = 46 -60 score |



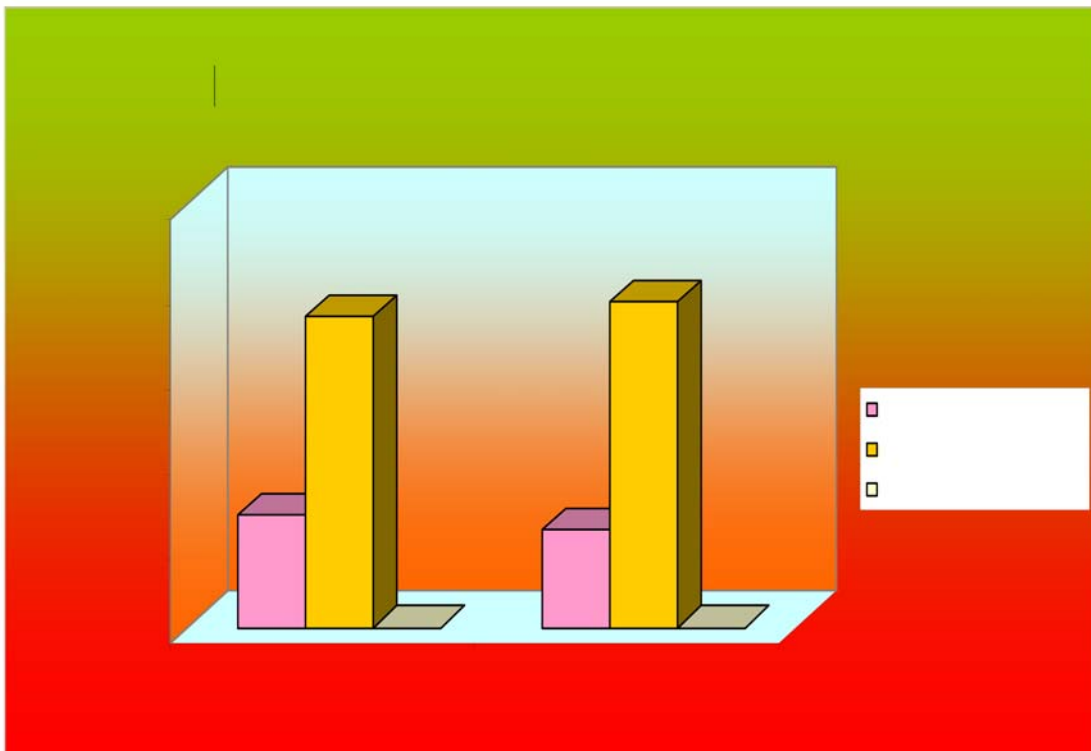
**Figure5.a**

**Table 10.b**

**LEVEL OF ATTITUDE IN CONTROL GROUP**

<b>Level of Practice</b>	<b>Pre-test</b>	<b>Post-test</b>
Inadequate	8(26.7%)	7(23.3%)
Moderately Adequate	22(73.3%)	23(76.7%)
Adequate	0(0.0%)	0(0.0%)

Above table shows the level of attitude in the control group in pretest, 8 (26.70%) of the participants had inadequate attitude, 22(73.3%) of the participants had moderately adequate attitude and none of them had adequate attitude, in post-test 7(23.3%) of the respondents had inadequate attitude, 23(76.7%) of the participants had moderately adequate attitude and none of them had adequate attitude.



**Figure5.b**

## SECTION IV

Table 11.a

### COMPARISON THE PRE-TEST AND POST TEST KNOWLEDGE OF EXPERIMENTAL AND CONTROL GROUP REGARDING FAMILY PLANNING METHOD

Knowledge	Pretest knowledge		Posttest knowledge		Student'spaired t-test
	Mean	SD	Mean	SD	
Experiment group	7.73	2.16	16.40	1.65	<b>t=17.78</b> <b>P=0.001significant</b>
Control group	7.33	2.23	8.03	3.01	t=1.24 P=0.22 not significant

Above table shows comparison of pretest and post-test overall knowledge score. In the experimental group pretest knowledge 7.33 and in the control group it was 7.33. The t value was 1.24 which was significant.

In the post-test, the knowledge score of the experimental group was 16.40 and the control group was 8.03. The t value was 1.24, which was not significant.



Figure 6

Table 11.b

**COMPARISON OF EXPERIMENT AND CONTROL GROUP  
OVERALL KNOWLEDGE SCORE**

Knowledge	Experiment group		Control group		Student's Independent t-test
	Mean	SD	Mean	SD	
Pre-test	7.73	2.16	7.33	2.23	t=0.70 P=0.48 not significant
Post-test	16.40	1.65	8.03	3.01	<b>t=13.34 P=0.001 significant</b>

Above table shows the pretest knowledge in experimental group was 7.73 and in control group was 7.33 and t value 0.70 which is not significant and the post-test knowledge of the experimental group was 16.40 and control group was 8.03 and t value 13.34 which was significant

## SECTION V

### COMPARISON THE PRE-TEST AND POST TEST AND ATTITUDE OF EXPERIMENTAL AND CONTROL GROUP REGARDING FAMILY PLANNING METHOD

Table 12.a

#### COMPARISON OF PRETEST & POSTTEST OVERALL ATTITUDE SCORE

Attitude	Pretest knowledge		Posttest knowledge		Student's paired t-test
	Mean	SD	Mean	SD	
Experiment group	34.30	2.168	49.67	2.758	<b>t=26.85 P=0.001 significant</b>
Control group	33.37	2.399	34.50	2.980	t=1.74 P=0.09 not significant

Above table represent that the overall pretest attitude and post-test attitude in experimental group was 34.30 and 49.67 respectively t was 26.85 (P=0.001) which was significant it showed effectiveness of structured teaching programme. In control group the overall pretest and post-test attitude was 33.37 and 34.50 respectively (t=1.74, P=0.09) which revealed they are not significant.

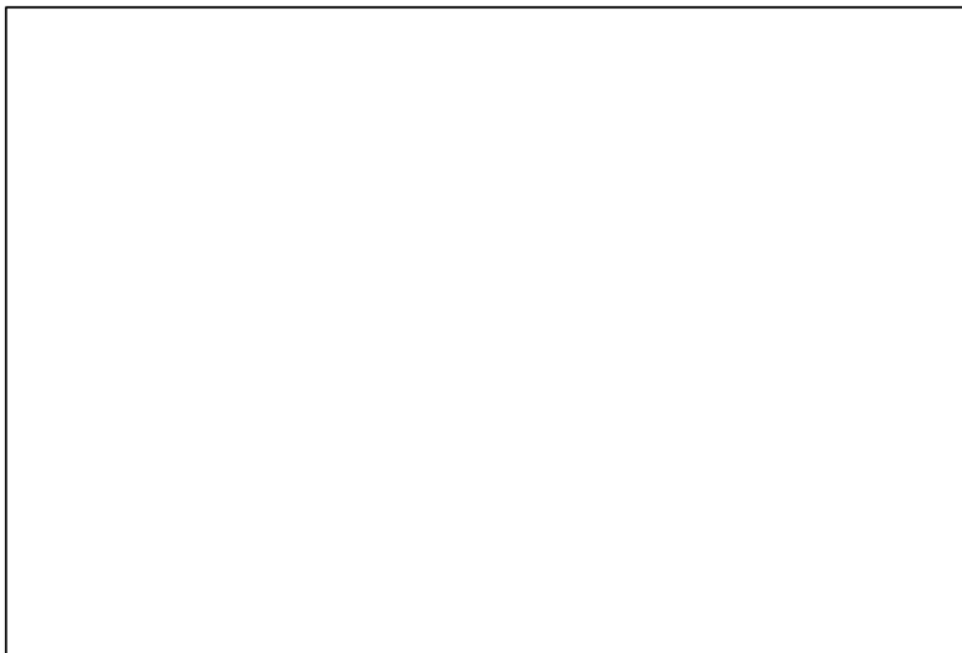


Figure 7

**Table 12.b**

**COMPARISON OF EXPERIMENT AND CONTROL GROUP**

**OVERALL ATTITUDE SCORE**

Attitude	Experiment group		Control group		Student's Independent t-test
	Mean	SD	Mean	SD	
Pre-test	34.30	2.16	33.37	2.39	t=1.58 P=0.12 not significant
Post-test	49.67	2.75	34.50	2.98	<b>t=20.45 P=0.001 significant</b>

Above table showed that the pretest attitude of experimental group and control group was 34.30 and 33.37,  $t=1.58$  which showed no significance.

In post-test the attitude of experimental group and control group was 49.67 and 34.50 respectively.  $t$  value 20.45 and  $p=0.001$  and was significant.

**Table 13**

**EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME**

		Pre-test	Post-test	% of Difference	Net Benefit
Knowledge	Experiment	38.65%	82.05%	43.40%	39.55%
	Control	36.65%	40.50%	3.85%	
Attitude	Experiment	57.60%	82.78%	25.18%	23.30%
	Control	55.62%	57.50%	1.88%	

The above table shows knowledge of experimental group pretest was 38.65% and post-test was 82.05% the difference was 43.40%, attitude of experimental group in pretest was 57.60% and post-test was 82.78% . The difference was 25.18% and in the control group knowledge in pretest was 36.65% and post-test was 40.50% and there were difference 3.85% and attitude in pretest was 55.62% and post-test was 57.50%. Difference was 1.88%. Net benefit (23.30%) It showed the effectiveness of structured teaching programme.

## SECTION VI

### CORRELATION BETWEEN KNOWLEDGE AND ATTITUDE OF EXPERIMENTAL AND CONTROL GROUP REGARDING FAMILY PLANNING METHOD

Table 14.a

#### CORRELATION BETWEEN KNOWLEDGE AND ATTITUDE EXPERIMENTAL

Test	Correlation between	mean score	Karl Pearson correlation coefficient	Interpretation
		Mean±SD		
Pre-test	Knowledge	7.73±2.16	r = 0.05 P=0.79	No Correlation.  It means there is no correlation between knowledge and attitude
	Attitude	34.30±2.17		
Post-test	Knowledge	16.40±1.65	r = 0.57 P=0.001	<b>Moderate Positive Significant correlation.</b>  <b>It means when knowledge increases their attitude also increases</b>
	Attitude	49.67±2.76		

The above table shows the pretest level of knowledge and attitude was 7.73±2.16, 34.30±2.17 respectively r=0.05, p=0.79 in which there is no correlation between knowledge and attitude.

Post-test, knowledge and attitude was 16.40±1.65, 49.67±2.76, r=0.57, p=0.001. Which showed when knowledge increases their attitude also increases.



**Table 14.b**

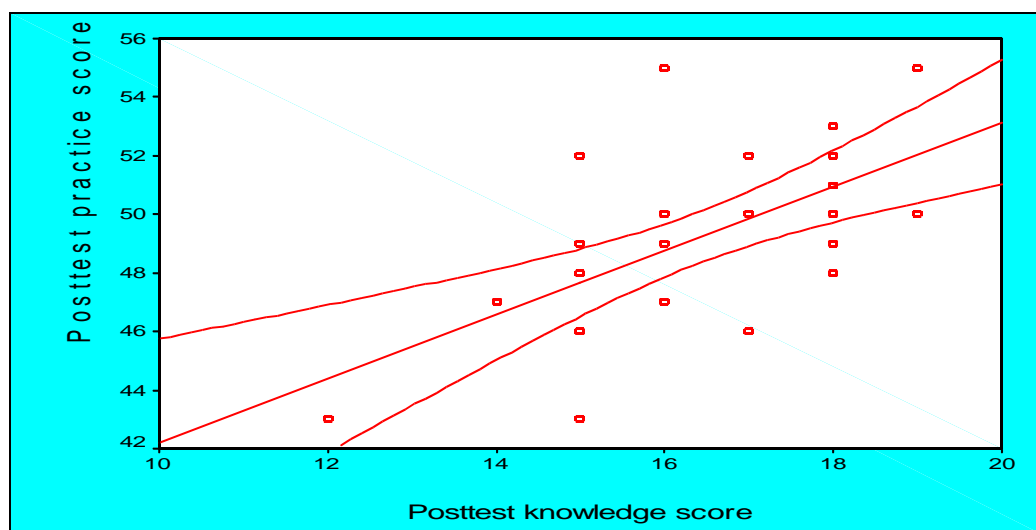
**CORRELATION BETWEEN KNOWLEDGE AND ATTITUDE IN CONTROL**

**GROUP**

Test	Correlation between	Mean score	Karl Pearson correlation coefficient	Interpretation
		Mean±SD		
Pre-test	Knowledge	7.33±2.23	r = 0.08 P=0.51	Poor Correlation.  It means there is no correlation or poor correlation between knowledge and attitude
	Attitude	33.37±2.40		
Post-test	Knowledge	8.03±3.01	r = 0.10 P=0.55	<b>Poor Positive correlation.</b>  <b>It means there is no correlation or poor correlation between knowledge and attitude</b>
	Attitude	34.50±2.98		

The above table shows the pretest level of knowledge and attitude in pretest among control group. The r value was 0.08 which revealed that there was poor correlation between knowledge and attitude.

In post test the knowledge level and attitude was 8.03 and 34.50 respectively. The r=0.10, (P=0.55) which showed no correlation between knowledge and attitude.



**Figure 8**

## SECTION VII

### ASSOCIATION BETWEEN LEVEL OF KNOWLEDGE ON FAMILY PLANNING METHOD WITH SELECTED DEMOGRAPHIC VARIABLES IN CONTROL AND EXPERIMENTAL GROUP

**Table 15.a**

#### ASSOCIATION BETWEEN LEVELS OF PRETEST KNOWLEDGE AND THEIR DEMOGRAPHIC VARIABLES IN EXPERIMENTAL GROUP

Demographic variables		Pre-test level of knowledge				Significance
		Inadequate		Moderately adequate		
		n	%	n	%	
<b>Age of eligible couple</b>	<b>&lt; 25 yrs</b>	7	87.5%	1	12.5%	$\chi^2=0.07$ P=0.96 not significant
	<b>26 -41yrs</b>	14	87.5%	2	12.5%	
	<b>42 -49 yrs</b>	5	83.3%	1	16.7%	
<b>Number of children in family</b>	<b>No children</b>	5	83.3%	1	16.7%	$\chi^2=0.10$ P=0.96 not significant
	<b>&lt;Two children</b>	15	88.2%	2	11.8%	
	<b>&gt; Two children</b>	6	85.7%	1	14.3%	
<b>Educational Status</b>	<b>Illiterate</b>	3	100.0%			$\chi^2=0.66$ P=0.72 not significant
	<b>Primary/secon dary</b>	19	86.4%	3	13.6%	
	<b>Graduate</b>	4	80.0%	1	20.0%	
<b>Monthly income</b>	<b>Rs.2000 -5000</b>	6	85.7%	1	14.3%	$\chi^2=0.52$ P=0.77 not significant
	<b>Rs.5001 -10000</b>	17	85.0%	3	15.0%	
	<b>&gt; Rs.10000</b>	3	100.0%			
<b>Occupation</b>	<b>Professional</b>	5	100.0%			$\chi^2=1.97$ P=0.37 not significant
	<b>Coolie/farmer</b>	17	81.0%	4	19.0%	
	<b>Others</b>	4	100.0%			
<b>Religion</b>	<b>Muslim</b>	4	100.0%			$\chi^2=2.88$ P=0.24 not significant
	<b>Christian</b>	4	66.7%	2	33.3%	
	<b>Hindu</b>	18	90.0%	2	10.0%	

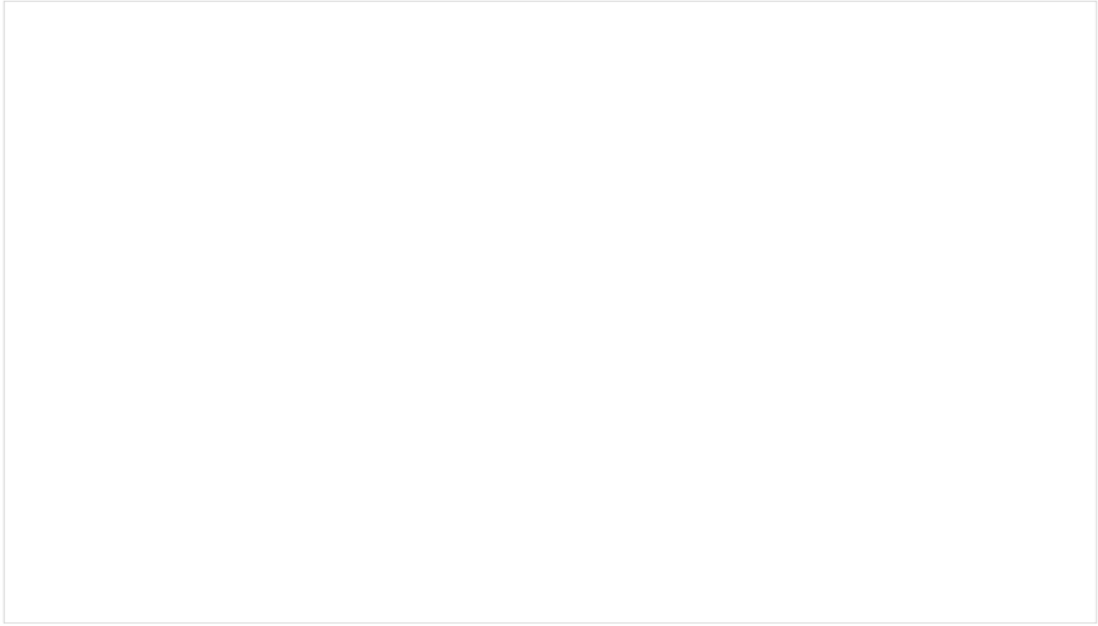
The above table shows the association between demographic variables and their pretest level of knowledge regarding family planning methods among rural male population in experimental group. None of the variables are associated with their level of knowledge. Statistical significance difference was calculated using Pearson chi square test.

**Table 15.b**

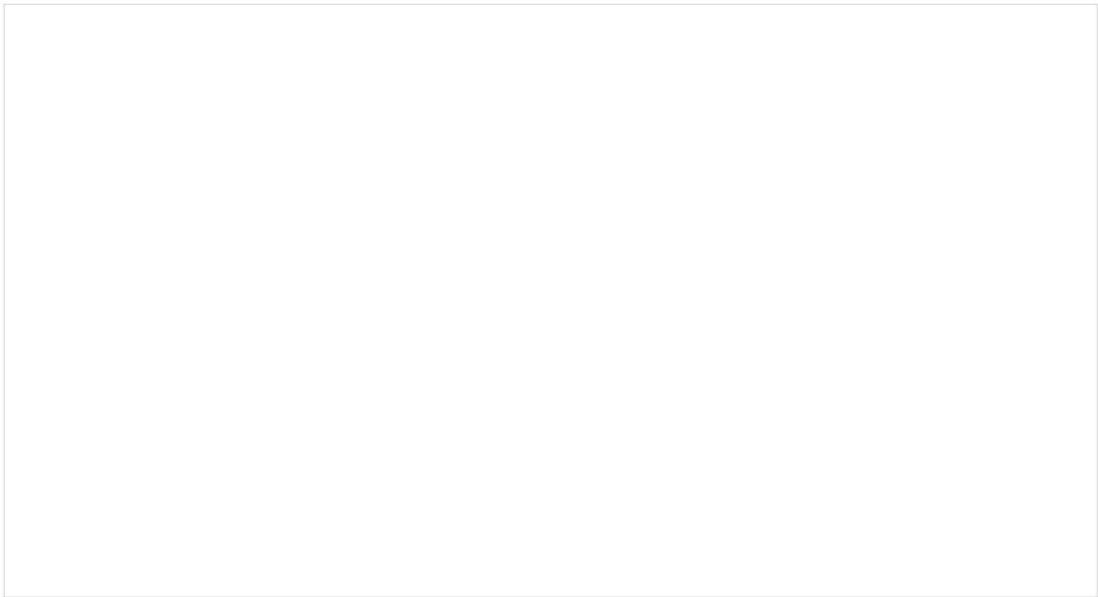
**ASSOCIATION BETWEEN LEVELS OF POST-TEST KNOWLEDGE  
AND THEIR DEMOGRAPHIC VARIABLES IN EXPERIMENTAL  
GROUP**

Demographic variables		Post-test level of knowledge				Significance
		Moderately adequate		Adequate		
		n	%	N	%	
Age of eligible couple	< 25 yrs	2	25.0%	6	75.0%	$\chi^2=10.56$ <b>P=0.005</b> significant
	26 -41yrs	2	12.5%	14	87.5%	
	42 -49 yrs	5	83.3%	1	16.7%	
Number of children in family	No children	1	16.7%	5	83.3%	$\chi^2=1.06$ P=0.59 not significant
	<Two children	5	29.4%	12	70.6%	
	> Two Children	3	42.9%	4	57.1%	
Educational Status	Illiterate	3	100.0%	0	0.0%	$\chi^2=7.79$ <b>P=0.02</b> significant
	Primary/secondary	5	22.7%	17	77.3%	
	Graduate	1	20.0%	4	80.0%	
Monthly income	Rs.2000 -5000	2	28.6%	5	71.4%	$\chi^2=0.02$ P=0.99 not significant
	Rs.5001 -10000	6	30.0%	14	70.0%	
	> Rs.10000	1	33.3%	2	66.7%	
Occupation	Professional	2	40.0%	3	60.0%	$\chi^2=1.38$ P=0.50 not significant
	Coolie/farmer	5	23.8%	16	76.2%	
	Others	2	50.0%	2	50.0%	
Religion	Muslim	1	25.0%	3	75.0%	$\chi^2=3.57$ P=0.17 not significant
	Christian			6	100.0%	
	Hindu	8	40.0%	12	60.0%	

The above table shows the association between demographic variables and their posttest level of knowledge regarding family planning methods among rural male population in experimental group. Age and education are associated with their level of knowledge statistical significance difference was calculated using Pearson chi square test.



**Figure 9.a**



**Figure 9.b**

**Table 15.c**

**ASSOCIATION BETWEEN LEVEL OF PRETEST KNOWLEDGE  
AND THEIR DEMOGRAPHIC VARIABLES IN CONTROL GROUP**

Demographic variables		Pretest level of knowledge				Significance
		Inadequate		Moderately adequate		
		n	%	n	%	
<b>Age of eligible couple</b>	< 25 yrs	7	100.0%			$\chi^2=1.66$ P=0.43 not significant
	26 -41yrs	12	80.0%	3	20.0%	
	42 -49 yrs	7	87.5%	1	12.5%	
<b>Number of children in family</b>	No children	5	100.0%			$\chi^2=1.05$ P=0.59 not significant
	<Two children	14	82.4%	3	17.6%	
	> Two children	7	87.5%	1	12.5%	
<b>Educational Status</b>	Illiterate	3	75.0%	1	25.0%	$\chi^2=1.28$ P=0.53 not significant
	Primary/secondary	20	90.9%	2	9.1%	
	Graduate	3	75.0%	1	25.0%	
<b>Monthly income</b>	Rs.2000 -5000	10	90.9%	1	9.1%	$\chi^2=0.75$ P=0.68 not significant
	Rs.5001 -10000	14	82.4%	3	17.6%	
	> Rs.10000	2	100.0%			
<b>Occupation</b>	Professional	2	100.0%			$\chi^2=1.15$ P=0.56 not significant
	Coolie/farmer	20	83.3%	4	16.7%	
	Others	4	100.0%			
<b>Religion</b>	Muslim	2	100.0%			$\chi^2=0.36$ P=0.83 not significant
	Christian	5	83.3%	1	16.7%	
	Hindu	19	86.4%	3	13.6%	

The above table shows the association between demographic variables and their pretest level of knowledge regarding family planning methods among rural male population in control group. None of the variables are associated with their level of knowledge statistical significance difference was calculated using Pearson chi square test.

**Table 15.d**

**ASSOCIATION BETWEEN LEVEL OF POST-TEST KNOWLEDGE  
AND THEIR DEMOGRAPHIC VARIABLES IN CONTROL GROUP**

Demographic variables		Pretest level of knowledge				Significance
		Inadequate		Moderately adequate		
		n	%	N	%	
<b>Age of eligible couple</b>	< 25 yrs	7	100.0%			$\chi^2=2.19$ P=0.33 not significant
	26 -41 yrs	12	80.0%	3	20.0%	
	42 -49 yrs	7	87.5%	1	12.5%	
<b>Number of children in family</b>	No children	5	100.0%			$\chi^2=0.73$ P=0.69 not significant
	<Two children	14	82.4%	3	17.6%	
	> Two children	7	87.5%	1	12.5%	
<b>Educational Status</b>	Illiterate	3	75.0%	1	25.0%	$\chi^2=2.18$ P=0.34 not significant
	Primary/secondary	20	90.9%	2	9.1%	
	Graduate	3	75.0%	1	25.0%	
<b>Monthly income</b>	Rs.2000 -5000	10	90.9%	1	9.1%	$\chi^2=4.89$ P=0.09 not significant
	Rs.5001 -10000	14	82.4%	3	17.6%	
	> Rs.10000	2	100.0%			
<b>Occupation</b>	Professional	2	100.0%			$\chi^2=2.10$ P=0.35 not significant
	Coolie/farmer	20	83.3%	4	16.7%	
	Others	4	100.0%			
<b>Religion</b>	Muslim	2	100.0%			$\chi^2=2.18$ P=0.34 not significant
	Christian	5	83.3%	1	16.7%	
	Hindu	19	86.4%	3	13.6%	

The above table shows the association between demographic variables and their Posttest level of knowledge regarding family planning methods among rural male population in control group. None of the variables are associated with their level of knowledge statistical significance difference was calculated using Pearson chi square test.

## SECTION VIII

### ASSOCIATION BETWEEN LEVEL OF ATTITUDE ON FAMILY PLANNING METHOD WITH SELECTED DEMOGRAPHIC VARIABLES IN CONTROL AND EXPERIMENTAL GROUP

**Table 16.a**

#### ASSOCIATION BETWEEN LEVEL OF PRETEST ATTITUDE AND THEIR DEMOGRAPHIC VARIABLES IN EXPERIMENTAL GROUP

Demographic variables		Pretest level of attitude				Significance
		Inadequate		Moderately adequate		
		n	%	n	%	
<b>Age of eligible couple</b>	< 25 yrs	0	0.0%	8	100.0%	$\chi^2=5.25$ P=0.07 not significant
	26 -41yrs	5	31.3%	11	68.8%	
	42 -49 yrs	0	0.0%	6	100.0%	
<b>Number of children in family</b>	No children	0	0.0%	6	100.0%	$\chi^2=1.80$ P=0.41 not significant
	<Two children	4	23.5%	13	76.5%	
	>Two children	1	14.3%	6	85.7%	
<b>Educational Status</b>	Illiterate	0	0.0%	3	100.0%	$\chi^2=0.68$ P=0.71 not significant
	Primary/secondary	4	18.2%	18	81.8%	
	Graduate	1	20.0%	4	80.0%	
<b>Monthly income</b>	Rs.2000 -5000	0	0.0%	7	100.0%	$\chi^2=2.16$ P=0.34 not significant
	Rs.5001 -10000	4	20.0%	16	80.0%	
	> Rs.10000	1	33.3%	2	66.7%	
<b>Occupation</b>	Professional	0	0.0%	5	100.0%	$\chi^2=1.29$ P=0.53 not significant
	Coolie/farmer	4	19.0%	17	81.0%	
	Others	1	25.0%	3	75.0%	
<b>Religion</b>	Muslim	0	0.0%	4	100.0%	$\chi^2=5.71$ P=0.06 not significant
	Christian	3	50.0%	3	50.0%	
	Hindu	2	10.0%	18	90.0%	

The above table shows the association between demographic variables and their pretest level of attitude regarding family planning methods among rural male population in experimental group. None of the variables are associated with their level of attitude, statistical significance difference was calculated using Pearson chi-square test.

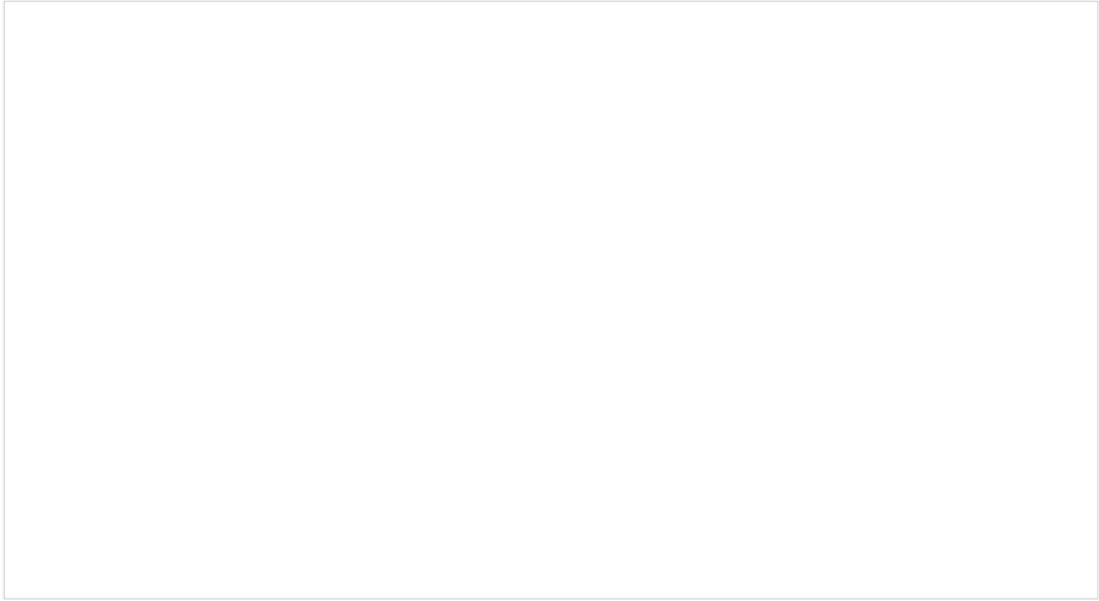
**Table 16.b**

**ASSOCIATION BETWEEN LEVEL OF POSTTEST ATTITUDE AND  
THEIR DEMOGRAPHIC VARIABLES IN EXPERIMENTAL GROUP**

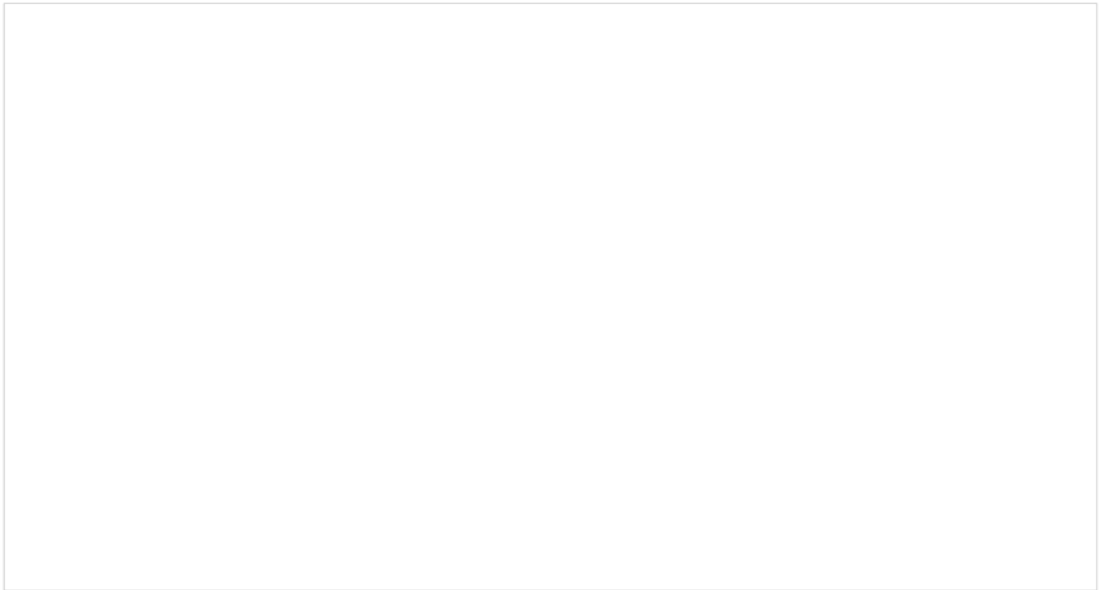
Demographic variables		Post-test level of attitude				Significance
		Moderately adequate		Adequate		
		n	%	n	%	
<b>Age of eligible couple</b>	< 25 yrs	4	50.0%	4	50.0%	$\chi^2=6.56$ <b>P=0.04</b> significant
	26 -41yrs	2	12.5%	14	87.5%	
	42 -49 yrs	0	0.0%	6	100.0%	
<b>Number of children in family</b>	No children	2	33.3%	4	66.7%	$\chi^2=0.87$ P=0.65 not significant
	<Two children	3	17.6%	14	82.4%	
	>Two children	1	14.3%	6	85.7%	
<b>Educational Status</b>	Illiterate	0	0.0%	3	100.0%	$\chi^2=0.85$ P=0.65 not significant
	Primary/secondary	5	22.7%	17	77.3%	
	Graduate	1	20.0%	4	80.0%	
<b>Monthly income</b>	Rs.2000 -5000	2	28.6%	5	71.4%	$\chi^2=0.97$ P=0.62 not significant
	Rs.5001 -10000	3	15.0%	17	85.0%	
	> Rs.10000	1	33.3%	2	66.7%	
<b>Occupation</b>	Professional	0	0.0%	4	100.0%	$\chi^2=8.10$ <b>P=0.02</b> significant
	Coolie/farmer	2	10.5%	17	89.5%	
	Others	4	57.1%	3	42.9%	
<b>Religion</b>	Muslim	2	50.0%	2	50.0%	$\chi^2=2.60$ P=0.27 not significant
	Christian	1	16.7%	5	83.3%	
	Hindu	3	15.0%	17	85.0%	

The above table shows the association between demographic variables and their post-test level of attitude regarding family planning methods among rural male population in experimental group. None of the variables are associated with their level of attitude. Statistical significance difference was calculated using Pearson chi square test.





**Figure 10.a**



**Figure 10.b**

**Table 16.c**

**ASSOCIATION BETWEEN LEVEL OF PRETEST ATTITUDE AND  
THEIR DEMOGRAPHIC VARIABLES CONTROL GROUP**

Demographic variables		Pretest level of attitude				Significance
		Inadequate		Moderately adequate		
		n	%	n	%	
<b>Age of eligible couple</b>	< 25 yrs	2	28.6%	5	71.4%	$\chi^2=2.24$ P=0.13 not significant
	26 -41yrs	2	13.3%	13	86.7%	
	42 -49 yrs	5	62.5%	3	37.5%	
<b>Number of children in family</b>	No children	2	40.0%	3	60.0%	$\chi^2=1.59$ P=0.21 not significant
	<Two children	2	11.8%	15	88.2%	
	>Two children	5	62.5%	3	37.5%	
<b>Educational Status</b>	Illiterate	1	25.0%	3	75.0%	$\chi^2=4.45$ P=0.11 not significant
	Primary/secondary	5	22.7%	17	77.3%	
	Graduate	3	75.0%	1	25.0%	
<b>Monthly income</b>	Rs.2000 -5000	4	36.4%	7	63.6%	$\chi^2=1.07$ P=0.58 not significant
	Rs.5001 -10000	5	29.4%	12	70.6%	
	> Rs.10000			2	100.0%	
<b>Occupation</b>	Professional			2	100.0%	$\chi^2=1.62$ P=0.44 not significant
	Coolie/farmer	7	29.2%	17	70.8%	
	Others	2	50.0%	2	50.0%	
<b>Religion</b>	Muslim			2	100.0%	$\chi^2=1.78$ P=0.41 not significant
	Christian	1	16.7%	5	83.3%	
	Hindu	8	36.4%	14	63.6%	

The above table shows the association between demographic variables and their pretest level of attitude regarding family planning methods among rural male population in control group. None of the variables are associated with their level of attitude. Statistical significance difference was calculated using Pearson chi square test

**Table 16.d**

**ASSOCIATION BETWEEN LEVEL OF POST-TEST ATTITUDE AND THEIR DEMOGRAPHIC VARIABLES IN CONTROL GROUP**

Demographic variables		Post-test level of attitude				Significance
		Inadequate		Moderately adequate		
		n	%	n	%	
<b>Age of eligible couple</b>	< 25 yrs	2	28.6%	5	71.4%	$\chi^2=3.60$ P=0.17 not significant
	26 -41yrs	2	13.3%	13	86.7%	
	42 -49 yrs	4	50.0%	4	50.0%	
<b>Number of children in family</b>	No children	2	40.0%	3	60.0%	$\chi^2=4.61$ P=0.10 not significant
	<Two children	2	11.8%	15	88.2%	
	> Two children	4	50.0%	4	50.0%	
<b>Educational Status</b>	Illiterate	1	25.0%	3	75.0%	$\chi^2=5.59$ P=0.06 not significant
	Primary/secondary	4	18.2%	18	81.8%	
	Graduate	3	75.0%	1	25.0%	
<b>Monthly income</b>	Rs.2000 -5000	3	27.3%	8	72.7%	$\chi^2=0.79$ P=0.67 not significant
	Rs.5001 -10000	5	29.4%	12	70.6%	
	> Rs.10000			2	100.0%	
<b>Occupation</b>	Professional			2	100.0%	$\chi^2=1.87$ P=0.89 not significant
	Coolie/farmer	6	25.0%	18	75.0%	
	Others	2	50.0%	2	50.0%	
<b>Religion</b>	Muslim			2	100.0%	$\chi^2=1.33$ P=0.51 not significant
	Christian	1	16.7%	5	83.3%	
	Hindu	7	31.8%	15	68.2%	

The above table shows the association between demographic variables and their posttest level of attitude regarding family planning methods among rural male population in control group. None of the variables are associated with their level of attitude. Statistical significance difference was calculated using Pearson chi square test.

## CHAPTER V

### DISCUSSION

This chapter deals with the discussion of the study with appropriate literature review, statistical analysis and findings of the study based on objectives of the study. The aim of the study was to evaluate the effectiveness of STP on family planning methods among rural male who were residing in Paruvachi,, Bhavani Taluk, Erode District, ..

The first objective of the study was to **assess the pretest and post test knowledge and attitude of experimental group regarding family planning methods.**

- In the pretest and post test, overall level of knowledge for experimental group males. In pretest 86.7% of males are having inadequate knowledge regarding family planning methods.13.3% of males were having moderately adequate knowledge and 0.0% of males are having adequate knowledge.
- In the post test none of males are having inadequate knowledge regarding family planning methods .30% males are having moderately adequate knowledge and 70% of males are having adequate knowledge.

The second objective of the study was to **assess the pretest and post test knowledge and attitude of control group regarding family planning methods.**

- In the pretest and post test overall level of knowledge for control group males in pretest 86.7% of males are having inadequate knowledge regarding family planning methods. 13.3% of males are having moderately adequate knowledge in 0.0% males are having adequate knowledge regarding family planning methods in posttest 83.3% of males are having inadequate knowledge 66.7%

of males are having moderately adequate knowledge, 0.0% of males are having adequate knowledge regarding family planning methods.

- In the pretest and post test overall level of attitude for the experimental group the pretest 16.7% are having inadequate attitude regarding family planning methods 83.3% are having moderately adequate attitude and 0.0% are having adequate attitude regarding family planning methods. In post test none of are having inadequate attitude 20.0% are having moderately adequate attitude regarding family planning methods.
- In the pretest and post test overall level of attitude for the control group the pretest 26.7% are having inadequate attitude 73.3% are having moderately adequate attitude. 0.0% are having adequate attitude regarding family planning methods. In the post test 23.3% are having inadequate attitude 76.7% are having moderately adequate attitude 0.0% are having adequate attitude regarding family planning methods. Compare the pretest posttest knowledge of experimental and control group.

The third objective of the study was to **assess the pretest and post test knowledge and attitude of the experimental group and control group regarding family planning methods**

- Comparison of pretest and posttest overall knowledge score revealed in the experimental group pretest knowledge mean was 7.73 and standard deviation was 2.16 in post test knowledge the mean was 16.40 and standard deviation was 1.65 and  $t=17.78$  which is significant that 0.01 level. Control group the pretest knowledge mean was 7.33 and standard deviation was 2.23 in the post test knowledge mean was 8.03 and whereas standard deviation was 3.01 and  $t=1.24$ ,  $p=0.22$  not significant. It showed that STP was effective.

- Comparison of pretest and posttest overall attitude score, revealed that in experimental group the pretest attitude mean was 34.30 and SD was 2.168 and post test attitude was 49.67 and SD was 2.758 and  $t=26.85$  it was significant at  $p=0.01$ . In control group the pretest attitude was 33.37, SD was 2.399 post test attitude mean was 34.50 and SD was 2.980 and  $t=1.74$ ,  $p=0.09$  it is not significant.

The fourth objective of the study was to find **out correlation between knowledge and attitude of experimental and control group.**

- In experimental group the pretest knowledge mean score and SD was  $7.73 \pm 2.16$  in pretest attitude mean score was  $34.30 \pm 2.17$ ,  $r=0.05$ ,  $p=0.79$  it indicate no correlation. It means there is no correlation between knowledge and attitude. In post test knowledge mean score and SD was  $16.40 \pm 1.65$ . In pretest attitude was  $49.67 \pm 2.76$ ,  $r=0.57$ ,  $p=0.001$  it indicates moderate positive significant correlation it means when knowledge increases their attitude also increases.
- In control group pretest knowledge means and SD score was  $7.33 \pm 2.23$  pretest attitude mean and SD was  $33.37 \pm 2.40$ ,  $r=0.08$ ,  $p=0.51$  it indicating poor correlation it means there is no correlation or poor correlation between knowledge and attitude. Posttest knowledge mean and SD was  $8.03 \pm 3.01$  post test attitude mean and SD was  $34.50 \pm 2.98$ ,  $r=0.10$ ,  $p=0.55$ . It indicates poor positive correlation it means there is no correlation or poor correlation between knowledge and attitude.

The fifth objective of the study was to **find out the association between demographic variable with knowledge and attitude.**

- The association between the demographic variables and their pretest level of knowledge regarding family planning methods among rural male population.
- In experimental group, none of the variables were associated with their level of knowledge.
- The association between demographic variables and their posttest level of knowledge regarding family planning methods among rural male population in experimental group. Age and education were associated with their level of knowledge.
- In control group showed the association between demographic variables and their pretest level of knowledge regarding family planning methods among rural male population in control group. None of the variables were associated with their level of knowledge.
- In control group showed that the associated between demographic variables and their post test level of knowledge regarding family planning methods among rural male population in control group none of the variables were associated with their level of knowledge.
- In experimental group the associated between demography variables and their pretest level of attitude regarding family planning methods among rural male population in experimental group. None of the variable was associated with their level of attitude.
- The association between demographic variables and their posttest level of attitude regarding family planning methods among rural male population in

experimental group, none of the variables were associated with their level of attitude.

- In control group the association between demographic variables and their pretest levels of attitude regarding family planning methods among rural male population. In control group none of the variables were associated with their level of attitude.
- In the control group the association between demographic variables and their posttest level of attitude regarding family planning methods among rural male population. In control group none of the variables were associated with their level of attitude.



## **CHAPTER VI**

### **SUMMARY, CONCLUSION, RECOMMENDATION AND NURSING**

#### **IMPLICATION**

This chapter presents the summary of the study, conclusions and implications for nursing practice and the recommendations for the study.

#### **SUMMARY OF THE STUDY**

The purpose of the study was to assess the knowledge and attitude of rural male regarding family planning methods before and after STP (structured teaching programme) in Paruvachi,, Bhavani Taluk, Erode District, ..

Descriptive statistic (frequency, percentage, mean and standard deviation) and inferential statistics was used for analysis

The conceptual frame work of this study was based on general systems theory. The instrument used for data calculation was knowledge and attitude questionnaire regarding family planning methods. Simple random sampling was used for this study to select the samples.

#### **MAJOR FINDING OF THE STUDY**

**Section I:** Description of frequency and percentage distribution of selected demographic variables.

- The age of male in experimental group 8(26.7%) of the respondents were in the age group of less than 25 years, 8(26.7%) of the respondents were in the age group of 26-33 years, 8(26.7%) of the respondents were in the age group 34-41 years, 6(20%) of the respondents were in the age group of 42-49 years.
- In control group 7(23.3%) of the respondents were in the age group of less than 25 years, 7(23.3%) of the respondents were in the age group of 26-33 years,

8(26.7%) of the respondents were in the age group of 34-41 years, 8(26.7%) of the respondents were in the age group of 42-49 years.

- The majority of number of children in family is experimental group one child 33.3% and control group one child 30.0%.
- The majority of educational status in experimental group primary school 56.7% and control group primary school 46.7%.
- The majority of monthly income in experimental group Rs.5001-8000 50.0% and control group Rs.5001-8000 36.7%.
- The majority of occupation in experimental group farmer 53.3% and control group Farmer 60.0%.
- The majority of religion in experimental group hindu 66.7% and control group hindu 73.3%.

**Section II:** Assessment of pre-test and post test knowledge of experimental & control group regarding family planning method.

- In experimental group, the pretest level of knowledge was inadequate among 86.7% and moderately adequate among 13.3% and none of them had adequate knowledge. In post test, the level of knowledge was inadequate among 0.0% and moderately adequate among 30% and whereas adequate among 70% of participants.
- In control group, the pretests 86.7% of males are having inadequate knowledge regarding family planning methods. 13.3% of males are having moderately adequate knowledge and none of them are having adequate knowledge regarding family planning methods in posttest 83.3% of males are having inadequate knowledge 66.7% of males are having moderately adequate knowledge, 0.0% of males are having adequate knowledge regarding family planning methods.

**Section III:** Assessment of pre-test and post test attitude of experimental & control group regarding family planning method.

- In experimental group the pretest level of attitude 16.7% are having inadequate attitude regarding family planning methods 83.3% are moderately adequate attitude and 0.0% are having adequate attitude regarding family planning methods. In post test none of are having inadequate attitude 20.0% are having moderately adequate attitude regarding family planning methods. 80.0% are having attitude regarding family planning methods.
- In control group the pretest 26.7% are having inadequate attitude 73.3% are having moderately adequate attitude. 0.0% are having adequate attitude regarding family planning methods. In the post test 23.3% are having inadequate attitude 76.7% are having moderately adequate attitude 0.0% are having adequate attitude regarding family planning methods.
- STP was found to be effective in improving the knowledge regarding family planning methods among male population.

**Section IV:** Comparison the pre-test and post test knowledge of experimental and control group regarding family planning method.

- In the experimental group pretest knowledge mean score 7.73, SD-2.16 and in control group in mean score 7.73, SD-2.23, In the experimental group post-test mean score 16.40, SD-1.65 and in control group mean score 8.03, SD-3.01. Both are significant.

**Section V:** Comparison the pre-test and post test and attitude of experimental and control group regarding family planning method.

- In the experimental group pretest attitude mean score 34.30, SD-2.168 and in control group mean score 33.37, SD-2.399, in the experimental group post-test

mean score 49.67, SD-2.758, in the control group mean score 34.50, SD-2.980, in the experimental group pretest and post-test overall attitude were significant and in the control group were not significant.

**Section VI:** Correlation between knowledge and attitude of experimental and control group regarding family planning method.

- In experimental group pretest, there is no correlation between knowledge and attitude. In post test their attitude increases when their knowledge increases.
- There is no correlation between knowledge and attitude in pretest and post-test score of control group.

**Section VII:** Association between level of knowledge on family planning method with selected demographic variables in control and experimental group.

- There is no association between experimental group levels of pretest knowledge and their demographic variables such as age of eligible couple, number of children in family, educational status, monthly income, occupation and religion.
- There is association between experimental group level of post-test knowledge and their demographic variables such as age of eligible couples, educational status. There is no association between experimental group level of post test knowledge and their demographic variables such as number of children in family, monthly income, occupation and religion.
- There is no association between control group level of pretest and post test knowledge and their demographic variables.

**Section VIII:** Association between level of attitude on family planning method with selected demographic variables in control and experimental group.

- There is no association between experimental group level of pretest attitude and their demographic variables.

- There is association between experimental group level of post test attitude and their demographic variables such as age of eligible couple, occupation. There is no significant association between experimental group level of post test attitude and demographic variables such as no. of children's in family, educational status, monthly income, religion.
- There is no association between control group level of pretest and post test attitude and demographic variables.

## **CONCLUSION**

STP was affective to increase the knowledge regarding family planning methods among male population as per

- In experimental group, none of them had adequate knowledge in the pretest, whereas during the post test, level of knowledge of the study subjects was adequate among 70%. In control group none of the participants had adequate knowledge both in pretest and post-test. In experimental group, none of the participants had adequate attitude in the pretest whereas during the post test, the level of attitude of study subjects was adequate among 24%. In control group .none of the participants had adequate attitude in the pretest and post-test. It was assess that when knowledge increases attitude also increases.

## **IMPLICATIONS FOR NURSING PRACTICE**

The result of the study will help the nurses to enlighten their knowledge on the importance of health education. As the primary care provider, the nurse can assist in promoting confidence and competence through assessment, intervention and referral. By assessing the knowledge level, the nurse can identify the areas where they have to enhance the teachings.

- Nursing personnel must educate.
- Health education is the essential part of nursing service. So health education regarding family planning enhances the knowledge of male family planning and will help in adopting positive attitude.
- The use of visual aids (flash cards, video assisted teaching, chart) and materials to read at home or in the hospital setting are important tools to facilitate learner retention of information.
- Nurses in hospitals, private practice, the community and beyond must work together to enhance the knowledge on family planning

### **IMPLICATIONS FOR NURSING EDUCATION**

- ✚ In service education programme should be conducted which will help nurses to gain more knowledge and provide information to the male population on family planning methods.
- ✚ The community based nurse educator is responsible for teaching the various new concepts regarding family planning methods.
- ✚ The nurse educator should invite the community nurses to the hospital based education programmer to see the directions and guidance given to people.
- ✚ This programme will facilitate continuous educational services, will positively affect the learning confidence, satisfaction and bridge the collegial relationship among nurses.

### **IMPLICATIONS FOR NURSING ADMINISTRATION**

- Nursing administrator could formulate policies that will include all nursing staff and students to be actively involved in health education programmes

regarding family planning methods and their respective hospital and college.

- It is essential that the nurse administrator remains informed of policy changes and current research and made available to all people.
- STP should be initiated and nurses need to attend these programmes periodically and thus they can teach the males regarding family planning methods.

#### **IMPLICATIONS FOR NURSING RESEARCH.**

- One of the aims of nursing research is to expand and to broaden the scope of nursing.
- Finding of the study serve as a base for the professionals and the students to conduct their studies.
- Research suggests that education at prompt time will make the male population to understand about male family planning methods.

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## SOCIO DEMOGRAPHIC DATA

### 1. Age of eligible couple

- a) 15 – 49 yrs
- b) 26 – 33 yrs
- c) 34 – 41 yrs
- d) 42 - 49 yrs. [     ]

### 2. Number of children in family

- a) 0
- b) 1
- c) 2
- d) More than 2 [     ]

### 3. Educational Status

- a) Illiterate
- b) Primary School
- c) Secondary School
- d) Graduate [     ]

### 4. Occupation

- a) Professional
- b) Coolie
- c) Farmers
- d) Others [     ]

### 5. Socio -Economic Status (Income per month)

- a) Rs. 2000 – 5000
- b) Rs. 5001 - 8000
- c) Rs. 8001 – 11000
- d) Above 11000 [     ]

## 6. Religion

- a) Muslim
- b) Christian
- c) Hindu
- d) Others

[     ]

## KNOWLEDGE

Scores 1, 0

Correct Ans 1

Wrong Ans 0

### i) Knowledge regarding meaning of family planning

1. What is meaning of family planning?
  - a. Space between births
  - b. Relationship between couple
  - c. Preventing sexual transmitted diseases [     ]
  
2. What is the 'Indian slogan' for family planning
  - a) We two our two
  - b) We two our three
  - c) We two our one [     ]
  
3. How much space needed in between each conception?
  - a) 1 yr
  - b) 3 yr
  - c) 5 yr [     ]
  
4. What are the ideal age recommended by Govt. norms for marriage in male and female.
  - a) 21 yrs – 18 yrs.
  - b) 21 yrs – 21 yrs
  - c) 23 yrs – 20 yrs [     ]
  
5. What is the Reproductive age
  - a) 15 – 49 yrs
  - b) 20 – 40 yrs
  - c) 15 – 35 yrs [     ]

6. How to act the breast feeding as family planning method
- a) Natural method
  - b) Permanent method
  - c) No relationship in family planning [     ]

7. Which is the most commonest adopted type of sterilization
- a) Female sterilization
  - b) Male sterilization
  - c) None of both [     ]

**ii) Knowledge regarding temporary methods of family planning**

1. What is the trade name of condom?
- a) Mala – N
  - b) Today
  - c) Nirodh [     ]

2. Which is the male temporary contraceptive methods
- a) Oral pills
  - b) Condom
  - c) Diaphragm [     ]

3. Which disease is prevented from the use of condom
- a) Hepatitis – B
  - b) AIDS
  - c) (T.B.) Tuberculosis [     ]

4. What are the types of intrauterine devices
- a) Copper – T
  - b) Nirodh
  - c) Mala – D [     ]

5. What is recommended time to use of intrauterine devices
- a) 1 Yrs
  - b) 2 yrs
  - c) 5 yrs [     ]
6. What is ideal time for insertion of intrauterine devices after delivery
- a) 1 week
  - b) 2 week
  - c) 6 week [     ]
7. What is ideal day to start the first dose of oral contraceptive pills
- a) 5<sup>th</sup> day of menstruation
  - b) 1<sup>st</sup> day of menstruation
  - c) 10<sup>th</sup> day of menstruation [     ]
8. What do you mean by medical termination of pregnancy (MTP)
- a) Abortion
  - b) Temporary method of family planning
  - c) Permanent method of family planning [     ]
9. What is suitable time for medical termination of pregnancy (MTP)
- a) 4 -5 wks
  - b) 6-8 wks
  - c) 7 – 8 wks. [     ]

**iii) Knowledge regarding permanent methods of family planning**

1. What do you mean by vasectomy
  - a) Temporary surgical procedure for family planning for males.
  - b) Temporary surgical procedure for family planning for females.
  - c) Permanent surgical procedure for family planning for males. [     ]
  
2. When will you be discharged after vasectomy surgery?
  - a) 12 hrs
  - b) 24 hrs
  - c) 36 hrs [     ]
  
3. What do you mean by tubectomy?
  - a) Temporary surgical procedure for the family planning for males.
  - b) Permanent surgical procedure for the family planning for males.
  - c) Permanent surgical procedure for the family planning for female. [     ]
  
4. How long the female hospitalized after tubectomy.
  - a) 5 – 7 days
  - b) 10-15 days
  - c) 10 -20 days. [     ]



## ATTITUDE

Score – Agree – 3

Uncertain - 2

Disagree - 1

		Agree	Uncertain	Disagree
1.	The family planning methods will help to decrease the population explosion.			
2	Health and family planning are two sides of a coin.			
3	Family planning is necessary for the every country.			
4	Exclusive breast feeding is one of the natural methods of family planning after delivery.			
5	Natural family planning method is good for health and wealth.			
6	Small family gives high living standards than the large family.			
7	Coitus interrupts is the temporary method of family planning.			
8	Condom method is a cheapest method of family planning.			
9	Condom will decreases the chance of sexual transmitted disease.			
10	Condom is a safest method of contraception in male.			
11	Condom is helpful to prevent the unwanted pregnancy.			
12	It is necessary to use a new condom during the each sexual inter course.			
13	Vasectomy is a permanent methods of male sterilization.			

1 4	Laparoscopy vasectomy is a latest and non painful technique for permanent sterilization in males.			
1 5	Temporary contraceptive methods reduces the risks of unwanted pregnancies.			
1 6	Abstinence is a one of the method to prevent the pregnancy.			
1 7	Copper – T is a temporary intrauterine device.			
1 8	Mala – D and Mala – N are oral contraceptive pills.			
1 9	The emergency pill prevents unwanted pregnancy if ingested within 72 hrs.			
2 0	Tubectomy is permanent method of family planning for women.			

## **gq:Nfw;ghsH gw:wpa r%of tptuq;fs:**

1. jFjpahd jk;gjpah;fspd; taJ
  - a) 15 - 49
  - b) 26 - 33
  - c) 34 - 41
  - d) 42 - 49
2. FLk;gj;jpd; Foe;ijfspd; vz;zpf;if
  - a) 0
  - b) 1
  - c) 2
  - d) 2 mjw;F Nky;
3. fy;tpawpT
  - a) fy;yhik
  - b) Kjy;epiy
  - c) ,ilepiy
  - d) gl;ljhhp
4. njhopy;
  - a) Ntiytha;g;G rk;ge;jkhd
  - b) \$yp
  - c) tptrhap
  - d) kw;wit
  
5. khj tUkhdk;
  - a) 2000 - 5000
  - b) 5001 - 8000
  - c) 8001 - 11000
  - d) 11000 - mjw;F Nky;
6. kjk;
  - a) K];yPk;
  - b) fphp];bad;
  - c) ,e;J
  - d) kw;wit

**FLk;gf; fl;LghL gw;wpa mwptpid Nrhjpi;jy;**

1. FLk;gf; fl;LghL vd;why; vd;d?
  - a) ,uz;L Foe;ijf;Fk; cs;s ,ilntsp
  - b) jk;gjpaw;F ,ilapy; cs;s cwT
  - c) gpwg;GWg;G Neha; njhw;Wjiyj; jLj;jy;
2. FLk;gf; fl;Lg;ghl;bd; RNyhfk; vd;d?
  - a) ehk; ,Uth; ekf;F ,Uth;
  - b) ehk; ,Uth; ekf;F %th;
  - c) ehk; ,Uth; ekf;F xUth;
3. xt;nthU fUj;jwpj;jYf;Fk; cs;s ,ilntsp?
  - a) 1 tUlk;
  - b) 3 tUlk;
  - c) 5 tUlk;
4. MZf;Fk; ngz;Zf;Fk; murhy; tpjpf;fg;gl;l jpUkz taJ?
  - a) 21 – 18
  - b) 21 – 22
  - c) 23 – 20
5. ,dg;ngUf;f taJ vJ?
  - a) 15 – 49
  - b) 20 – 40
  - c) 15 – 35
6. jha;ghy; mspj;jy; vt;tif FLk;g fl;LghL Kiw?
  - a) jw;fhypf
  - b) epue;ju
  - c) rk;ge;jk; ,y;yhjJ
7. vJ nghJthf nra;ag;gLk; FLk;gf; fl;LghL Kiw
  - a) Mz; FLk;gf; fl;LghL
  - b) ngz; FLk;gf; fl;LghL

**jw;fhypf FLk;gf; fl;LghL Kiw gw;wpa mwptpid Nrhjpi;jy;:-**

1. fhz;l;jpy; th;j;j ngah; vd;d?
  - a) khyh
  - b) UNl
  - c) epNuhj;
2. vJ Mz; jw;fhypf FLk;gf; fl;LghL Kiw?
  - a) khj;jpiufs;
  - b) fhz;lk;
  - c) ilahg;uk;
3. fhz;lk; cgNahfpg;gjhy; vt;tif Neha;fis jLf;fyhk;
  - a) vg;gill;B]; - 3
  - b) va;l;];
  - c) fhrNeha;
4. fUg;ig rhjdk; vit?

- a) fhg;gh; - T
  - b) epNuhj;
  - c) khyh – D
5. fUg;ig rhjdq;fis cgNahfg;gLj;Jk; fhyk;?
- a) 1 tUlk;
  - b) 2 tUlk;
  - c) 5 tUlk;
6. gpurtj;jpw;F gpwF fUg;ig rhjdk; cl;GFj;j jFe;j Neuk; vJ?
- a) 1 thuk;
  - b) 2 thuk;
  - c) 6 thuk;
7. tha;top fUj;jil khj;jpiufs; cl;nfhs;Sk; Neuk;?
- a) khjtplhapd; 5 MtJ ehs;
  - b) khjtplhapd; Kjy; ehs;
  - c) khjtplhapd; gj;jhtJ ehs;
8. kUj;Jt fUr;rpijt vd;why; vd;d?
- a) fUf;fiyg;G
  - b) jw;fjyph FLk;g fl;Lg;ghL
  - c) epue;jpu FLk;g fl;Lg;ghL
9. kUj;Jt fUf;fiyg;G vg;NghJ nra;a Ntz;Lk;?
- a) 4 – 5 tJ thuk;
  - b) 6 – 8 tJ thuk;
  - c) 7 – 8 tJ thuk;

**epue;jpu FLk;gf; fl;Lg;ghL Kiwia gw;wpa mwptpid Nrhjpj;jy:-**

1. thrf;lkp vd;why; vd;d?
- a) Mz;fSf;fhd jw;fhypf FLk;gf; fl;Lg;ghL
  - b) ngz;fSf;fhd jw;fhypf FLk;gf; fl;Lg;ghL
  - c) Mz;fSf;fhd epue;jpu FLk;gf; fl;Lg;ghL
2. thrf;lhcp mWit rpfpr;ir gpwF vg;NghJ b];rhh;[] nra;a Ntz;Lk;?
- a) 12 kzp Neuk;
  - b) 24 kzp Neuk;
  - c) 36 kzp Neuk;
3. bAgf;lkp vd;why; vd;d?
- a) Mz;fSf;fhd jw;fhypf FLk;gf; fl;Lg;ghL
  - b) Mz;fSf;fhd epue;jpu FLk;gf; fl;Lg;ghL
  - c) ngz;fSf;fhd epue;jpu FLk;gf; fl;Lg;ghL

4.  $v_j; jid\ ehl; fs; ngz; fs; mWit\ rpfpr; irf; F\ gpd; kUj; Jtkidapy; jq; fpapUf; f$

Ntz; Lk; ?

- a) 5 – 7 ehl; fs;
- b) 10 – 15 ehl; fs;
- c) 10 – 20 ehl; fs;

<b>t.vz;</b>	<b>Nehf;fk;</b>	<b>Vw:W nfhs;fpNw d;</b>	<b>vg;NghjhtJ</b>	<b>Vw:Wf; nfhs;skhl;Nld;</b>
1.	FLk;gf; fl;Lg;ghL Kiw kf;fs; njhif ngUf;fj;ij Fiwf;Fk;			
2.	cly; eyd; kw;Wk; FLk;gf; fl;Lg;ghL ehzaj;jpd; ,U gFjpf;			
3.	Xt;nthU ehl;bw;f;F FLk;g fl;Lg;ghL Njit			
4.	gpurtj;jpw;F gpwF jha;ghy; xU rpwe;j fUj;jil Kiw			
5.	,aw;if FLk;gf; fl;Lg;ghL Kiw cly;eyj;jpw;F eyd;			
6.	rpW FLk;gf; Nfhl;ghL tho;f;if juj;ij cah;j;Jk;			
7.	cly;cwtpypUe;J tpyfpapUj;jy; jw;fhypf FLk;g fl;Lg;ghL Kiw			
8.	fhz;lk; xU tpiyf; Fiwe;j jw;fhypf FLk;g fl;Lg;ghL Kiw			
9.	fhz;lk; gpwg;Gwg;G njhw;W Nehia jLf;fpwJ			
10.	fhz;lk; ghJfhg;ghd fUj;jil Kiw			

11.	fhz;lk; Njitaw;w fUTWjij jLf;fpwJ			
12.	xt;nthU KiwAk; Gjpa fhz;l;ij gad;gLj;jNtz;Lk;			
13.	thrf;lkp xU epue;ju Mz; FLk;g fl;Lg;ghL Kiw			
14.	yhg;uh];Nfhgp thrf;lkp typaw;w Mz;fSf;fhd epue;ju mWit rpfpr;ir Kiw			
15.	jw;fhypf fUj;jil Kiw Njitaw;w fUTWjij jLf;fpwJ			
16.	tpyfpapUj;jy; xU rpwe;j top fUTWjij jLf;f			
17.	fhg;gh; - b xU rpwe;j jw;fhypf fUg;ig rhjdk;			
18.	khyh – D kw;Wk; khyh – N xU fUj;jil khj;jpiufs;			
19.	mtru fUj;jil khj;jpiufis 72 kzp Neuj;jpw;Fs; cl;nfhs;s Ntz;Lk;			
20.	bAgf;lkp xU epue;ju ngz;fSf;fhd FLk;g fl;LghL Kiw			





<b>Fwptf;Nfhs;</b>	<b>Neuk;</b>	<b>nghUs;</b>	<b>fw:gpi;jy ; Kiw</b>	<b>fpuhkg;G w Mz:fspd; nray;ghL</b>	<b>fw:gpi;jy; top Kiwfs;</b>	<b>jpwdha;T</b>
jiyg;ig gw:wpa KfTiu		<b>FLk:gf; fl;LghL gw:wpa KfTiu:-</b> cyf kf;fs; njhifapy; ,e;jpah> rPdhtpw;F mLj;J ,uz;lhk; ,lj;ij tfpf;fpwJ. xU ehisf;F Rkhh; [k;gj;J [e;jhapuk; Foe;ijfs; gpwg;gjhhf; fz;lwpag;gl;Ls;sJ. ,jdhy; xt;nthU tUIKk; Rkhh; gjp%d;W kpy;ypad; kf;fs; njhifapy; \$Ltjhff; 1981 y; fzf;fplg;gl;Ls;sJ. by;ypapy; cs;s kj;jpa Rfhjhu FOtpd; Rfhjhuf; fzf;nfLg;gpd; gb 1981 Mk; Mz;Ld; nkhj;j kf;fs; njhif 683 kpy;ypaDk;> 1988 y; 792 kpy;ypad;fs; vdf; fz;lwpag;gl;Ls;sJ. ,J ,e;jpa kf;fs; njhifapd; mjpNtf tsh;r;rpiaf; fhl;LfpwJ.	tiuaiu nra;jy;	ftdpj;jy; kw;Wk; tpilaspi;jy;		
FLk;g fl;Lg;ghL Kiw gw:wpa tiuaiw		<b>FLk:gf; fl;LghL gw:wpa tiuaiw:-</b> FLk;gf; fl;LghL vd;gJ ek; vz;zj;jpYk; tho;tpYk; jd;dpr;irahf Vw;Wf;nfhs;sg;gLfpwJ ,J xU jdpkdpjd; kw;Wk; jk;gjpah;fspd; cly;ey Kd;Ndw;wj;jpw;fhfTk;> FLk;g eyDf;fhfTk;> kw;Wk; rKjha Kd;Ndw;wj;jpw;fhfTk;> xUthpd;	tpsf;Fjy;	ftdpj;jy; kw;Wk; tpilaspi;jy;		FLk;gf; fl;LghL vd;why; vd;d

		mwptpd;gb cs;Szh;NthL nghWg;Ngw;W vLf;f;gLk; KbT <b>(eyf Rfhjhu mikg;G 1971)</b>				
		<b>FLk;g eyd::</b> FLk;g eyd; FLk;gf; fl;Lghl;il tpl FLk;g ed;ikapd; gq;F tphpthJ. FLk;g ed;ikapd; cl;fUj;J mbg;gilapy; tho;f;ifapd; juj;NjhL njhlh;GilaJ ,J fy;tp> czT rj;J> Rfhjhuk;> Ntiytha;g;ig cl;nfhz;lJ> kw;Wk; ngz;fspd; eyd;> chpik> ghJfhg;G> ghJfhf;fg;gl;l FbePh; Nghd;w midj;J Kf;fpa fhuzpfisf; nfhz;lJ	tpsf;Fjy;	ftdpj;jy; kw;Wk; tpilaspj;jy		FLk;gf; fl;LghL vd;why; vd;d
		<b>jFjpahd jk;gjpfs:-</b> jFjpahd jk;gjpfs; (.yf;F jk;gjpfs;) vd;gJ jpUkzkhd jk;gjpfs; mjpYk; ngz;fspd; ,dg;ngUf;f taJ (15 – 45 Mf ,Uf;f Ntz;Lk;). ,J Rkhh; 180 jFjpahd jk;gjpfs; kw;Wk; Vw;fdNt ,uz;L Foe;ijfSila jk;gjpah;fis ,yf;fhff; nfhz;l Cf;Ftpf;Fk; Kaw;rp	tpsf;Fjy;	ftdpj;jy; kw;Wk; tpilaspj;jy		jFjpahd jk;gjpfs; tpthp
		<b>Foe;ijg; ngWjydpd; .ilntsp:-</b> FLk;gf; fl;LghL vd;gJ FLk;g vz;zpf;ifia	tpsf;Fjy;	ftdpj;jy; kw;Wk;		

<p>FLk;g fl;Lg;ghL Fwpf;Nfhs; gw;wp gl;baypLjy;</p>	<p>Fiwg;gJ kl;Lk; my;yhJ; Foe;ijg; ngWjydpd; ,ilntspia giwrhw;WfpwJ. xU Foe;ijf;Fk; kw;nwhU Foe;ijf;Fk; Rkhh; 3 Mz;Lfs; ,ilntsp ,Ue;jhy; gpwf;Fk; Foe;ij ey;y cly; eyj;NjhL tho;f;ifia Jtq;Fk;&gt; mJ kl;Lk; my;yhJ&gt; jha;f;F Nghjpa Neuk; mhp;fg;Ltjhy; Ke;ij gpurtj;jpd; rf;jp ,oj;jiypUe;J Fzkila cjTtNjhL jhapd; cly; eyj;ijAk; Ngzpf;fhf;fpwJ.</p> <p><b>FLk;gf; fl;Lghl;bd; Fwpf;Nfhs;-</b></p> <p>FLk;gf; fl;LghL Kiw vd;gJ xU jdpegh; kw;Wk; jk;gjpah;fs; Fwpg;gpl;l ,yl;rpaj;ij mila cjTtjhFk;. (cyf Rfhjhu mikg;G 1971).</p> <ol style="list-style-type: none"> <li>1. Njitaw;w gpwg;Gfis jtph;g;gJ</li> <li>2. tpUg;gKw;w gpwg;Gfisf; nfhz;LtUtJ</li> <li>3. ,U fUj;jhpj;jypd; ,ilntspia mjpfg;gLj;JtJ.</li> <li>4. Ngw;Nwhhpd; tajpw;F Vw;g fUj;jhpj;jypd; Neuj;ijf; fl;Lg;gLj;JtJ.</li> <li>5. xU FLk;gj;jpy; Foe;ijfspd; Neuj;ij</li> </ol>		<p>tpilaspi;jy</p>		<p>FLk;gf; fl;Lghl;bd; Fwpf;Nfhs; ahit</p>
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<p>kf;fs; njhif ngUf;fj;jpd; fhuzpfis fzf;fpL</p>		<p>eph;zak; nra;tJ. <b>.e;jpa kf;fs; njhifapd; mjpfhpg:gpd; fhuzq;fs:-</b> mjpf gpwg;G tpfjpk; kw;Wk; Fiwe;j ,wg;G tpfjpk; kf;fs; njhif ngUf fhuzk; 1991 fzf;nfLg:gpd; gb gpwg;G tpfjpk; 1000 kf;fs; njhiff;F Xh; Mz;bw;F 30.5 MfTk;&gt; ,wg;G tpfjpk; 10.2 Mf fzf;fplg;gLs;sJ. gpwg;G tpfjj;jpd; cah;Tf;F Kf;fpa fhuzq;fs; 1. Fwpj;j fhy;jpw;F Ke;ija jpUkzk; 2. vq;F tho;f;ifj;juk; FiwfpwNjh mq;F gpwg;G tpfjpk; mjpfhpf;fpwJ vq;F tho;f;ifj;juk; cah;fpwNjh mq;F gpwg;G tpfjpk; FiwfpwJ. 3. Fiwe;j fy;tpawpT my;yJ fy;yhik 4. Guk;giu tof;fk; kw;Wk; fyhr;ruhk; (v.fh) xt;nthU ngz;Zk;&gt; MZk; jpUkzkhfp Foe;ijfisg; ngw;wpUf;f Ntz;Lk;&gt; Foe;ijfs; flTspd; ghpR 5. FLk;g fl;Lg;ghL gw;wpa mwptpd;ik 6. nghOJNghf;F trjpfs; ,y;yhjhy;&gt; rpy jk;gjpah;fs; Foe;ijg; ngWjypy; &lt;LgLfpd;wdh;.</p>	<p>tpsf;Fjy;</p>	<p>ftdpj;jy; kw;Wk; tpilaspj;jy</p>		
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		<p><b>.wg;G tpfjk; Fiwtpd; fhuzq;fs:-</b></p> <ol style="list-style-type: none"> <li>1. ,aw;if kuzk;&gt; gQ;rk; Nghh; kw;Wk; Neha; Njhw;Wjyhy; Vw;gLk; ,wg;G tpfjk; jw;NghJ ngUk; msT Fiwf;fg;gl;Ls;sJ.</li> <li>2. kNyhpah&gt; vyp fha;r;ry;&gt; nghpa mk;ik&gt; Nghd;w Neha;fs; fl;Lg;gLj;jg;gl;Ls;sJ.</li> <li>3. kUj;Jt Jiwapd; tsh;r;rp (v.fh) fPNkhNjugp&gt; Mz;bigNahbf;]; kw;Wk; g+r;rpnfhy;ypfs;</li> <li>4. Nkd;ikahd cly; eyk; kw;Wk; czit ngw;W nfhs;Sjy;</li> <li>5. tho;f;if Kiw kw;Wk; cly;eyid cah;j;Jtjw;F cyfshtpa njhz;L epWtzq;fspd; cjtp</li> <li>6. rKjha tpopg;Gzh;T</li> </ol> <p><b>kf;fs; njhif tsh;r;rpahy; Vw;gLk; tpisTfs:-</b></p> <ol style="list-style-type: none"> <li>1. [e;jhz;L jpl;lq;fs; ,Ue;Jk; Fiwe;j tho;f;if juk;</li> <li>2. Cztpd;ik&gt; Cl;lr;rj;J Fiwtpw;F Kf;fpa fhuzk;</li> </ol>				
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		<p>3. Tajhdth;fs; cj;jpNahfj;jpw;F Xa;T ngw;w gpd;Dk; coif;Fk; mtyk;</p> <p>4. ,sk; tajpdh;fs; fy;tpf;fhf coif;Fk; mtyk;</p> <p>5. Ntiyapd;ik&gt; tPL Nehpry;&gt; rl;lk; rhh;e;j gpur;ridfs; MFk;.</p> <p><b>rpW FLk:g Nfhl:ghL kw;Wk; Kf:fpaj;Jtk:-</b></p> <p>FLk:g vz;zpf;if&gt; kdpjh;fspd; tho;f;if juj;ijf; Fiwf;fpwJ. FLk:g vz;zpf;if gpd;tUk; Nfhzq;fis ghjpf;fpwJ.</p> <p>1. xU kdpjdpd; mbg;gil Njit</p> <p>2. tUkhdk; kw;Wk; nghUshjhu tsh;r;rp</p> <p>3. czT kw;Wk; Cl;r;rj;jpd; juk;&gt; msT&gt;</p> <p>4. epyk; kw;Wk; nghJ tsh;r;rp jpl;lq;fis cgNahfpg;gjpy; rpf;fy;</p> <p>5. jha; kw;Wk; Foe;ijapd; cly;eyf;NfL</p> <p>6. Foe;ijfspd; fy;tp</p>			
<p>kf;fs; njhif ngUf;fj;jhy; tpisAk; jPikfis gw;wp tpthjpj;jy;</p>		<p><b>nghpa kw;Wk; jpl:lk;kw;w FLk:gq;fspdhy; tpisAk; jPq:F:-</b></p> <p>nghpa kw;Wk; jpl:lk;kw;w FLk:gq;fspdhy; tpisAk; jPikfis; jha; kw;Wk; Foe;ijfis ghjpg;gNjhly;yhky; FLk;gj;ijAk; rKjhaj;jiAk; ghjpf;fpwJ.</p>	<p>tpsf;Fjy;</p>	<p>ftdpj;jy; kw;Wk; tpilaspj;jy</p>	<p>jpl;lkw;w nghpa FLk:gq;fspdhy; tpisAk; jPikfis;</p>

		<p>1. ,sk; taJ jpUkzq;fs; fh;gk; jhpg;gjpYk; Foe;ijg; ngWtjpYk; gy rpf;fy;fis cUthf;FfpwJ. (v.fh) fUr;rpjT&gt; Fioe;ij ,we;J gpwe;jy;&gt; Fiwg;gpurtk;&gt; kw;Wk; fUg;ig tha; Gw;WNeHa;fs; mJkl;Lk; my;yhJ fy;tpia ghjpapy; epWj;Jtjhy; jFe;j Ntiyf;F nry;yhj epiy Vw;gLfpwJ.</p> <p>2. kpf ,sk; taJ fh;gj;jhy; cz;lhFk; tpisTfs; fUj;jhpj;jpYk;&gt; gpurtj;jpYk; rpf;fy;&gt; vil Fiwe;j Foe;ij&gt; cly;eyf; Fiwe;j jha;&gt; Foe;ij ,wg;G tpfjpk; kw;Wk; jha; ,wg;G tpfjpk; mjpfhpj;jy;.</p> <p>3. mbf;fb fUj;jhpj;jyhy; tpisAk;;; jPikfs; kfpo;r;rpapd;ik&gt; FLk;gj;jpy; Nerkpd;ik Foe;ijfSf;F fy;tp mspg;gjpy; rpf;fy; fUj;jhpj;jy; kw;Wk; gpurtj;jpy; rpf;fy;.</p>				
rpW FLk;g Nfhl;ghl;bd; Kf;fpaj;Jtj;ij		<b>rpW FLk;g</b> <b>Vw;Wf;nfhs;tjhy;</b> <b>ed;ikfs;-</b>	<b>Nfhl;ghl;il</b> <b>tpisAk;</b>			



<p>tpthpj;jy;</p>	<p><b>jha;f;F tpisAk; ed;ikfs:-</b></p> <ol style="list-style-type: none"> <li>1. rpwpa jpl;lf; FLk;gj;jpdhy; jha; jd;Dila cly;eyid Ngzpf;fhf;f KbAk;</li> <li>2. ,J tpUg;gw;w fUj;jhpg;gjpdhy; Vw;gLk; gaj;ij Nghf;FfpwJ.</li> <li>3. msthd Foe;ijfspdhy; jha; ftiyaw;w ,Uf;f KbAk;.</li> <li>4. jha;f;F NghJkhd Neuk; ,Ug;gjhy; Foe;ijfspd; Nky; jFe;j ftdj;ij nrYj;j KbAk;.</li> <li>5. ey;y Ntiytha;;g;ig gad;gLj;jpf; nfhs;s KbAk;.</li> <li>6. jha;f;F Nghjpa Neuk; fpilg;gjhy; fy;tp&gt; Ntiytha;g;G&gt; rKjha jpl;lj;jpy; gq;Nfw;f KbAk;.</li> <li>7. Jha; Foe;ijfspd; cly; eyid Ngzpf; fhf;f KbAk;. ,jdhy; Fe;ij ,wj;jy;&gt; gpwtpf; Fiwg;ghLfs; kw;Wk; Foe;ijfs; ,wg;G tpfpj;j;ij Fiwf;f KbAk;.</li> </ol> <p><b>Foe;ijfSf;F Vw;gLk; ed;ikfs:-</b></p> <ol style="list-style-type: none"> <li>1. Foe;ijfSf;F jFe;j cly;tsh;r;rp kw;Wk; kdtsh;r;rp mspf;Fk; #oiy cz;lhf;FfpwJ.</li> </ol>				
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		<p>2. Foe;ijf;F jFe;j Cl;lr;rj;J&gt; fy;tp&gt; ngw;Nwhhpd; md;G kw;Wk; ghJfhg;ig ngw KbAk;</p> <p>3. Foe;ij FLk;gj;jpw;F Nghjpa nghUshjhuj;ij &lt;l;Ltjpy; cjtpahf ,Uj;jy;.</p> <p><b>je;ijf;F tpisAk; ed;ikfs:-</b></p> <p>1. je;ij Foe;ijf;F fy;tp&gt; Nghjpa czT&gt; cil&gt; nghOJNghf;if mspf;f KbAk;.</p> <p>2. je;ij ftiyaw;W ey;y cly;eyj;Jld; ,Uf;f KbAk;.</p> <p>3. Je;ij tho;f;if juj;ij cah;jjp&gt; ey;y cly;eyj;Jld; gzk; &lt;l;l KbAk;.</p> <p><b>rKjhaj;jpw;F Vw:gLk; ed;ikfs:-</b></p> <p>1. rpW FLk;g Nfhl;ghl;lhy; ,aw;if tsq;fis Nkk;gLj;j KbAk;</p> <p>2. mjpf Ntiy tha;g;ig cz;lhf;FfpwJ.</p> <p>3. rKjhaj;jpw;F NghJkhd gs;spfs;&gt; kUj;Jtkid kw;Wk; mbg;gil trjpfis mspf;fpwJ.</p> <p>4. ,J kfpo;r;rp&gt; mikjp xw;Wik&gt; kw;Wk; nrKikia jUfpwJ.</p> <p><b>fUj;jil Kiwfs:-</b></p> <p>fUj;jil Kiwfs; ,uz;L gphpTfshf gphpf;fyhk;</p>				
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<p>fUj;jil Kiwfis gphpj;J fhl;Ljy;</p>		<p>1. ,ilntsp Kiw (m) jw;fhypf Kiw 2. ,Wjpahd (m) epue;ju Kiw <b>1) jw;fhypf Kiwapd; gphpTfs:-</b> a) jilnra; Kiw b) ntspg;Gw Kiw c) ,urhaz Kiw d) ,izf;fg;gl;l Kiw 2. fUg;ig rhjdk; 3. cl;rug;G Kiw 4. fUj;jwpj;jYf;F gpd; gpd;gw;Wk; Kiw 5. kw;wit 2) ,WjpahdKiw 1. Mz; FLk;gf; fl;Lg;ghL Kiw 2. ngz; FLk;gf; fl;Lg;ghL Kiw <b>jilnra; Kiw</b> a. ntspg;Gw Kiw 1. fhz;lk;- fhz;lk; vd;gJ nky;ypa ug;ghpdhy; Md ciw Mz;fshy; cly; cwtpd; NghJ gad;gLj;jf; \$baJ. <b>ed;ikfs::</b> ❖ midj;J FLk;g ikaq;fspYk; vspjpy; ,ytrkhf fpilf;ff; \$baJ. ❖ cgNahfg;gLj;JtJ kpfTk; vspJ.</p>				
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		<ul style="list-style-type: none"> <li>❖ Njitaw;w fUTUjiyj; jLf;fpwJ.</li> <li>❖ Va;l;] kw;Wk; gpwg;GWg;G njhw;W Neha;fisj; jLf;fpwJ.</li> <li>❖ kUj;Jt ftdpg;G mw;wJ.</li> </ul> <p><b>Fiwfs:-</b></p> <ul style="list-style-type: none"> <li>❖ jhk;gj;a jpUg;jpiaf; Fiwf;fpwJ.</li> <li>❖ Xt;nthU KiwAk; Gjpa fhz;lk; cgNahfg;gLj;j Ntz;Lk;.</li> <li>❖ tpyFk; tha;g;G cs;sJ.</li> </ul> <p><b>Fwpg;G:-</b></p> <ul style="list-style-type: none"> <li>❖ tpyFtjw;F Kd; fhz;lk; eOthky; ghj;j;Jf; nfhs;s Ntz;Lk;</li> <li>❖ xUKiw kl;LNk cgNahfg;gLj;j Ntz;Lk;</li> <li>❖ Ehhpy; 14 ngz;fs; fw;gkila tha;g;G cs;sJ.</li> </ul> <p><b>1. ngz; fhz;lk;:-</b></p> <p>ngz; fhz;lk; ghypAhpNjd; vd;Dk; ciuahy; MdJ. ,J fh;gigapd; thapy; mzptJ ,J gpwg;Gwg;G njhw;W Nehiaj; jLf;fpwJ.</p> <p><b>2. ilahg;uk;:- (lr; Nfg;)</b></p> <p>ilahg;uk; fUigapd; thapy; jilnra; Kiw Kiwahd msit Njh;e;njLf;f Ntz;Lk;. ,J cly; cwtpw;F Kd;G mzpa Ntz;Lk;. cly;</p>				
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<p>jw;fhypfkhd kw;Wk; epue;ju FLk;g fl;Lg;ghL Kiwfs; gw;wp tpthpj;jy;</p>	<p>cwtpw;F gpd; 6 kzpNeuj;jpw;F Nky; mzpaf;\$lhJ.</p> <p><b>ed;ikfs:-</b> 1. ,jpy; gf;ftpisTfs; FiwT.</p> <p><b>jPikfs:-</b> 1. kUj;JtNuh my;yJ nrtpypaNuh mzpAk; Kiwg;gw;wp fw;gpj;jy; Ntz;Lk;. 2. fHg;gg; ig thapy; gQ;R itj;jy;. ,J ilahg;uik tpl nray;ghl;by; FiwthdJ</p> <p><b>.uhrz Kiw:-</b> Eiufs;&gt; Eiu khj;jpiufs; G+r;Rfs;&gt; Fok;Gfs;&gt; \$o;fs;</p> <p><b>fiury;fs:</b> Mz;tpe;J nfhy;ypfs; ntspg;Gwk; cgNahfg;gLj;jg;gLfpwJ. ,J tpe;Jfspy; Xl;bf;nfhz;L mitf;F Rthrf; fhw;iw jilnra;Jf; nfhs;fpwJ</p> <p><b>jPikfs:-</b> ➤ mjpgf tPo;r;rp tpfjk; ➤ cly;cwtpw;F Kd;G xt;nthU KiwAk; cgNahfg;gLj;j Ntz;Lk;. ➤ fUg;igapd; EithapypYk; cgNahfg;gLj;j Ntz;Lk;.</p>				
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	<p>➤ ,J vhp;r;iy cz;lhf;ff; \$baJ.</p> <p><b>fUg;ig rhjdq;fs:-</b></p> <p>a. fhg;gh; - b</p> <p>b. Ypg;]; Yhg;</p> <p>a. Fhg;gh; - b (jhkpuk;-b)</p> <p>,jpy; gy tif cz;L</p> <p>(v.fh) fhg;gh;-7&gt; fhg;gh;-b&gt; Mdhy;</p> <p>,e;jpahtpy; rhjhuzkhf cgNahfg;gLj;JtJ</p> <p>fhg;gh; -b 200</p> <p>Fhg;gh; -b g;sh];bf;fhy; MdJ ,jpy;</p> <p>jhkpuk; fk;gp xU jz;bd; Nky;</p> <p>Rw;wg;gl;bUf;Fk; ,ij cly;</p> <p>ghpNrhjidf;gpd;Nd cgNahfg;gLj;j</p> <p>Ntz;Lk;. ,J %d;wpypUe;J Ie;jhz;Lfs; tiu</p> <p>cgNahfg;gLj;jyhk;. ,J fUg;ig thapy;py;</p> <p>cgNahfg;gLj;j Ntz;Lk;. ,J jhkpuj;ij</p> <p>ntspapLk;.</p> <p><b>ypg;gP]; Yhg;gpd; ed;ikfs:-</b></p> <p>- kpfTk; rpwpaJ</p> <p>- Fiwe;j typ</p> <p>- Ntf nray;ghLf; nfhz;lJ</p> <p><b>ypg;gP]; lhg:-</b></p> <p>,J s tbt g;sh];bf; rhjdk; ,J nky;ypa</p>				
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	<p>Ehyphdy; Md ieyhd; ,J rpwpa msT Nghpak; fjph;fisf; nfhz;LJ.</p> <p><b>mzpAk; fhyk;:-</b></p> <p>fUg;ig rhjdq;fis khjtplhapd; 3ypUe;J 7 ehl;fSf;Fs; mzpa Ntz;Lk;. ,J gpurtj;jpw;F gpd; 1 thuk; fopj;Jk; mzpayhk; ,J mzptJ RygkhdJ my;yJ khjtplha; Md Kjy; ehspypUe;J 1 thuj;jpw;Fs; mzpa Ntz;Lk;.</p> <p><b>gf;f tpisTis;:</b></p> <ul style="list-style-type: none"> <li>- Mb tapw;W typ</li> <li>- ,uj;jg; Nghf;F</li> <li>- Fiwe;j khjtplha; ehl;fs;</li> <li>- ,jpy; gpur;ridfs; ,Ue;jhYk;&gt; rpfpr;irmspj;jhy; Fzkilaf; \$baJ.</li> <li>- Mdhy; fha;r;rNyh&gt; kpFe;j typNah ,Ue;jhy; ,ij vLj;j tpl Ntz;Lk;</li> </ul> <p><b>ed;ikis;:</b></p> <ul style="list-style-type: none"> <li>- Fiwe;j tPo;r;rp tpfjpk;</li> <li>- tpiy cah;e;jJ</li> <li>- Jha;g;ghy; mspf;Fk; jha;f;F Vw;wJ</li> </ul>				
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		<ul style="list-style-type: none"> <li>- ,J xU Kiw kl;LNk mzpaf;\$baJ</li> <li>- tpUg;gk; NghJ tpyf;fpf; nfhy;yyhk;</li> <li>- ,J jhk;gjpaj;ij ghjpf;fhJ.</li> <li>- Foe;ij ,ilntspf;F nghpJk; cjTtJ</li> </ul> <p><b>jPikfs:-</b></p> <ul style="list-style-type: none"> <li>- mzpAk; NghJ typia cz;lhf;ff; \$baJ</li> <li>- gf;f tpisTfs;- 3 khjj;jpw;F ,uj;jg;Nghf;F cz;lhf tha;g;G cs;sJ</li> <li>- fUg;ig Rtiu ciuAk; tha;g;G cs;sJ</li> <li>- 3ypUe;J 9 rjtpjk; fUTUjYf;F tha;g;G cs;sJ</li> </ul> <p><b>jtph;f;fg;gl Ntz;bait:-</b></p> <ul style="list-style-type: none"> <li>❖ fUTWjypy; gpur;rid</li> <li>❖ fUg;ig Eiothapy; Ez;fpUkpfs;</li> <li>❖ gpwg;Gwg;G njhw;W Neha;fs;</li> <li>❖ ,uj;jNghf;F kw;Wk; gpwg;Gwg;G Gw;WNeha;fs;</li> </ul> <p><b>cly;Rug;gpfs; fUj;jilfs:-</b></p> <ul style="list-style-type: none"> <li>❖ gpy;l;</li> <li>❖ Crp %yk; nrYj;Jjy;</li> <li>❖ Njhypy; mbapy; nrYj;Jjy;</li> </ul>				
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	<p><b>khj:jpiufs:-</b></p> <ul style="list-style-type: none"> <li>❖ ,jpy; rpwpa msT &lt;];l;u[pd; kw;Wk; g;u[];l;uhd; cs;sJ.</li> <li>❖ ,J kpFe;j nryy; jpwe;j nfhz;lJ</li> <li>❖ Rygkhf ngwf;\$baJ</li> <li>❖ ,J fUKl;il ntspahtijj; jLf;fpwJ.</li> <li>❖ ,J 100% nray;jpwd; nfhz;lJ</li> <li>❖ khyh – N</li> <li>❖ khyh - D</li> </ul> <p><b>cl;nfhs;Sk; Kiw:-</b></p> <p>,jpy; nkhj;jk; 28 khj:jpiufisf; nfhz;lJ 21 khj:jpiufs; fUj;jilkhj:jpiufs;&gt; 7 khj:jpiufs; ,Uk;G rj;J khj:jpiufs;</p> <ul style="list-style-type: none"> <li>❖ khjtplha; Md 5 MtJ ehspypUe;J cl;nfhs;s Ntz;Lk;</li> <li>❖ jpdKk; xU khj:jpiu tPjk; cl;nfhs;s Ntz;Lk;</li> </ul> <p><b>gf;f tpisTfs:-</b></p> <ul style="list-style-type: none"> <li>• Kjy; thu cl;nfhs;Sk;NghJ Fkl;ly;&gt; jiy Rw;wy;&gt; jiytyp&gt; vil \$Ljy;&gt; khh;G typ Nghd;wit</li> </ul> <p><b>khj:jpiuia tpl:LtpLjy:-</b></p> <p>Njitg;gLk; NghJ khj:jpiu cl;nfhs;sjiy epWj;jpf; nfhs;syhk; ed;ikfs;-</p>				
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	<p>❖ 100% nray;jpwd; tha;e;jJ</p> <p>❖ ,J jhk;gjpaj;ij ghjpf;fhJ</p> <p><b>jPikfs:-</b></p> <ul style="list-style-type: none"> <li>- khj;jpiu cl;nfhs;tjw;Fs; Kd; cly; ghpNrhjid nra;jy; Ntz;Lk;</li> <li>- Cf;fKk;&gt; ew;gz;Gk; Njit</li> <li>- vy;yhg; ngz;fSk; cl;nfhs;s ,ayhJ.</li> </ul> <p><b>jtph;f;f Ntz:bait:-</b></p> <ul style="list-style-type: none"> <li>- fUTw;Wjydpd; NghJ</li> <li>- 35 Nky; cs;s ngz;fs;</li> <li>- ,uj;j nfhjpg;G&gt; rh;f;fiu Neha;&gt; fida Neha; khh;gf kw;Wk; gpwg;Gwg;G Gw;WNeha; cs;sth;fs; khj;jpiuia cl;nfhs;sf; \$lhJ</li> <li>- ghy; nfhLf;Fk; jha;kh;fs; Kjy; xU tUlj;jpw;F cl;nfhs;sf; \$lhJ.</li> </ul> <p><b>Crp%oyk; nrYj;Jk; fUj;jil kUj;Jfs:-</b></p> <ul style="list-style-type: none"> <li>- DMPA</li> <li>- NET</li> </ul> <p>,jpy; g;Nuh[ ];l;uhd; cly;Rug;gpfs; cs;sd ,ij jirfspy; nrYj;j Ntz;Lk; Net I 2</p>				
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	<p>khjj;jpw;F xUKiwAk;&gt; DMPA it 3  khjj;jpw;F xUKiwAk; Nghl Ntz;Lk;</p> <p><b>C. mb Njhypd; Fj;Jjy:-</b>  ,J kpfTk; nray;jpwd; tha;e;jJ. ,jpy;  g;u[];l;uhd; kl;LNk cs;sJ. ,J Njhypd; mb  gFjpapy; cl;GFj;jg;gLfpwJ. 2 tUl;jpw;F  gpwF ,jd; nray;ghl;il ghpNrhjpf;f Ntz;Lk;</p> <p><b>3. fHg;gk; jhpj;jypd; fUj;jilfs:-</b>  <b>fU fiyj;jy:-</b></p> <ul style="list-style-type: none"> <li>➤ fUfiyj;jy; vd;gJ fUTw;w 28  thuj;jpw;Fs; nra;a Ntz;Lk;</li> <li>➤ fUfiyj;jy; rl;lk; 1972 Vg;uy; khjk;  eilKiwgLj;jg;gl;lJ.</li> <li>➤ ,e;j rl;lk; 20 thuj;jpw;Fs; kl;LNk  mDkjpf;fpwJ.</li> </ul> <p><b>Mgj;Jfs:-</b></p> <ul style="list-style-type: none"> <li>- ,uj;jg;Nghf;F</li> <li>- Ez;fpUkp njhw;Wjy;</li> <li>- fUg;ig Rthpy; Xl;il</li> </ul> <p><b>kw;witfs:-</b>  <b>tpyfpypUj;jy:-</b>  fUTWjiy jLf;f cly;cwtpypUe;J  tpyfpapUj;jy;</p> <p><b>gpd; thq;Fjy:-</b></p>				
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	<p>,J jd;dpr;irahf nra;Ak; Kiw&gt; tpe;J ntspahtjw;Fs; gpd;thq;Fjy; <b>fhy ml;ltid Kiw:-</b> ,J x[pNdh vd;gtuhy; 1930 Mk; Mz;L fz;lwpag;gl;J. khjtplha;f;F xU thuj;jpw;F Kd; kw;Wk; 9 thuk; gpd; filg;gpbff;\$baJ. <b>jha;ghy; mspj;jy:-</b> jha;ghy; xU ,aw;if fUj;jilahf rKjhaj;jpy; cgNahfg;gLj;jg;gLfpwJ. jha; xU tUl fhyk; jha;ghy; mspj;jy; rpwe;j fUj;jil MFk;. <b>.Wjpahd Kiw:-</b> <b>FLk;g fl;Lg;ghL Kiw:-</b> FLk;g fl;Lg;ghL Kiw rpwe;j fUj;jil Kiw ngz; fUj;jil 85 &gt; Mz; fUj;jil 10-15 nra;ag;gLfpwJ. <b>Mz; Kiw:-</b> FLk;g fl;Lg;ghL Kiw kpfTk; vspik kw;Wk; ghJfhg;gdhJ <b>fUj;jil tpl Kiw:-</b> FLk;g fl;Lg;ghL Kiw rpwe;jJ. ,J xU Kiw nra;ag;gLtJ. ,jw;F njhlh; Cf;Ftpg;G Njitapy;iy <b>ngz; Kiw:-</b> <b>FLk;gf;fl;Lg;ghL:-</b></p>				
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		<p>fUg;ig Foha;fis fl;Ljy; kw;Wk; mWj;njLj;jy;. ,J gpurtj;jpw;F 1-3 ehl;fSf;Fs; nra;ag;gLtJ.</p> <p>,jpy; %d;W tiffs; cz;L</p> <p>1) guk;giu lAgf;lkp:-</p> <p>,jpy; fUg;ig Foha;fspd; rpW Jz;Lfis ,Uf;fp tpyf;fjy;. cly;kwg;G kUe;Jfis KJFjz;L Kyk; nrYj;Jjy;. ,jw;F 5-7 ehl;fs; kUj;Jtkidapy; rpfpr;irg; ngw Ntz;Lk;</p> <p>ngz;fs; rpfpr;irf;F 10 ehl;fSf;F gpwF tPl;L Ntiyfis nra;ayhk;. 3 thuq;fSf;F gY Jhf;Fk; Ntiyfis nra;a \$lhJ. 4 thuk; fopj;J jhk;gj;jpaj;jpy; &lt;Lglyhk;</p> <p><b>2) rpwpaNyg; mWit rpfpr;ir:-</b></p> <p>,J guk;giu FLk;g fl;Lg;ghL Kiwia Xw;wpaJ. ,J Rygkhd Kiw.</p> <p><b>3) Nyg;uh];Nfhgp:-</b></p> <p>,J kpfTk; nraw;ifahd mWit rpfpr;ir ,J Nyg;uh];Nfhg; vd;Dk; fUtpia cl;GFj;jp kUj;Jtf; FOf;fshy; nra;ag;gLk; mWitrpfpr;ir</p> <p>4) thrf;lkp (m) Mz;</p> <p><b>FLk;g fl;Lg;ghL:-</b></p> <p>,J kpfTk; nray;jpwd; tha;e;jJ. ,J fUg;ig rhjdg;fs; khj;jpiufis tpl rpwe;jJ. ,J epue;ju</p>				
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	<p>Kiw ,uz;L Foe;ijfs; cs;s Mz;fSf;F chpa rpwe;j mWit rpfpr;ir Kiw ,J kpfTk; vspikahd ghJfhg;ghd Kiw kaf;fkUe;J mspj;J nra;ag;gLtJ. ,jpy; tpe;J Foha;fis fl;Ltjhy; 100 nray;jpwd; tha;e;jJ.</p> <p><b>mWit rpfpr;irf;Fg; gpd:-</b></p> <p>mWit rpfpr;irf;Fg; gpd; 2 kzp NeukhtJ xa;T vLf;f Ntz;Lk;</p> <ul style="list-style-type: none"> <li>➤ mWit rpfpr;ir mspj;j ,lj;jpy; rpWePNuh kyNkh glhjthW ghh;j;Jf; nfhs;Sjy;</li> <li>➤ mWit rpfpr;ir gFjp eizahjthW Fspj;jy; Ntz;Lk;</li> <li>➤ gFjpapy; fPuy; tpohjthW ghh;j;J nfhs;Sjy;</li> <li>➤ ijaiy mfw;w 5 Mk; ehs; kUj;Jtkidia mZf Ntz;Lk;</li> <li>➤ 1 khjktJ fl;Lj; Jzpia mzpa Ntz;Lk;</li> <li>➤ 15 ehl;fSf;F kpjptz;bia cgNahfg;gLj;jy; \$lhJ</li> <li>➤ 3 khjj;jpw;F cly;cwT nfhs;sf;\$lhJ</li> <li>➤ 3 khjj;jpw;F gpwF tpe;J ntspahtij Nrhjid nra;jy; Ntz;Lk;</li> </ul> <p><b>ed:ikfs:-</b></p> <p>- ,J rpwe;j Kiw</p>				
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		<ul style="list-style-type: none"> <li>- ghJfhg;ghdJ</li> <li>- gf;f tpisTfs; mw;wJ</li> <li>- jhk;gjpaj;ij ghjpf;fhJ</li> <li>- kUj;Jtkidapy;                      jq;fpapUf;fj; Njitapy;iy</li> </ul> <p><b>jPikfs:-</b> Ez;fpUkpfs; njhw;Wk; mghak;</p> <p><b>KbTiu:-</b>       ,J tiu ehk; FLk;g fl;Lg;ghL yiuaiw Foe;ij ,ilntsp&gt; Fwpf;Nfhs;fs;&gt; ,e;jpa kf;fs; njhif ngUf;fk;&gt; rpW FLk;g Nfhl;ghL&gt; fUj;jil Kiwfs;&gt; gad;fs jPikfis ghh;j;Njhk;.</p>				
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### **nghJthd Fwpi:Nfhs;fs:-**

jpl;lkpl;l fy;tp Kiwf;F gpwF xt;nthU MZk; FLk;g fl;Lg;ghL Kiwfs; gw;wpa mwptpidg; ngw;wpLth;.

### **Fwpg;gl;l Fwpi:Nfhs;fs:-**

#### **Kiw:-**

- ❖ FLk;g fl;Lg;ghL Kiwia tiuaiw
- ❖ FLk;g fl;Lg;ghL Fwpi:Nfhs;fs; gl;baypL
- ❖ Kf;fs; njhif ngUf;fj;jpd; fhuzpfis fzf;fpL
- ❖ Kf;fs; njhif ngUf;fj;jhy; tpisAk; jPikfis tpthjp
- ❖ rpW FLk;g Nfhl;ghl;bd; Kf;fpaj;Jtj;ij tpthp
- ❖ jpl;lkplhf; FLk;gj;jpd; jPikfis gl;baypL



❖ fUj;jil Kiwfis gphpj;J fhl;Lf

❖ jw;fhypfkhd kw;Wk; epue;ju FLk;g fl;Lg;ghL Kiwfs; gw;wp tpthpj;jy;