

**EFFECTIVENESS OF COMMUNITY CHANGE
AGENTS ON KNOWLEDGE AND ATTITUDE
REGARDING REPRODUCTIVE HEALTH AMONG
WOMEN IN SELECTED VILLAGES ADOPTED BY
OMAYAL ACHI COMMUNITY HEALTH CENTRE,
THIRULALLUVAR DISTRICT, CHENNAI, 2011.**

DISSERTATION SUBMITTED TO
THE TAMIL NADU DR.M.G.R.MEDICAL UNIVERSITY
CHENNAI.

IN PARTIAL FULFILMENT OF REQUIREMENT FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

APRIL 2012

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DISTRICT, CHENNAI, 2011.**

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ABSTRACT

A pre experimental study to assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women in selected Villages adopted by Omayal Achi Community Health Centre, Thiruvalluvar district, Chennai 2011.

INTRODUCTION

The global burden of reproductive tract infections which affects the quality of women's health is increasing rapidly. Breast cancer and cervical cancer in women are the major public health problem throughout the world. Cervical cancer is the primary cause of cancer-related deaths in developing countries. Cervical cancer, in women, is the second most common cancer worldwide, next only to breast cancer. Every year cervical cancer is diagnosed in about 500,000 women globally and is responsible for more than 280,000 deaths annually. The incidence is rapidly rising in developing countries.

One in ten of all new cancers diagnosed worldwide each year are cancer of the female breast. More than 1.1 million cases are diagnosed and more than 410,000 patients die of it worldwide (**Ferlay et al. 2004**)⁷⁷. It is the second most common cancer now, about 55% of the global burden is currently experienced in developed countries, but incidence rates are rapidly rising in developing countries.

According to the report, the incidence of breast cancer has doubled in the metropolitan cities in the past 24 years. (**Indian Council for Medical Research (ICMR)**)⁶⁸. 1 out of 20 women in Delhi suffer from breast cancer. Moreover, half the patients suffering from the condition come for treatment when it is in its last stage, making treatment much more difficult. (**Dr. Rajni Mutneja, head of preventive oncology at Rajiv Gandhi Cancer Institute, Delhi. 2010**)⁹⁵.

The awareness regarding these diseases is necessary for each woman that should be enhanced in their living area.

Objectives

1. To assess the pretest and post test level of knowledge and attitude regarding reproductive health among women.
2. To assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women.
3. To correlate the mean differed knowledge score with mean differed attitude score of women regarding reproductive health.
4. To associate the mean differed knowledge score and attitude score of women with selected demographic variables.

METHODOLOGY

Pre experimental one group pre test and post test within subject design.

Setting

The setting for the study was 4 adopted villages of Omayal Achi community health centre. Selected villages of Omayal Achi Community Health Centre were Arakkambakkam, Gowdipuram Karalapakkam and Keezhkondaiyar.

Participants

The study sample comprised of women between the age of 15 -49 years who fulfilled the inclusive criteria.

Measurements and Tools

The level of knowledge was assessed using structured interview schedule and the level of attitude was assessed using 5 point Likert scale. Both descriptive and inferential statistics were used for analysis.

Intervention

Community change agents were selected and trained by the investigator in 5 phases to provide teaching for the women who are residing in their own community area. The community change agents were trained and empowered by the investigator by lecture and discussion with the structured training module, pamphlets, posters and flash cards. After confirmation that they acquired adequate knowledge and favourable attitude they were allowed to teach community women by means of lecture and discussion with the structured training module, pamphlets, posters and flash cards.

RESULTS

The findings of the study revealed that the overall knowledge pretest mean value was 8.75 with S.D of 2.8 and the post test mean value was 12.9 with S.D of 2.6. The mean differed knowledge score was 4.15 with t value of 12.75, which was highly significant at $p < 0.001$ level. The pre test mean was 42.4 and S.D was 8.27. The post test attitude mean value was 52.2 and S.D of 11.1, . The mean differed attitude was 9.8 with 't' value of 9.65, which was highly significant at $p < 0.001$ level. . The correlation between the post test level of knowledge and post test level of attitude showed a 'r' value of 0.635, which was moderately significant at $p < 0.01$ level.

The mean differed knowledge score shows significant association with demographic variable of members of voluntary group at $p < 0.001$, family history of reproductive tract infection at $p < 0.001$, with family history of cervical cancer at $p < 0.001$ and with family history of breast cancer at $p < 0.05$ level, marital status at $p < 0.05$ and with previous history of reproductive tract infection association found at $p < 0.001$. The differed attitude score shows significant association with educational status at $p < 0.05$ and with occupation association found at $p < 0.001$, family history of cervical cancer shows $F=4.99$ which shows the significant

association at the level of $p < 0.05$ and mild significant association of mean differed attitude score with years of married life at $p < 0.01$ level.

DISCUSSION

There was a significant improvement on knowledge and attitude of the women in the post test after teaching given by community change agents. Thus the community change agents approach was effective in improving the knowledge and attitude of women regarding reproductive health. This approach in turn will improve the self reliance and quality of life of community women.

Implications for Community Practice

Community health nurse has the key responsibility to provide comprehensive care for the people especially for the vulnerable populations such as women. It is important to enhance the self reliance among the people towards their health and to motivate that there is a need for constant source of information. Through the creation of the community change agents the community health nurse can make it available for the women.

CHAPTER – I

INTRODUCTION

BACKGROUD OF THE STUDY

Women are replenishing the earth. Health of families and communities are tied to the health of the women .The illness or death of women has a serious consequence for the health of her children. The slogan "Healthy women, Healthy world" embodies the fact. In family, healthy women plays a critical role in maintaining health and well being of their family. Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to reproductive system and its functions.

Reproductive health care is defined as the collection of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, not just counseling and care related to reproduction and sexually transmitted infections.

According to the **International Conference on Population and Development**, reproductive health " implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relationships, and not merely counseling and care related to reproductive and sexually transmitted infections. (ICPD, Cairo, 1994)⁸¹.

Sexual and Reproductive Health (SRH) outcomes are important measures of the general health and social well-being of a population. The scope of Sexual and Reproductive Health (SRH) covers the entire lifespan and extends across several Public Health domains.

Indian population constitutes around 1028.6million and among this population 22.2 % are in the age group of 15-49 years according to the census of 2001. Reproductive and sexually ill health accounts for 26% of global burden of ill health for the women and 14% for men. Safe reproductive health is a moral, social and economic investment that must be given national priority. **(Singh et al, Journal of communicable diseases. 2006).**

The common problems of reproductive age group women are problems arises due to primary and secondary complications out of pregnancy, childbirth, and postnatal period and childrearing. Other problems also which has an considerable effect on mortality and morbidity on women's health are menstrual problems, malnutrition(anemia,), systemic disorders and malignancy conditions of which breast cancer, cervical cancer and reproductive tract infections are the major burden for women who are in reproductive age.

The centre for disease prevention (CDC) reported in 1988 that 136 countries or union territories throughout the world had reported a total of 84,256 cases of acquired immunodeficiency syndrome (AIDS) to the Global Programme on AIDS. From 1979 through1988, the number of AIDS cases increased markedly in all geographic regions. The cumulative world total increased from 11,965 in 1984 to 25,150 in 1985 and to 48,413 in 1986. Forty-two countries in the Americas have reported 73% of the world total of AIDS cases. United States had reported a total of 54,233 cases. In 2004 the total number of people infected with AIDS accounts to about one million in North America, 1.7 million in Latin America.

Breast cancer and cervical cancer in women are the major public health problem throughout the world. They are the most common cancers among women both in developed and in developing countries and should work while planning public health services for women of reproductive age women. Cervical cancer is the primary cause of cancer-related deaths in developing countries. Cervical cancer, in women, is the second most common cancer worldwide, next only to breast

cancer. Every year cervical cancer is diagnosed in about 500,000 women globally and is responsible for more than 280,000 deaths annually. There is a wide variation in the incidence of cervical cancer across the globe.

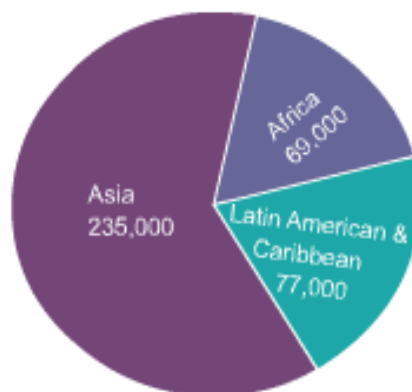


Fig.1: Incidence of cervical cancer across the globe.

In urban areas, cancer of the cervix account for over 40% of cancers while in rural areas it accounts for 65% of cancers. (**Cancer registry in Barshi**)⁴⁷. Eastern and South Africa, Central and South America and the Caribbean's too report very high incidence of cervical cancer. Cervical cancer accounted for 487,300 new cases and 269,500 deaths among which less developed countries accounted for more than 80% of the cervical cancer cases and deaths. (**International agency for research on cancer, Lyon, France. 2008**)⁷⁷.

In **India**, cervical cancer is the most common woman-related cancer, followed by breast cancer. 80% of the new cervical cancer cases occur in developing countries, like India, which reports approximately one fourth of the world's cases of cervical cancer each year.

One in ten of all new cancers diagnosed worldwide each year are cancer of the female breast. It is also the principal cause of death from cancer among women globally. More than 1.1 million cases are diagnosed and more than 410,000 patients die of it worldwide (**Ferlay et al. 2004**)⁷⁷. It is the second most common cancer now, about 55% of the global burden is currently experienced in developed countries, but incidence rates are rapidly rising in developing countries. 411,000

breast cancer deaths occurred around the world in 2006 among which 221,000 (54%) occurred in low- and middle-income countries (LMCs).

Breast cancer cases are rising alarmingly all over the world and India is not an exception. This is more evident in urban India as suggested by the analysis of cancer cases in Delhi, Mumbai, Chennai and Bangalore. (**Indian Council for Medical Research (ICMR 2005)**)⁵⁵. According to its report, the incidence of breast cancer has doubled in the metropolitan cities in the past 24 years.

This does not compare favorably with cervical cancer which is the most common in Indian women. 1 out of 20 women in Delhi suffer from breast cancer. Moreover, half the patients suffering from the condition come for treatment when it is in its last stage, making treatment much more difficult. (**Dr. Rajni Mutneja, head of preventive oncology at Rajiv Gandhi Cancer Institute, Delhi. 2010**)⁹⁵.

In Mumbai, 30 percent of the cancer cases in women, 26.9 percent in Delhi and Bangalore, while 26.5 percent in Chennai, 17.2 percent in Kolkata and 28.9 percent in Pune, were that of breast. The Director General of ICMR, Dr V M Katoch is looking at ways to improve the diagnostic capabilities of breast cancer as India by taking note of the anatomical websites cancer.

The government authorities are also sounding the alarm on this issue. According to an official working in health ministry, around 10 years ago, one out of one lakh women were detected with breast cancer, but now this figure has reached 23. In some cities such as Chennai, the statistics reveal a gruesome situation. 1 out of 33 women are afflicted with breast cancer in the city. (**International agency for research on cancer, Lyon, France. 2008**)⁷⁷.

NEED FOR THE STUDY

The term reproductive health was first adopted at the International conference on population and development to ensure health services utilization for

those age groups and herald a major shift of thinking and approach to population issues from pure population control through family planning to a much wider field encompassing not only the fertility control but also safe sex, pregnancy, free from coercion and discrimination. MCH needs to be replaced by women health needs not merely maternal and child health care but women health care should be provided through community based participatory approach and not by through technocratic vertical programmes. (**“Sexual and Reproductive health MF Fathilla, Aug 2008”**)⁵⁹.

Reproductive health care needs to be broadened beyond maternal care, family planning to include the care for gynaecological and sexual problems. Safe abortion services and reproductive health services are priority needs. Low coverage of life saving preventive health intervention stemming from unhealthy social norms, attitude, practices and lack of knowledge among key population groups and health care providers.

Epidemiologic study of rural women shows that very high prevalence of Gynecological diseases. Traditional gender roles and inequality of sexes are identified as major barriers to better reproductive health care. **"Silver ding free University of Berlin, Germany"**. More than 1 billion people are living with little estimated shortage of 4.3 million trained health care workers worldwide.

Although solutions for many problems are available the uptake of interventions to improve the health status is questionable because of inadequate knowledge, awareness, social and structural barriers to behaviour change and inadequate number of stake holders. In the west, early detection through regular screening has aided to significantly control the prevalence of this disease, thereby, lowering its incidence. In the last 50 years in the United States, the Pap smear tests have reduced the deaths related to cervical cancer by three-quarters. At one time cervical cancer was one of the most dreaded cancer and the leading causes of death in women in the US but now it is the eighth most common cancer there. Guidelines

for breast health care (early detection, diagnosis, and treatment) that were developed in high-resource countries cannot be directly applied in LMCs, because these guidelines do not consider real world resource constraints, nor do they prioritize which resources are most critically needed in specific countries for care to be most effectively provided. (WHO report 2008)⁷⁵.

Sihavang.A., et al (2011)⁶⁶ conducted a qualitative study on community perception and treatment seeking behaviour regarding reproductive tract infections including sexually transmitted infections in Lao by using fourteen focus group discussion and 20 in depth interviews. It held among 76 women and 56 men. The major finding was that both male and female participants had a variety of misconceptions about the causes and symptoms of RTI/STIs and their cure and a reluctance to seek health care. The main reasons for not going to health facilities were fear of social discrimination or shyness. They suggested strengthening health education and promotion through interventions at the community level to improve the quality of RTI/STI management. Health education messages should be more accessible in rural areas and urged need to improve communication between RTI/STI patients and clinicians.

There has been a regular campaign against cervical cancer for 30 years in India, but this has had little impact on the morbidity and mortality from the disease, with India ranking fourth worldwide. The number of deaths due to cervical cancer is estimated to rise to 79,000 by the year 2010. The cancer mostly affects middle-aged women (between 40 and 55 years), especially those from the lower economic status who fail to carry out regular health check-ups due to financial inadequacy. Other than that communication barrier is the major problem in the transmission of reproductive health information as it is sensitive issue.

Rama CH., et al (2010)⁶¹ conducted a cross sectional survey on awareness and knowledge of HPV, cervical cancer and vaccine. 37% of them reported that they” had ever heard about HPV “ but only 19% and 7% respectively knew that

HPV is a sexually transmitted infection (STI) and that it can cause cervical cancer. Survey indicated that among primi parous young women was low. They suggested for primi and secondary cervical cancer prevention programs for young low income primiparous women.

Hence the investigator felt that although the availability and easy accessibility of health care services, there is low utilization of the services. The major cause for this is inadequate knowledge and attitude of using this services, ignorance and social factors. So community change agents reside in the community will be helpful to identify barriers of the uptake of proven decreased utilization of services.

It was supported by the study conducted by **Cash K., (1993)⁹²** comparing the effect of various HIV/AIDS prevention activities among unmarried migrated women ages between 14-24 years in Thailand. The peer leaders and health promoters were trained for 3 months and led weekly educational sessions. The project improved their communication skills, their self-confidence, and their perceptions of risk. The most significant improvements were found among the women enrolled in the groups facilitated by peer leaders and they were more sensitive to the needs of the women and more capable of leading group discussions and participatory learning activities.

STATEMENT OF THE PROBLEM

A pre experimental study to assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women in selected villages adopted by Omayal Achi Community Health Centre, Thiruvalluvar district, Chennai. 2011.

OBJECTIVES

1. To assess the pretest level of knowledge and attitude regarding reproductive health among women.

2. To assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women.
3. To correlate the mean differed knowledge score with mean differed attitude score of women regarding reproductive health.
4. To associate the mean differed knowledge score and attitude score of women with selected demographic variables.

OPERATIONAL DEFINITIONS

Effectiveness

Effectiveness in this study refers to the gained knowledge and attitude regarding reproductive health among women as a result of teaching given by community change agents.

Community Change Agents

In this study community change agents refers to women aged above 30 years and has minimum educational qualification of 10th standard , who is residing in the same community area of the samples and selected by the investigator by using criteria checklist and are willing to undergo training to enhance the knowledge of women regarding reproductive health by using structured training module and empowered to disseminate the knowledge on reproductive health to other women.

Knowledge

It refers to understanding level of the reproductive age group women about reproductive tract infection, sexually transmitted infection and life threatening cancers of women such as cervical cancer and breast cancer and was assessed by using structured interview schedule.

Attitude

It refers to beliefs and ideas of the reproductive age group women about reproductive tract infection, sexually transmitted infection and life threatening

cancers of women such as cervical cancer and breast cancer and was assessed by using 5 point likert scale.

Reproductive health

In this study reproductive health includes,

- **Reproductive tract infection**
- **Life threatening cancers among women**

Reproductive tract infections

- meaning
- causes
- clinical features
- preventive measures such as menstrual hygiene

Sexually transmitted infections

- meaning
- causes
- clinical features
- preventive measures such as safe sex practices

Life threatening cancers of women

➤ **Cervical cancer**

- meaning
- causes
- clinical features
- early identification by pap smear
- preventive measures

➤ **Breast cancer**

- meaning
- causes
- clinical features
- early identification by self breast examination
- preventive measures

Women

It refers to the reproductive age group women between the age group of 15 - 49 years and residing in the same community of community change agents.

Adapted Villages

The villages which are selected by Omayal Achi community health centre to render its health services in an affordable manner.

ASSUMPTIONS

1. Women are prone for reproductive health problems.
2. Women may have some knowledge and attitude regarding reproductive health.
3. Community change agents may enhance the knowledge and attitude of women regarding reproductive health.
4. Community change agents approach helps the women to gain self reliance and they will be available permanently in the community to clarify the queries of women as representative of community health nurse.

NULL HYPOTHESES

NH₁– There is no significant difference between pre test and post test level of knowledge and attitude regarding reproductive health among women at $p < 0.05$.

NH₂ –There is no significant correlation between the mean differed levels of knowledge score with mean differed attitude score at $p < 0.05$.

NH₃ –There is no significant association between the mean differed level of knowledge and attitude score with selected demographic variables at $p < 0.05$.

DELIMITATION

The study was limited to the period of 4 weeks.

CONCEPTUAL FRAMEWORK

The concept is a thought, idea or mental image framed in mind on response to learning something new. Framework is a basic structure supporting anything. Conceptual framework deals with abstraction, which is assembled by nature of their relevance to a common theme. **“Christenson J.Paula 2006”**.

The conceptual framework gives the idea of the researcher’s main view and common theme of the research that is a visual diagram by which the researcher explains the specific areas of interest. One of the important purposes of the conceptual framework is to communicate clearly the relationship of various concepts. The present study is aimed to evaluate the effectiveness of training community change agents to improve the knowledge and attitude of the women who are residing in their own area. The conceptual framework set up for the study was integrated model of **Widen Bach’s prescriptive theory** and **Stufflebeam’s evaluation model**.

Earnestain Widen Bach is a nurse theorist, who proposed a perspective theory in 1964 in which she described about conceiving of a situation and the ways to attain the explicit goal. Another model used for the study was stufflebeam’s evaluation model of planned programme. It is mainly useful for obtaining useful information for taking decisions. It provides the comprehensive, systematic and continuously ongoing framework for programme evaluation. He prescribed 4 types of evaluation such as context evaluation, input evaluation, process evaluation and product or outcome evaluation.

According to **Widenbach** the practice of nursing comprises of wide variety of services each is directed towards the attainment of one of three components. They are

- 1. IDENTIFICATION OF THE NEEDY FOR HELP**
- 2. MINISTERING FOR THE NEEDED**
- 3. VALIDATING THAT THE NEEDY FOR HELP WAS MET**

1. IDENTIFICATION OF THE NEEDED FOR HELP

The investigator identified the needed people through the collection of following information. They are statistical information about the scenario of RTI, cancer cervix and breast cancer, demographic variables, pre assessment of knowledge and attitude of the people about reproductive health. He found that the obtained information evidencing the need to teach the women about reproductive health. The investigator also have done the context evaluation in which he confirms the need to train the community change to enhance the knowledge and attitude of women through community change agent approach.

Central Purpose

It refers to what the investigator wants to accomplish or the goal towards which she strives by specially directing activities for client's benefits.

In this study the investigator has the central purpose to evaluate the effectiveness of teaching given by community change agent approach towards enhancing the knowledge and attitude of women on reproductive health aspects.

2. MINISTERING FOR THE NEEDED

In ministering for the needed the investigator has the goal to enhance the knowledge and attitude of women about reproductive health through community change agents approach. Here various factors play in the situation are identified as realities that are the agent, recipient, goal means and framework.

Agent

Agent in the study refers to the community change agents who were selected based on her criteria and trained by the investigator to enhance the knowledge and attitude of women.

Recipient

Recipient in the study refers to the women who are in reproductive age group and residing in the same community area of community change agents.

Means & Prescription

Means are the skills, techniques and procedures used by the investigator to achieve the goal. Means are process of training of the community change agents, self instructional module, pamphlets, posters and flashcards.

Prescription

The main prescriptions given are maintenance of menstrual hygiene, method of doing self breast examination, pap smear test and their importance in early identification of breast cancer and cervical cancer.

Input Evaluation

The input for the study was the concept of community change agents approach and the means used by the investigator. They were validated by the experts and the reliability was done.

Framework

It refers to human, environmental and professional organizational structure and facilities in which the intervention is practiced. Here the intervention was given at the residence of community change agents.

Process Evaluation

The process evaluation in Stufflebeam's model provides the feedback to decision makers (investigator) to detect and predict the problems in teaching of women through community change agents approach.

3. VALIDATING THE NEEDED FOR HELP WAS MET

Validating the needed for help was met and the product evaluation of stuffle beam's model serves the same purpose. The product or outcome evaluation is summative in nature and it measures the extent to which goals have been achieved. The outcome expected in the study is enhancement of knowledge and attitude of women through community change agents approach.

It enables the researcher to make suitable decision and recommended action to continue or drop or modify the training of community change agents approach to enhance the awareness of women. It refers to the post test assessment after ministering the needy and the comparison and analysis to infer the outcome. The expected outcome was classified by the researcher into positive and negative in which the positive outcome comprises of improvement of knowledge and attitude whereas the negative outcome is sustaining level of inadequate knowledge and attitude. The positive outcome enhances the community change agents approach to educate the women where as in negative attitude the investigator reinforces the training for community change agents to gain positive outcome.



OUTLINE OF THE REPORT

CHAPTER I : Dealt with the back ground of the study, need for the study, statement of the problem, objectives, operational definitions, null hypotheses, assumptions, delimitations and conceptual frame work.

CHAPTER II : Focuses on review of literature related to the present study.

CHAPTER III: Enumerates the methodology of the study.

CHAPTER IV : Presents the data analysis and data interpretation.

CHAPTER V : Deals with the discussion of the study

CHAPTER VI : Gives the summary, conclusion, implications, recommendations and limitations of the study.

The study report ends with selected Bibliography and Appendices.

CHAPTER – II

REVIEW OF LITERATURE

This chapter deals with the related literature review which aids to generate a picture of what is known and not known about a particular situation.

According to Geri LoBiondo-Wood et.al (2006)¹³, Review of literature is an organized critique of important scholarly literature which supports a study and a key step in research process. The literature review was based on extensive survey of the books, journals and international nursing indicates.

An extensive review of literature was done by the investigator to gain an insight into the problem, collect maximum information from systematic and critical review of scholarly publications, unpublished scholarly print materials to lay down a broad foundation for the study and a conceptual framework to proceed with the study. The logical sequence of the chapter is organized under the following sections:

LITERATURE REVIEW HAS THE FOLLOWING FOUR SECTIONS:

Section–A : Reviews related to reproductive health.

Section –B: Reviews related to reproductive tract infection and sexually transmitted tract infection.

Section–C : Reviews related to gynecological cancers.

Section–D : Reviews related to peer education.

SECTION –A: REVIEWS RELATED TO REPRODUCTIVE HEALTH

Wang Z., et al (2011)⁸¹ assessed reproductive health knowledge and service utilization among unmarried rural to urban migrants in three major cities , China by using cross sectional survey.3412 unmarried migrants (male-1680, female-1732) were selected by purposive sampling method. Study revealed that RH knowledge and utilization of RH services were inadequate in all 3 major cities. The study highlighted the requirement of tailored intervention and further research to address the needs and demands more effectively.

Agius PA., et al (2010)⁴⁷ reviewed the knowledge on sexual behavior among adolescents by using cross sectional stratified sampling. The study revealed that the knowledge on HIV and AIDS is adequate but knowledge on other STI and hepatitis was moderate. The study recommended conducting more awareness programs on STI to promote health seeking behavior.

Makhubele JC (2010)⁷¹ assessed the attitude of students towards reproductive health and rights through social work perspective study in South Africa. The study found that female students were till assailed by health and social pathologies with regard to their reproductive health and rights and female students were more vulnerable to STIs than their male counterparts , as the beliefs is that the use of condom is un-African.

Regmi PR., et al (2010)⁶⁰ explored the barriers to sexual health services for young people in Nepal. 10 focus group and 31 in depth interviews were conducted. The study revealed that socio economic, cultural and physical norms imposed as barriers to access the information on sexual health and relevant services. The study concluded that the establishment of youth friendly service centers in convenient places helps to encourage youth people to use sexual health services.

Adeokun LA.,et al (2009)⁴⁶ conducted a survey on sexual and reproductive health knowledge , behavior and educational needs among adolescents in northern Nigeria among 989 adolescents. The study revealed that out of the interviewed respondents , 72% of females were aware about knowledge of menstruation 3.1% were aware about ovulation 47% knew about pregnancy ,56% were aware about contraception.84% suggested that adolescents should be given with sexual health education. The study concluded that sexuality education should be provided for school adolescents through their preferred and reliable source of information.

Rondini S and Kruger JK, (2009)⁶¹ conducted a study on knowledge, attitude and practices on RH among women in Northern Ghana. Both qualitative and qualitative data were collected on adolescent's perception regarding STI s, HIV/AIDS, family planning, male- female relationship and vulnerability to sexual violence. The study found that infrastructures and low accessibility of the services had led down to uneven distribution of RH educational programs in the country. It urges more programs and intervention aimed at high risk groups.

Van Rossem R and Meekers D., (2007)⁷² evaluated the reach and impact of social marketing and reproductive health communication campaigns (selected radio and television programs) regarding about family planning and HIV/AIDS public in Zambia. The results evidenced that the reproductive health and social marketing Campaigns in Zambia reached a large portion of the population and had a significant impact. The results suggested that future reproductive health communication campaigns that invest in radio programming may be more effective than those investing in television programming and future campaigns should seek to increase their impact among women.

SECTION-B: REVIEWS RELATED TO REPRODUCTIVE TRACT INFECTION AND SEXUALLY TRANSMITTED TRACT INFECTION

Jackson D ., et al (2011)⁵⁹ narrated on condom negotiation and experience among sexually active young women in New south Wales , Australia by using feminist narrative approach. Ten women's stories were collected via online interviews. The findings revealed that none of the women initiated or negotiated use of the male condom promotion relies on the recognition of the gender factors that impede young women's condom negotiation and use. Strategies that overcome gender dynamics and empower women to negotiate condom use have the ability to promote condom use among this group.

Sihavang A ., et al (2011)⁶⁶ conducted a qualitative study on community perception and treatment seeking behaviour regarding reproductive tract infections including sexually transmitted infections in Lao by using fourteen focus group discussion and 20 in depth interviews. It held among 76 women and 56 men. The major finding was that both male and female participants had a variety of misconceptions about the causes and symptoms of RTI/STIs and their cure and a reluctance to seek health care. The main reasons for not going to health facilities were fear of social discrimination or shyness. They suggested strengthening health education and promotion through interventions at the community level to improve the quality of RTI/STI management. Health education messages should be more accessible in rural areas and urged need to improve communication between RTI/STI patients and clinicians.

Whiteshield YO., et al (2011)⁷⁵ conducted a cross sectional study on self perceived risk of HIV infection and attitudes about pre exposure prophylaxis among sexually transmitted disease clinic attendees among 405 STD clinic attendees in south Carolina. Self perceived risk of HIV infection and attitudes were assessed using three questions from a self administered survey. These results

suggested the need for the creation of PrEP implementation programs that are tailored to self perceived risk perception, age and gender.

Bale and Brugha R (2011)⁴⁹ disclosed STI testing activities the influence of emotions and social networks among thirty young adults (18- 29 years). The study revealed that their practices a secret was difficult and emotionally draining. Health care professionals are a particular valued group to whom respondents disclosed the need for STI testing. Findings highlighted the roles played by emotions and social networks in impression management activities.

Ghezahay KW., et al (2010)⁵⁸ conducted across sectional study on knowledge and attitudes and sexual practices regarding HIV/AIDS among the Eritrean military situated in the Horn of America with a high prevalence of 2.4% among 1350 pregnant women using random sample. The survey results showed high levels of knowledge and relatively positive attitude and beliefs about STIs. They recommended strengthening the HIV/AIDS education programs especially around attitudes. The development and improvement of partnership between government, non government and international organization is essential to strengthen the fight against HIV/AIDS in Eritrea.

Jayanna K., et al (2010)⁵⁷ assessed the attitude and practices of providers of services for individuals at high risk of HIV and STIs in Karnataka, south India by using 393 exit interviews of females. Focus group discussions were held among women to understand the perceptions of non- users of services. The findings showed that 60% of women reported that the clinics were accessible.76% of the women who visited clinic for consultations were offered a speculum examination but only 52% were advised for partner treatment. 69% of the women were referred for HIV testing. 79% of physicians felt that sex workers were responsible for spreading HIV in the community, and 47% believed that sex work should be a banned to control HIV. The study suggested improving further the attitudes of

providers towards sex work, and improving practices such as speculum examination and partner referral that can enhance quality of care.

Johnson SR., et al (2010)⁸⁴ observed attitudes and experiences of women to common vaginal infections to determine women's experience and knowledge of the 2 most common non sexually transmitted vaginal infections, vulvo vaginal candidiasis and bacterial vaginosis among 6010 women aged 16-55 years. The results showed that there was confusion between symptoms specially related to each condition, and women thought they were caused by poor hygiene., ill health or a sexually transmitted infection. The study concluded that increased education and better diagnosis of these 2 conditions is needed to remove the stigma and taboo especially for BV and to ensure correct diagnosis with appropriate treatment.

Kang M and skinner R, (2010)⁸⁹ reviewed the interventions for young people in Australia to reduce HIV and STDs among young people aged 12-25 years. Fourty two studies met the inclusion criteria. Studies facilitated participation in Chlamydia and other STI testing, access to testing directly, provision to education, novel immunization strategies and evaluating the impact of STI surveillance programs on prevalence rates. The study suggested for evaluation of testing strategies in general practice setting. New technologies such as the internet and SMS are useful adjuncts for influencing behaviour such as condom use and STI testing. Media campaigns that promote STI testing can have a positive impact on testing rates.

Thakor HG., et al (2010)⁷⁴ conducted a STIs prevalence study on knowledge and practices related to STIs and HIV among 125 sex workers in an urban area of Gujarat , India. 85-90% were aware about various symptoms / diseases transmitted by unsafe sexual practice in male and female. 23.4% took treatment from health worker for such problems ; 87.9% were aware that consistent use of condom could protect her from HIV infections and 2.6% reported for non

treatment of STD.58% were not aware about behavioural changes needed to reduce the risk.

Crepaz N ., et al (2009)⁵⁰ reviewed the efficacy of HIV/STI behavioural intervention and identified factors associated with intervention efficacy for American African females in the United states by using meta- analysis from 37 relevant studies. The results showed that behavioural intervention had a significant impact on reduction in HIV risk sex behaviour and STIs. The concluded as behavioural interventions were efficacious in preventing HIV and STIs among African American females. They suggested conducting more research to examine the potential contribution of prevention strategies that attend to community level and structural level factors affecting HIV infection and transmission in the population.

Du P Thoms ., et al (2008)⁵² compared the knowledge , attitudes and behaviours and health care preferences between STD clinic clients an high risk individuals in community area in the New York state. 100 individuals were screened from two STD clinic and 400 individuals were selected from two community areas by random digit dialing telephone survey. Overall STD related KAP was similar between STD clinic and high risk community samples. The result evidenced that STD clinic clients were more knowledgeable about specific STDs and more likely to feel embarrassment about getting STD.

Valentine JA (2008)⁵⁴ assessed the impact of attitudes and beliefs on STD prevention and control in African American communities in the united states, Study explored that although efforts to engage affected black communities in improving STD health care delivery have been undertaken Bias, sterio typing continue to contribute to negative experiences for many blacks across health care settings. The study concluded as understanding and addressing the potential impact of both provider and patient attitudes could improve these service outcomes.

Sudha RT., et al (2005)⁶⁸ conducted a cross-sectional study awareness, attitudes, and beliefs of the general public towards HIV/AIDS in Hyderabad, a capital city from south India. The study was conducted for a period of 2 months in 2004 on 800 individuals living in Hyderabad. The study showed despite the vigorous outreach programmes, many people had several misconceptions about HIV or about people living with HIV/AIDS. The study concluded that the Government and Health educators should provide tailor-made education programmes for those at the lower education levels.

Montazeri A., (2005)⁷⁰ conducted population-based study on AIDS knowledge and attitudes in Iran using a short questionnaire, random sample of 1172 individuals aged between 15 and 65 years were interviewed. The majority of the respondents (87%) said that the mass media including radio, television and newspapers were the main source of their information about HIV/AIDS. The findings from this study indicate that although misconception exist among Iranian about AIDS, in general they have fairly good knowledge and have positive attitudes towards AIDS and people with AIDS. Such findings suggest that prevention programs should be encouraged and these might have the potential role to limit the emergence of Iran's HIV/AIDS epidemic.

Shrotri A., et al (2003)⁶⁷ interviewed 707 randomly selected antenatal mothers to find awareness of HIV/AIDS and household environment of pregnant women in Pune, India. Results evidenced that 75% of women displayed knowledge of primary transmission routes. Nearly 70% of women demonstrated knowledge of maternal to child transmission; however, only 8% knew of any methods of prevention. Study concluded that TV and written material were more strongly related to knowledge than access to radio messages or conversations with individuals.

Lagarde E., (1998)⁶⁰ conducted a cross-sectional study to describe sources of information on HIV/AIDS and their relationship with AIDS-related knowledge and sexual behaviour in a rural area of south Senegal, France. 240 men and 242 women aged 15-59 years were selected randomly from the general population. The findings showed that the source of HIV/AIDS information was radio for men (61% of men) and the local health centre for women (52% of women). Study concluded that attendance at health centers for maternity purposes increases an opportunity to receive prevention messages and radio and television also seems to deliver effective messages.

SECTION- C: REVIEWS RELATED TO GYNECOLOGICAL CANCERS

Cooper CP., et al (2011)⁵¹ Conducted a multi site qualitative study regarding women's knowledge and awareness of gynecologic cancer in s state the united states by using fit teen focus groups among women aged 40-60 years .The results showed that most participants had heard of cervical, ovarian and uterine cancer but were unfamiliar with vaginal and vulvar cancers. Some knew that the HPV (human papilloma virus)could cause cervical cancer. And unexplained vaginal bleeding could a symptom of cervical cancers; participants generally were unfamiliar with gynecologic cancer symptoms. They concluded that the participants lacked critical knowledge needed to understand their gynecologic cancer risk and care and the mass media also supports the viability of multimedia educational strategies.

Mc.Ree AL., et al (2011)⁸⁷ conducted a survey on mother-daughter communication about HPV vaccine among 609 mothers of girls aged between 11 and 20 years living in North Carolina. Most mothers (81%) reported have discussed HPV vaccine with their daughters. Mothers most commonly reported having discussed the potential HPV vaccine benefits usually protection against cervical cancer (56%) the reasons for and against getting vaccinated (86%) and less frequently reported having discussed the perceived disadvantages of HPV vaccine.

They concluded as HPV vaccine conversations may provide opportunities for sexual health promotion and sexually transmitted infection (STI) prevention.

Kobetz E., et al (2010)⁹⁰ reviewed knowledge of HPV on opportunities and challenges of cancer prevention among united states Hispanic women by using data from the 2007 Health Interview National Trends Survey (HINTS) and a cross sectional survey and a cross section of callers to the NATIONAL CANCER INSTITUTE'S (NCI) Cancer Information service(CIS) on HPV awareness and knowledge. Data indicated that HPV awareness was high in both samples (69.5% and 63.8% had heard of the virus) but that knowledge of the virus and its association with cervical cancer varied between the two groups of women.

Maree JE and Wright SC (2010)⁸⁸ explored the effectiveness of message in promotion of cervical cancer screening if information presented in a non-stigmatizing manner in south Africa by using exploratory, contextual, quantitative door to door survey. The sampling method used was convenience (n=105). Structured interview schedule was used gather the self reported data. The study provided the evidence that presenting information on cervical cancer in a non-stigmatizing manner based on the theme of self protection promoted cervical screening.

Seth T., et al(2005)⁶³ conducted field-based cross-sectional survey on knowledge, attitudes and behaviours of urban slum dwellers regarding common cancers in west New Delhi. The results showed that only 13% (10.6-15.7%) of the study participants were aware of Pap smears, and only 2% (1.1-3.3%) were able to identify all the common signs of cancer. Overall, 51% (47.2-54.7%) had some knowledge pertaining to cancer. The concluded that focused, concerted and effective information, education and communication drive is urgently needed for all aspects of common cancers in India.

SECTION – D: REVIEWS RELATED TO PEER EDUCATION

Drummond P., et al (2011)⁹⁹ conducted a study by using peer education to increase the sexual health knowledge among West African refugees in Western Australia. Ten bilingual west African peer educators conducted a 3 hours workshop on sexual health for small groups of western African refugees (n= 58) who recently settled in Perth, western Australia. There were significant increases in the participants knowledge on sexually transmitted infections and HIV, their spread and the measures to protect against infection. They concluded that the peer education approach was successful in assisting new and emerging community to work effectively on sexual health topics generally considered as ‘taboos’ or too sensitive to discuss.

Doyle AM., et al (2010)⁵³ evaluated the effectiveness of biological and behavioural impact of an adolescent sexual health intervention and follow up community based cross sectional survey in Tanzania. An adolescent sexual and reproductive health intervention was implemented in ten randomly chosen communities in rural Tanzania within a community randomized trial. The intervention consisted of teacher led peer assisted school education, youth friendly health services and community activities. The findings showed the impact on “upstream” knowledge, attitude and reported behaviour outcomes lead to a reduction in HIV-1 and HIV-II infection rates.

Adedimeji AA., et al (2008)⁸⁶ assessed the social factors, social support and condom use behavior among young urban slum inhabitants in south west Nigeria by using cross sectional study. Sexually active 448 boys and 338 girls aged between 15-24 years were selected by using multi stage sampling techniques. Findings showed that girls who perceived social support from peers and non parental figures were more likely to use condoms, whereas in boys high risk perception and self efficacy were associated with condom use. They concluded that the programs aiming to increase condom use among young people need to address these factors through community based strategies especially peer education.

Boyer CB ., et al (2007)⁹⁸ evaluated the effectiveness of Youth United Through Health Education in the community level by using peer- led outreach to increase the awareness and screening of non invasive sexually transmitted infections. Youths aged 12-22 years, who anonymously participated in the in the urban African American YOUTH program were selected. A street and venue based intercept approach was used. Non equivalent control group design was implemented. Results showed that the respondents who reported both single and multiple contacts with YOUTH program were more likely tested for STI. They concluded that the peer-led , street and venue based community outreach approach is a feasible means for reaching large numbers of adolescents for STI prevention.

Cash.K., (1993)⁹² conducted focused group discussions and interviews to find the effectiveness of peer education in the prevention of AIDS in Thailand. 240 single adolescent women were selected. The peer education program lasted for 3 months by 10 peer educators, after which participants received a certificate. Post-program evaluation indicated widespread acceptance of condoms as a contraceptive option for women and enhanced relational skills in negotiating for safe sex.

CHAPTER – III

RESEARCH METHODOLOGY

This chapter describes the methodology following to assess the effectiveness of Community change agents on knowledge and attitude of women who are residing in their own community.

This chapter deals with research design, variables, setting of the study, population, sample, criteria for sample selection, sample size, sampling technique, development and description of the tool, content validity, reliability of the tool, pilot study, procedure for data collection and plan for data analysis.

RESEARCH APPROACH

The research approach selected for this study was quantitative approach.

RESEARCH DESIGN

The design used in this study was pre experimental one group pre test post test design.

PRE TEST O ₁	INTERVENTION X		POST TEST O ₂
	Stage 1	Stage II	
Assess the pre intervention level of knowledge and attitude of women about reproductive tract infection and life threatening cancers of women i.e., Cervical cancer and breast cancer.	Selection, training, evaluation and empowering of community Change agents by the investigator.	Community change agents educate women on knowledge and attitude regarding reproductive health through lecture method and discussion by using structured training module, pamphlets, posters and flash cards.	Assess the post intervention level of knowledge and attitude of women about reproductive tract infection and life threatening cancers of women ie. cervical cancer and breast cancer.

VARIABLES

Independent Variable

Education given by community change agents to the women regarding reproductive health.

Dependent Variables

Knowledge and attitude regarding reproductive health among the women.

Extraneous Variables

The extraneous variables identified by the researcher were

- Age
- Educational status
- Occupational status
- Monthly family income
- Religion
- Type of family
- Source of reproductive health information
- Membership of voluntary group
- Family history of RTI
- Family history of cervical cancer and
- Family history of breast cancer
- Age at menarche
- Menstrual history
- Age at marriage
- Years of married life
- Status of having children
- Previous history of abortion or stillbirth
- Previous history of RTI or gyneacological problems

SETTING OF THE STUDY

The setting for the study was 4 adopted villages of Omayal Achi community health centre. Omayal Achi community health centre is an NGO which was established to serve the comprehensive service and it adopted nearly 40 villages to render its accessible health care services for those people. Selected villages of Omayal Achi community health centre were Arakkambakkam, Gowdipuram Karalapakkam and Keezhkondaiyar.

POPULATION

Reproductive age group women residing at selected villages of Omayal Achi Community Health Centre Such as Arakkambakkam which has 325 women, Karalapakkam which has 370 women, Keezhkondaiyar which has 356 women and Gowdipuram which has 184 Women.

The target population was **2928**. The accessible population was **1335** women who were available at the time of data collection.

SAMPLE

The study sample comprised of women between the age of 15 -49 years who fulfilled the inclusive criteria.

CRITERIA FOR SAMPLE SELECTION

Inclusive Criteria

- 1) Women ages between 15-49 years and are residing in the same community.
- 2) Women who can understand and respond in Tamil.
- 3) Women who were willing to participate in the study.
- 4) Women who were interested to receive knowledge from teaching of community change agents.
- 5) Women who were selected by community change agents to attend their teaching.

Exclusive Criteria

1. Working women for whom it is difficult to attend the training of community change agents.
2. Women who were already undergone the any training programme about reproductive health.

SAMPLE SIZE

A total of 80 women (20 from each village) were selected as samples for the study.

SAMPLING TECHNIQUE

Non probability convenient sampling technique was used to select the women.

DEVELOPMENT AND DESCRIPTION OF THE TOOL

After an extensive review of literature and discussion with the experts in the field of community health nursing a structured interview schedule and 5 point attitude was devised for data collection. The data collection tool used for the study included 3 sections. They were

SECTION – A

This section deals with the demographic variables of women such as

- Age
- Educational status
- Occupational status
- Monthly family income
- Religion
- Type of family
- Source of reproductive health information
- Membership of voluntary group
- Family history of RTI

- Family history of cervical cancer and
- Family history of breast cancer
- Age at menarche
- Menstrual history
- Age at marriage
- Years of married life
- Status of having children
- Previous history of abortion or stillbirth
- Previous history of RTI or gynecological problems

SECTION B:

PART 1- INTERVIEW SCHEDULE FOR KNOWLEDGE

This section dealt with interview schedule to assess the knowledge on reproductive health which comprised of 20 questions in two components (reproductive tract infection and life threatening cancers among women) with 4 options. Participants were asked to select the answer from the 4 options.

Reproductive tract infection	- 10
Life threatening cancers among Women	- 10
Total no of questions	- 20

SCORING PROCEDURE

All of the 20 questions were objective and closed ended items. All had multiple choice questions and have single correct answer. Scoring for correct answer was “1” mark and for wrong answer “0” marks was given. No negative marks for the wrong answer.

Maximum score -20 marks.

Minimum score -0.

LEVEL OF KNOWLEDGE

SCORE	LEVEL OF KNOWLEDGE
<50%	Inadequate knowledge.
50–75%	Moderate adequate knowledge
>75%	Adequate knowledge.

SECTION – B:**PARTII- 5 POINT LIKERT SCALE FOR ATTITUDE SCALE**

Attitude was assessed by 5 point Likert scale under which 3 concepts were included were general information, reproductive tract information and life threatening cancers of women which comprised of 15 statements.

QUESTIONS	DIMENSIONS
1 – 5	General information about reproductive health.
6 – 10	Reproductive tract infection
11 – 15	Life threatening cancers among Women

SCORING FOR ATTITUDE SCALE

Both positive and negative statements were selected. Each statement had 5 responses to select. For positive statements the score given was as follows.

STATEMENTS	STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
POSITIVE STATEMENT	5	4	3	2	1
NEGATIVE STATEMENT	1	2	3	4	5

LEVEL OF ATTITUDE

SCORE	LEVEL OF ATTITUDE
<50%	Unfavourable attitude.
50–75%	Moderately favourable attitude
>75%	Favourable attitude.

INTERVENTION TOOL

Intervention tool comprised of selection and training of community change agents by the investigator by using structured training module. The community change agents were selected from the villages after the detailed review of their interest to participate in the study, to spend time to attend the health training and to participate in teaching of their village women and their availability at all the time. Selection and training of community change agents was done in the community under the following phases.

PHASE I

In this phase the selection of community care agents were done by using following criteria.

1. Permanent resident of community.
2. Able to read and write Tamil.
3. Interest in involving community health work and able to spend at least 2 hours in a community area.
4. Possess good communication skills.
5. Has interest in teaching and has experience or participated in community programmes.

Women who fulfilled the above criteria were selected by non probability convenient sampling method. A total of 8 women (2 from each village) were selected. The investigator gave the brief introduction of the study and their involvement for the successful completion of the study. Then those women were asked to select their trainees according to their convenience (10 per each community change agents).

PHASE II

The investigator conducted the pre assessment to assess the knowledge and attitude of community change agents regarding reproductive health was done by using interview schedule and 5 point Likert scale. The duration of the pretest was 30 minutes.

PHASE III

On the same day of pre test the investigator started training for community change agents regarding various aspects of reproductive health by using structured educational module and using pamphlets, posters and flash cards. The training period was 4 hours daily for 3 consecutive days.

PHASE IV

After 5 days post test was conducted for community change agents on knowledge and attitude of reproductive health by using the same interview schedule and attitude scale. They were categorized based on the level of knowledge and attitude.

PHASE V

Empowering the community change agents by the investigator to train them to teach the women and a kit was given to them, which consists of structured educational module which contains about reproductive tract infection and life threatening cancers of women. Pamphlets about reproductive tract infections, STIs, cervical cancer and breast cancer, posters about reproductive tract infection and flashcard on life threatening cancers of women.

CONTENT VALIDITY

The validation of the data collection tool and structured training schedule was obtained from 1 community medicine expert and 3 nursing experts in the field of community health nursing. Modification was done and in the tool and module

was refined by the experts and it was incorporated in the main study. And the tools were finalized.

MODIFICATION:

The module was concised according to the need of community women. Medical jargon was excluded.

ETHICAL CONSIDERATION

Beneficence

This study benefited to the study participants by enhancing knowledge and attitude on reproductive health.

- 1) Study participants were protected from harm and discomfort, exploitation by getting informed written consent.
- 2) Respect from human dignity

Clients were given full freedom to decide on participating in the study. Those who were interested only selected for the study.

3) Justice

The women who are willing to participate in the study with out the discrimination of educational and occupational status were selected for the study. They all are given with the training on knowledge and attitude on reproductive health.

PILOT STUDY

Pilot study is a trial run for main study to test the reliability feasibility of the study and the tool. The pilot study was conducted in the month of June at New Kanniamman Nagar. It was conducted after receiving the formal permission from the Principal of Omayal Achi College of Nursing. The permission to conduct the study was obtained from the President of Newkanniamman Nagar Village.

On the first day the investigator entered into the site and introduced herself to the Panchayat President and explained about the purpose of study .He referred the investigator to the self help group.

The investigator met the women and briefly explained the purpose of her visit and selected 14 women by using non probability convenient sampling. Privacy was provided and confidentiality regarding the data was assured to the women so as to get the co operation in the procedure. After getting the written consent, data collection was carried out. Altogether pre test was conducted for 14 women on the second day in the residence of community change agent. The room was well ventilated with natural and artificial ventilation. Women were comfortably sat on the floor in a circular order over the mat. The investigator gave the small introduction about the pre test and the investigator had done the pretest for the women with help of research assistant. The duration of the pretest was 20 minutes. In the test initially the personal characteristics were collected by using personal data sheet and followed by knowledge and attitude was collected by using structured interview schedule and 5 point Likert attitude scale.

After the pretest on the same day the investigator started the training schedule of community change agents in the residence of community change agent regarding various aspects of reproductive health with the use of structured training module, pamphlets and posters. The class was arranged for 4 hours per day in 3 consecutive days by the investigator. Then after 7 days post test was conducted to the community change agent by the investigator for the period of 20 minutes.

After confirmation the community change agents have gained the adequate knowledge and favourable attitude on reproductive health, the women were provided with training materials and the training by community change agents to women was done for the period of 4 hours daily in the 2 days. The training was takes place in the residence of community change agents under the supervision of investigator. The rooms were well ventilated. After 7 days post test was conducted to the women by the investigator.

CHANGES MADE IN THE TOOL AFTER PILOT STUDY

Third component of family planning was removed from the intervention tool and data collection tool.

RELIABILITY OF THE TOOL

For structured interview schedule, tool reliability was checked by using inter rater method with the samples by 2 researchers. The reliability score of interview schedule to assess knowledge was 0.96 and reliability for attitude scale was established by split half method. The reliability score was 0.92 hence the tool was considered reliable to proceed with main study.

PROCEDURE FOR DATA COLLECTION

The main study was conducted in the adopted villages of OACHC such as Arakkampakkam, keezhkondaiyar, Karalapakkam an and Gowdipuram. It was conducted after receiving the formal permission from the Principal of Omayal Achi College of nursing. The permission was obtained from the President of the respective villages before conducting the study.

On the first day the investigator went of all 4 villages and introduced herself to the Panchayat Presidents and explained about the purpose of study and there identified 2 women in each villages and advised them to select 10 women per each as per their convenience. On 2nd day the investigator went to Arakkampakkam village met the women and briefly explained the purpose of her visit. Privacy was provided and confidentiality regarding the data was assured to the women so as to get the co operation in the procedure. After getting the written consent, data collection was carried out.

Altogether pre test was conducted for 22 women on the second day in the residence of community change agent. The room was ventilated with natural and artificial ventilation. Women were comfortably sat on the floor in a circular order over the mat. The investigator gave the small introduction and the pre test was done

with the help of research assistant. The duration of the pretest was 20 minutes. In the test initially the personal characteristics were collected by using personal data sheet and followed by that knowledge and attitude was collected by using structure interview schedule and 5 point Likert attitude scale.

After the pretest on the same day the investigator started the training schedule of community change agents in the residence of community change agent regarding various aspects of reproductive health with the use of structured training module, pamphlets and posters. The class was arranged for 4 hours per day in 3 consecutive days by the investigator. After 5 days post test was conducted to the community change agent by the investigator for the period of 20 minutes. On 4th day the investigator went to keezhkondaiyar village and has done the selection and training of community change agents and next to that the investigator visited Karalapakkam and then to Gowdipuram and carried the procedure as mentioned above.

After confirmation the community change agents have gained the adequate knowledge and favourable attitude on reproductive health, the women were provided with training materials and the training by community change agents to women was done for the period of 4 hours daily in the 2 days. The training was takes place in the residence of community change agents under the supervision of investigator. The rooms were well ventilated. After 5 days post test was conducted by the investigator for the women with the help of research assistants.

PLAN FOR DATA ANALYSIS

Descriptive Statistics

- 1) Frequency and percentage distribution was used to analyze the demographic variables.
- 2) Mean and standard deviation was used to assess the pre test and post test level of knowledge and attitude.

Inferential Statistics

1. Paired t test was used to be used to compare the pre and post test level of knowledge and attitude scores.
2. Correlation coefficient was used to correlate the mean differed knowledge score with mean differed attitude score.
3. One way ANOVA was used to associate the mean differed level of knowledge and attitude with selected demographic variables between the groups.

CHAPTER-IV

DATA ANALYSIS AND DATA INTERPRETATION

This chapter deals with analysis and interpretation of the data collected from 80 women those who are residing at the adopted villages of the Omayal Achi Community Health Centre. The data was organized, tabulated and analyzed according to the objectives. The findings based on the descriptive and inferential statistical analysis is presented under the following sections.

ORGANIZATION OF THE DATA

The findings of the study were grouped and analyzed under the following sections.

- Section A** : Description of the demographic variables.
- Section B** : Assessment of pre and post test level of knowledge and attitude regarding reproductive health among women.
- Section C** : Comparison of pre and post test level of knowledge and attitude regarding reproductive health among women.
- Section D** : Correlation between mean differed level of knowledge score and attitude score regarding reproductive health among women.
- Section E(a)**: Association of mean differed knowledge score with selected demographic variables of women.
 - (b)**: Association of mean differed attitude score with selected demographic variables of women.

PRESENTATION OF THE DATA

SECTION A: DESCRIPTION OF THE DEMOGRAPHIC VARIABLES.

Table 1(a) : Frequency and percentage distribution of demographic variables with respect to age of the mother, educational status, occupational status and monthly family income.

N= 80

S.No.	Demographic variables	Number	%
1	Age of the mother in years		
	15-24	25	32
	25-34	31	38
	35-44	12	15
	45 and above	12	15
2	Educational status		
	Primary	26	32.5
	High school	12	15
	Higher secondary	10	12.5
	Graduate	8	10
	Non literate	24	30
	Others	0	0
3	Occupational status		
	Skilled	5	6
	Semiskilled	4	5
	Unskilled	25	31
	Housewife	46	58
4	Monthly family income in rupees		
	<1500	14	18
	1500-3000	33	41
	3001-5000	27	34
	>5000	6	7

Table 1(a) describes frequency and percentage distribution of demographic variables such as age of the mother, educational status, occupational status and monthly family income of the women.

With regard to age of women most 31(38%) of them were between 26-35 years of age, 24 (26%) of women completed primary education. Most of them 46 (58%) were housewives and most of their family income 33 (41%) was between Rs 1501-3000.

Table 1(b): Frequency and percentage distribution of demographic variables such as religion, type of family, sources of reproductive health information and members of voluntary group.

N= 80

S.No.	Demographic variables	Number	Percentage
5	Religion		
	Hindu	50	62
	Christian	29	36
	Muslim	1	2
	Others	0	0
6	Type of family		
	Nuclear family	44	55
	Joint family	36	45
	Extended family	-	0
	Others	-	0
7	Sources of reproductive health information		
	Mothers and siblings	34	42
	Relatives	5	6
	Health personnel	15	19
	Mass media(TV, radio, newspaper)	26	33
8	Members of voluntary group		
	Self help group	38	47.5
	Mahila mandal	0	0
	Others	0	0
	Nil significance	42	52.5

Table 1(b) shows frequency and percentage distribution of demographic variables such as religion, type of family, sources of reproductive health information and members of voluntary group. With regard to religion majority 50(62%) of them belongs to Hindu religion, most of them 44(55%) were living in nuclear family and 34(42%) received reproductive health information from their mother and siblings and 26(33%) of them had access to mass media like TV, radio and Newspaper. Majority of them 50(62.5%) not belong to any voluntary organization and 30 (37.5%) of them were the members of self help groups.

Table 1(c): Frequency and percentage distribution of demographic variables such as family history of reproductive tract infection, family history of cervical cancer and family history of breast cancer.

N= 80

S.No.	Demographic variables	Number	%
9	Family history of RTI or STI		
	Yes	4	5
	No	76	95
	If yes		
	Mother	2	50
	Siblings	2	50
	Father	0	0
10	Family history of cervical cancer		
	Yes	2	2.5
	No	78	97.5
	If yes		
	Mother	2	100
	Siblings	0	0
11	Family history of breast cancer		
	Yes	3	3.75
	No	77	96.25
	If yes		
	Mother	3	100
	Siblings	0	0
	Father	0	0

Table 1(c) reveals frequency and percentage distribution of demographic variables such as family history of reproductive tract infection, family history of cervical cancer and family history of breast cancer.

With regard to demographic variables majority of women 76 (95%) possessed no family history of RTI, majority 79 (97.5%) had no family history of cervical cancer and 77(96.25%) of them possessed no family history of breast cancer.

Table 1(d): Frequency and percentage distribution of demographic variables such as marital status, age at menarche, menstrual history, age at marriage and years of married life.

N= 80

S.No.	Demographic variables	Number	%
12	Marital status		
	Married	76	95
	Unmarried	2	2.5
	Widow	2	2.5
	Others	0	0
13	Age at menarche		
	Below 13 years	40	50
	13-15 years	37	46
	Above 15 years	3	6
14	Menstrual history		
	Regular	73	92.5
	Irregular	6	7.5
	Treatment taken to menstrual problems	1	1
15	Age at marriage		
	Below 18 years	23	29
	18-21 years	45	57
	Above 21 years	10	14
16	Years of married life		
	<1 year	14	18
	1-2 years	22	28
	2-5 years	13	17
	>5 years	29	37

Table 1(d) shows frequency and percentage distribution of demographic variables such as marital status, age at menarche, menstrual history, age at marriage and years of married life.

With regard to demographic variable majority of women 76(95%) were married, 39 (49%) had attained menarche below 13 years of their age, majority 73 (92.5%) possessed normal menstrual history, among which 43 (58%) of women had got married in the age of 18-21 years.

Table 1(e): Frequency and percentage distribution of demographic variables such as status of having children, mode of delivery, place of delivery, previous history of abortion or stillbirth and previous history of RTI, STI or other gynecological problems.

N= 80

S.NO.	DEMOGRAPHIC VARIABLES	FREQUENCY	%
17	Do you have children		
	yes	74	95
	No	4	5
18	Mode of delivery		
	Vaginal delivery	63	85
	Cesarean section	9	12
	Both	2	3
19	Place of delivery		
	Institutional delivery	59	80
	Home delivery	13	18
	Both	2	3
20	Previous history of abortion or stillbirth		
	Yes	4	5
	No	74	95
21	Previous exposure to STI or RTI		
	Yes	5	6
	No	75	94

Table 1(e) illustrates frequency and percentage distribution of demographic variables such as status of having children, mode of delivery, place of delivery, previous history of abortion or stillbirth and previous history of RTI, STI or other gynecological problems.

With regard to demographic variables majority 76(95%) of women have children, among which 63 (85%) had undergone normal delivery and most 59 (80%) of them delivered at intuitional settings. Majority of them 74 (95%) were not possessing previous history of abortion of stillbirth and 75 (94%) were not exposed to STI or RTI.

SECTION B: ASSESSMENT OF PRE AND POST TEST LEVEL OF KNOWLEDGE OF WOMEN ABOUT VARIOUS ASPECTS OF REPRODUCTIVE HEALTH.

Table 2 : Frequency and percentage distribution of pre and post test level of knowledge on various aspects of reproductive health among women.

N= 80

Knowledge	Inadequate Knowledge (<50%)				Moderately Adequate knowledge (50 – 75%)				Adequate Knowledge (>75%)			
	Pre test		Post test		Pre test		Post test		Pre test		Post test	
	No.	%	No	%	No	%	No.	%	No	%	No	%
Reproductive tract infection	55	69	7	8.75	22	28	21	26.25	3	3	52	65
Life threatening cancers of women	52	65	10	12.5	26	34	26	32.5	2	1	44	55

The above table 2(a) depicts the frequency and percentage distribution of pre and post level of knowledge on reproductive health among women.

With regard to pretest and post test level of knowledge on reproductive tract infection majority 55(69%) had inadequate knowledge in pre test, while 7(8.75%) only had inadequate knowledge in post test, 52(65%) had inadequate knowledge about life threatening cancers of women in pre test, while 44(55%) had adequate knowledge in post test .

N=80

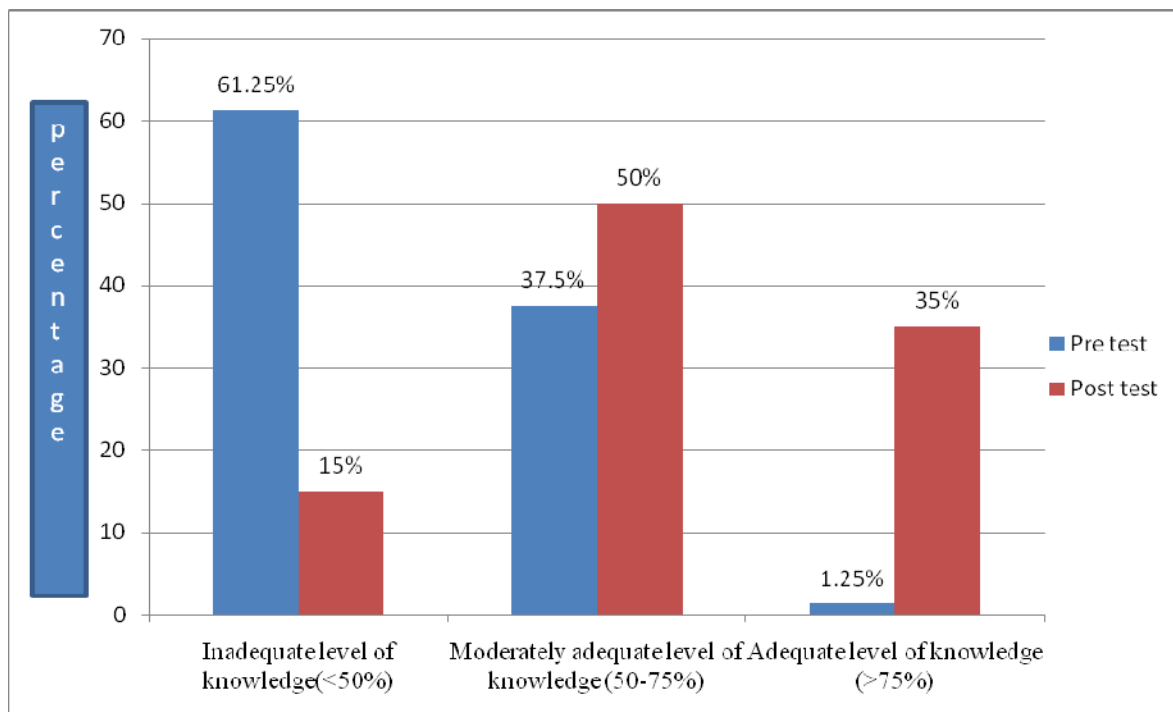


Fig.3: Percentage distribution of overall pre and post test level of knowledge of the women on reproductive health.

Fig.3 illustrates the percentage distribution of overall pre and post test level of knowledge of the women on reproductive health.

With regard to pre and post test level of knowledge majority of the women 49(61.25%) had in adequate knowledge in pretest whereas only 12(15%) had in adequate knowledge in post test. 30(37.5%) of women had moderately adequate knowledge and 1(1.25%) had adequate knowledge in pretest. Whereas in post test majority of the women 40 (50%) had moderately adequate knowledge and 28(35%) had adequate knowledge.

N=80

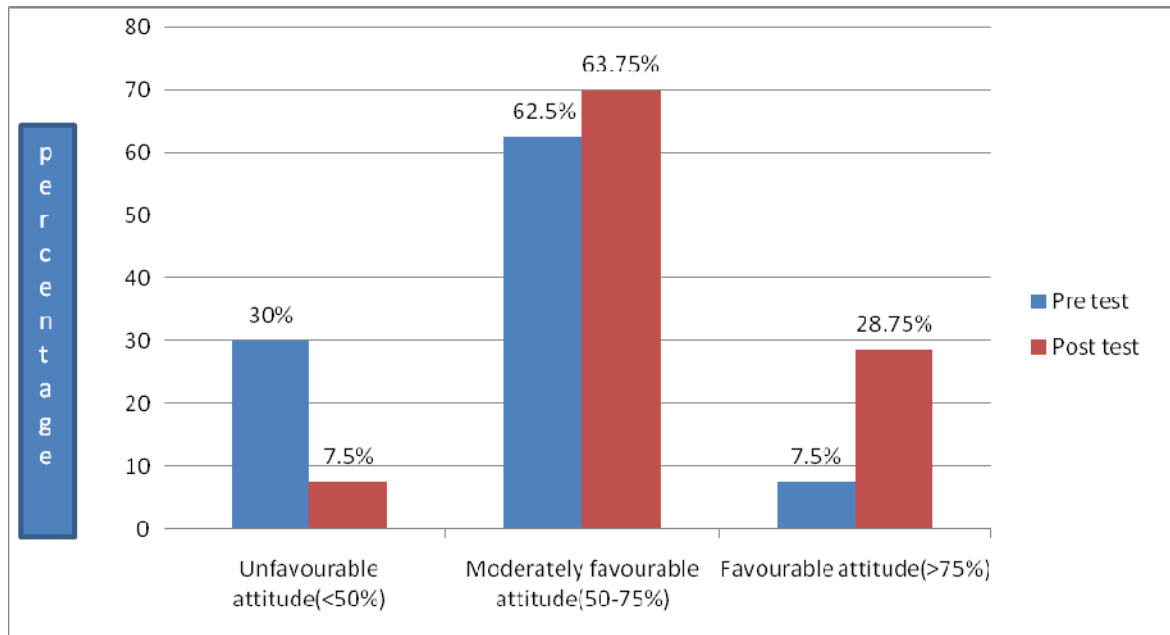


Fig.4: The overall pre and post test level of attitude of the women on reproductive health.

Fig.4 reveals the percentage distribution of overall pre and post test level of attitude of the women on reproductive health.

With regard to pre and post test level of attitude majority of the women 50(62.25%) had moderately favourable attitude in pretest and 24(30%) of women had unfavourable attitude and 6(7.5%) had favourable attitude in pretest where as in majority of the women 51 (63.75%) had moderately favourable attitude and 23(28.75%) had favourable attitude in post test.

SECTION – C: COMPARISON OF MEAN DIFFERED PRE AND POST TEST LEVEL OF KNOWLEDGE AND ATTITUDE ON REPRODUCTIVE HEALTH AMONG WOMEN.

Table 3 : Comparison of mean differed pre and post test level of knowledge and attitude on reproductive health among women.

N= 80

	Pre test	Post test	Mean difference	't' value
Knowledge	8.75	12.9	4.15	12.75*** (s)
Attitude	42.4	52.2	9.8	9.65*** (s)

***p<0.001, **p<0.01, *p<0.05, S – Significant

Table 3 reveals the effectiveness of community change agents by comparing pre and post test level of knowledge and attitude score.

The overall mean score for knowledge in pre test was 8.75% and mean pre test attitude score was 42.4 where as in post test the overall mean knowledge score was 12.9 and mean attitude score was 9.8. The calculated table value for knowledge was 't'=12.75 that is significant at p<0.001 and the 't' value for attitude was 9.65 which is significant at p<0.001. Hence there is evident for significant improvement of knowledge and attitude regarding reproductive health among women after the training given by community change agents.

SECTION – D: CORRELATION BETWEEN MEAN DIFFERED LEVEL OF KNOWLEDGE AND ATTITUDE SCORE OF WOMEN ABOUT REPRODUCTIVE HEALTH.

Table 4 : Correlation between mean differed knowledge and attitude score of women regarding reproductive health.

N= 80

Variables	Mean	Standard deviation	'r' value
Knowledge	12.9	2.6	r=0.63**
Attitude	52.2	11.1	(S)

***p<0.001, **p<0.01, *p<0.05, S – Significant

The above table 4 shows Correlation between mean differed level of knowledge and attitude score of women about reproductive health.

The findings revealed that the mean differed knowledge score was 12.9 with SD of 2.6, the mean differed attitude score was 52.2 with SD of 11.1 .The calculated 'r' value was 0.63 which shows that there was moderately positive correlation between the mean differed knowledge and attitude score at p<0.01.

SECTION E(a): ASSOCIATION OF MEAN DIFFERED KNOWLEDGE SCORE WITH SELECTED DEMOGRAPHIC VARIABLE OF WOMEN.

Table 5(a) : Association of mean differed knowledge score with selected demographic variable of women such as members of voluntary group, family history of reproductive tract infection, family history of cervical cancer and family history of breast cancer.

N= 80

Demographic variables	Pretest		Post test		Mean difference		Anova / 't' value
	Mean	SD	Mean	SD	Mean	SD	
Members of voluntary group							F= 25 P<0.001 S=***
Self help group	9.44	2.6	13.02	3.09	3.58	0.49	
Mahila mandal	-	-	-	-	-	-	
Others	-	-	-	-	-	-	
Nil significance	8.35	2.83	12.78	3.56	4.43	0.73	
Family history of reproductive tract information							F= 30.71 P<0.001 S***
Yes	10.25	2.94	15	3.08	4.75	0.14	
No	9.75	3.47	12.78	3.12	3.03	0.35	
Family history of cervical cancer							F=21.9 P<0.001 S***
Yes	10.5	1.5	11	3	0.5	1.5	
No	8.89	2.77	12.9	3.32	4.01	0.55	
Family history of breast cancer							F= 2.31 P<0.05 S*
Yes	8.33	2.49	13	4.32	4.67	1.83	
No	8.89	2.89	12.89	3.3	4	0.41	

***p<0.001, **p<0.01, *p<0.05, S – Significant.

Table 5(a) shows association of mean differed knowledge score with selected demographic variable of women such members of voluntary group, family history of reproductive tract infection, family history of cervical cancer and family history of breast cancer. Results evidenced that there was significant association of mean differed knowledge score with demographic variable of members of voluntary group at p<0.001, with family history of reproductive tract infection at p<0.001, with family history of cervical cancer at p<0.001 and with family history of breast cancer at p<0.05 level.

Table 5(b): Association of mean differed knowledge score with selected demographic variable of women such as marital status, and previous exposure to reproductive tract infection or gynecological problem.

N= 80

Demographic Variables	Pretest		Post test		Mean difference		Anova / 't' value
	Mean	SD	Mean	SD	Mean	SD	
Marital status							F= 4.05 P<0.05 S*
Married	8.99	2.82	12.81	3.38	3.82	0.56	
Unmarried	7	1	14.5	1.5	7.5	0.5	
Widow	6.5	1.5	14.5	2.5	8	1	
Others	-	-	-	-	-	-	
Previous history of reproductive tract infection or gynecological problem							't' = 12.44 p<0.001 S****
Yes	10.75	1.31	10.5	2.23	1.75	0.92	
No	8.90	2.73	12.89	3.39	3.99	0.66	

***p<0.001, **p<0.01, *p<0.05, S – Significant.

Table 5(b) shows association of mean differed knowledge score with selected demographic variable of women such as marital status and previous history of reproductive tract infection. Results evidenced that there was significant association of mean differed knowledge score with score with demographic variable of marital status at p<0.05 and with previous history of reproductive tract infection association found at p<0.001. The other demographic variables did not show any significant association with mean differed knowledge score.

SECTION–E(B): ASSOCIATION OF MEAN DIFFERED ATTITUDE SCORE WITH SELECTED DEMOGRAPHIC VARIABLE OF WOMEN.

Table 5(c) : Association of mean differed attitude score with selected demographic variable of women such as educational status and occupational status

N= 80

Demographic Variables	Pretest		Post test		Mean difference		Anova / 't' value
	Mean	SD	Mean	SD	Mean	SD	
Educational status							F=4.22 S* P<0.05
Primary	40.38	9.47	52.15	11.61	11.77	2.14	
High school	47.1	7.99	56.3	9.98	9.2	1.99	
Higher secondary	48.23	10.65	56.27	10.66	8.04	0.01	
Graduate	46	8.86	58.63	12.7	12.63	13.84	
Non literate	37.91	7.39	46.25	9.27	8.34	1.88	
Others	-	-	-	-	-	-	
Occupation							F=47.23 S*** P<0.001
Skilled	41.2	9.09	52.2	12.81	11	2.91	
Semiskilled	39.75	4.35	52.5	6.95	12.75	2.6	
Unskilled	37.92	8.95	47.52	8.36	9.6	0.59	
Housewife	45.13	10.20	54.25	12.57	9.52	2.37	
Professional	-	-	-	-	-	-	

***p<0.001, **p<0.01, *p<0.05, S – Significant.

Table 5(c) shows association of mean differed attitude score with selected demographic variable of women such as educational status and occupational status. Results evidenced that there was significant an association of mean differed knowledge score with score with demographic variable of educational status at p<0.05 and with occupation association found at p<0000. The other demographic variables did not show any significant association with mean differed attitude score.

Table 5(d): Association of mean differed attitude score with selected demographic variable of women such as family history of cervical cancer and years of married life.

N= 80

Demographic Variables	Pretest		Post test		Mean Dfference		ANOVA / 't' Vluе
	Mean	SD	Mean	SD	Mean	SD	
Family history of cervical cancer							't'=4.9 S* P<0.05
Yes	34.5	9.19	42	14.14	7.5	4.95	
No	42.85	10.64	52.43	11.40	9.58	0.76	
Years of married life							F=4.56 S** p<0.01
1	41.57	9.47	55.36	9.59	13.79	0.12	
2	41.38	7.72	51.59	11.59	10.21	3.87	
2-5	41.46	8.21	45.15	11.71	3.69	3.5	
Above 5	44.18	12.89	54.39	11.84	10.21	1.05	

***p<0.001, **p<0.01, *p<0.05, S – Significant.

Table 5(d) gives the association of mean differed attitude score with selected demographic variable of women such as family history of cervical cancer and years of married life.

Findings shows that there was significant association of mean differed attitude score with of demographic variable family history of cervical cancer at p<0.05 and there was mild significant association of mean differed attitude score with years of married life at p<0.01 level. The other demographic variables did not show any significant association with mean differed attitude score.

CHAPTER – VI

DISCUSSION

This chapter discusses in detail the finding of the analysis in relation to the objectives of the study. The following were the objectives of the study and further discussions will exemplify these objectives were satisfied by the study. The findings of the study based on the objectives were:

The first objective of the study was to assess pre and post test level of knowledge and attitude regarding reproductive health among the women.

The analysis of pre test and post test level of knowledge of women reveals that in pre test majority of the women 49(61.25%) had inadequate level of knowledge, 30(37.5%) had moderately adequate level of knowledge and only 1 (1.25%) had adequate level of knowledge. Whereas in post test level of knowledge majority of the women 40(50%) had moderately adequate level of knowledge, 28(35%) had adequate level of knowledge and only 12(15%) had inadequate level of knowledge.

Analyzing pre and post level of attitude reveals that majority of women 50(62.5%) had moderately favourable attitude and 24(30%) of the women had unfavourable attitude in pre test. While in post test majority of them 51(63.75%) had moderately adequate attitude, 23 (28.75%) of them had favourable level of attitude.

The finding was supported by the study conducted by **Jan Gerris M (2004)** effectiveness of health education interventions in slums regarding reproductive health among 200 women from 10 villages was assessed and it was found that the overall knowledge was improved from 18% to 76% in the post test.

The second objective was to assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women.

In analysis the pretest knowledge mean and standard deviation were 8.75 and 2.8. The post test knowledge mean and standard deviation were 12.9 and 2.6. The calculated 't' value was 12.75 and it revealed that there is highly statistical significant difference between the pre and post test level of knowledge of women at $p < 0.001$ level. Hence the null hypothesis NH_1 stated earlier that there is no significant difference between the pre test and post test level of knowledge was **rejected**.

In analysis Pretest attitude mean and standard deviation were 42.4 and 8.27 and post test attitude mean and standard deviation were 52.2 and 11.1 respectively. The calculated 't' value was 9.65. It revealed that there was statistical significant difference between the pre and post test level of attitude of the women at level of $p < 0.001$. NH_1 stated earlier that there is no significant difference between the pre test and post test attitude level of attitude was **rejected**.

The third objective was to correlate the mean differed knowledge score with mean differed attitude score of women regarding reproductive health.

The findings revealed that the mean differed knowledge score was 12.9 with SD of 2.6, the mean differed attitude score was 52.2 with SD of 11.1. The calculated 'r' value was 0.6 which shows that there is a moderately positive correlation between the mean differed knowledge and attitude score at $p < 0.01$. Therefore the null hypothesis NH_2 which stated earlier that there is no significant correlation between post test level of knowledge and attitude among the women was **rejected**.

The fourth objective was to associate the mean differed knowledge score and mean differed attitude score with selected demographic variables.

The analysis of association of mean differed knowledge score with demographic variables revealed that , with respect to belonging membership of voluntary group, the calculated F test value was 25, with family history of reproductive tract infection F=10.11 and with family history of cervical history analysis shows F= 21.9 , with regard to previous history of reproductive tract infection F= 12.44, by which all the above show the highly significance at the level of $p<0.001$ and with marital status shows F=4.05.which shows the significance at the level of $p<0.05$.Hece the null hypothesis NH_3 stated earlier that there is no significant association of mean differed knowledge score with membership of voluntary group, family history of RTI, family history of cervical cancer, marital status and previous history of RTI was **rejected and the with other variables were accepted.**

The analysis of association of mean differed attitude score with demographic variables revealed that, with regard to the educational status calculated F test value was 4.22, which shows the statistical significance at $p<0.05$, with occupational status F=42.73which evidences the highly statistical significance at $p<0.001$, family history of cervical cancer shows F=4.99 and with years of married life it was 4.56, which shows the significant association at the level of $p<0.05$. Hence the null hypothesis NH_3 stated earlier that there is no significant association of mean differed attitude score with educational status, occupational status, family history of cervical cancer and years of married life was **rejected and the with other variables were accepted.**

CHAPTER – VI

SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS

This chapter presents the summary, conclusion, implications, recommendations and limitations of the study.

SUMMARY

The present study was conducted to assess the effectiveness of community change agents on knowledge and attitude of women regarding reproductive health regarding reproductive health in selected Villages adopted by Omayal Achi Community Health Centre. The findings evidenced that there was an effectiveness of teaching given through community change agents for women regarding reproductive health aspects. There by it increases the self reliance of people and also it makes possible for the community health nurse to leave some one as her representative for health teaching permanently.

The objectives of the study were

1. To assess the pretest level of knowledge and attitude regarding reproductive health among women.
2. To assess the effectiveness of trained community level workers on knowledge and attitude regarding reproductive health among women.
3. To correlate the mean differed knowledge score with mean differed attitude score of women regarding reproductive health.
4. To associate the mean differed knowledge score and attitude score of women with selected demographic variables.

The null hypotheses formulated were

NH₁– There is no significant difference between pre test and post test level of knowledge and attitude regarding reproductive health among women at $p < 0.05$.

NH₂–There is no significant correlation between the mean difference levels of knowledge score with mean differed attitude score at $p < 0.05$.

NH₃ –There is no significant association between the mean difference level of knowledge and attitude score with selected demographic variables at $p < 0.05$.

The assumptions of the study were

1. Women are prone for reproductive health problems.
2. Women may have some knowledge and attitude regarding reproductive health.
3. Community change agents may enhance the knowledge and attitude of women regarding reproductive health.
4. Community change agents approach helps the women to gain self reliance and they will be available permanently in the community to clarify the queries of women as representative of community health nurse.

The review of literature was done from primary and secondary sources. The extensive review of literature, investigator's professional experience and expert guidance from the field of community health nursing helped the investigator as the basis for selection of the problem, design the methodology and formulation of tool for data collection and conceptual framework.

The conceptual framework for the study was based on the integrated model of Widenbach's prescriptive theory and Stuffle beam's evaluation model and it provided a comprehensive framework for achieving the objectives of the study. The modified framework portrays that a positive outcome promotes knowledge and attitude of women on reproductive health and this model helps to evaluate the process of the study at each step.

The researcher adopted a pre experimental design to assess the knowledge and attitude of the women on reproductive health. The study was conducted among the women aged 15-49 and residing at Arakkampakkam, Keezhkondaiyar, Karalapakkam and Gowdipuram. 80 samples were selected (20 from each village) by means of referent sampling through community change agents. Whereas the 8 community agents (2 from each village) were selected by using non probability convenient sampling.

The investigator developed the tool consists of demographic variables. Structured interview schedule to assess the pre and post test level of knowledge and 5 point likert scale was used to assess the pre and post test level of attitude. A brief introduction was given to the women before conducting the pretest. Pre test was conducted for 88 women (22 from each village). Among 8 women those who satisfy the criteria checklist of the investigator were selected as community change agents (2 from each village). They were undergone the training on reproductive health by the investigator and post test was conducted. Among that those who attained the adequate knowledge and attitude were selected to give the teaching for women and others were reinforced until they get adequate knowledge.

The women were undergone the teaching by community change agents on reproductive health and post test was conducted after the training.

The legal and ethical aspects of the research was maintained throughout the study by getting formal permission from the authorities and informed consent from the participants of the study. The pilot study was conducted at Kanniyamman Nagar and it was found practicable and feasible to proceed with main study.

The content validity was obtained from the experts. The reliability of the structured interview schedule was established by test re test method $r = 0.91$ and split half method was used to confirm the reliability Likert scale and $r = 0.85$ which showed the high reliability for both tools of knowledge and attitude. The data was

collected by personal interview schedule. The data was organized, tabulated, analyzed and interpreted by using descriptive and inferential statistics on the basis of objectives of the study and hypotheses to be tested. Parameters used are mean, standard deviation, paired 't' test, Karl Pearson's correlation coefficient, unpaired t test and one way ANOVA.

The major findings of the study were

The major findings of the study revealed the mean improvement level between pre test and post test level of knowledge. The mean value of knowledge in the pre test was 8.75 and it increased to 12.9 in the post test. The improved mean was 4.15 and S.D was 0.2. The paired 't' test score was 12.75, which was highly significant at $p < 0.001$. Hence the null hypothesis NH_1 stated earlier that there is no significant difference between the pre test and post test level of knowledge was **rejected**.

The study revealed the mean value of level of attitude in the pretest was 42.4 and that was increased to 52.2 in the post test. The improved mean was 9.8 and the S.D was 2.83. The paired 't' test value was 9.65, which was highly significant at $p < 0.001$ level. Hence the null hypothesis NH_1 stated earlier that there is no significant difference between the pre test and post test attitude level of attitude was **rejected**.

The findings showed that the correlation of post test level of knowledge and attitude among the women was " r " = 0.63 at $p < 0.01$ revealed moderate positive correlation of knowledge and attitude. Therefore the null hypothesis NH_2 which stated earlier that there is no significant correlation between post test level of knowledge and attitude among the women was **rejected**.

The analysis of association of mean improved knowledge score with demographic variables revealed that, with regard to the belonging membership of voluntary group the calculated F test value was 25, family history of reproductive

tract infection $F=10.11$ and with family history of cervical history analysis shows $F= 21.9$, with regard to previous history of reproductive tract infection $F= 12.44$, by which all the above show the highly significance at the level of $p<0.001$ and with marital status it shows $F= 4.05$.which shows the significance at the level of $p<0.05$. Hence the null hypothesis **NH₃ stated earlier that there is no significant association of mean differed level of knowledge with membership of voluntary group, family history of RTI, family history of cervical cancer, marital status and previous history of RTI was rejected and the with other variables were accepted.**

The analysis of association of mean improved attitude score with demographic variables revealed that, with regard to the educational status calculated F test value was 4.22, which shows the statistical significance at $p<0.05$, with occupational status $F= 42.73$ evidences the highly statistical significance at $p<0.001$, family history of cervical cancer shows $F=4.99$ and with years of married life it was 4.56, which shows the significant association at the level of $p<0.05$. **Hence the null hypothesis NH₃ stated earlier that there is no significant association of mean differed level of attitude with educational status, occupational status, family history of cervical cancer and years of married life was rejected and the with other variables were accepted.**

CONCLUSION

The community change agent approach is an effective model for health educating the people in the community as evidenced by increase in the level of knowledge and attitude of women trained by community change agent.

IMPLICATIONS

Nursing Education

Nurse educator can educate some responsible volunteer and through them she can achieve more number of people for the information transition and also it

hopes very effective as because they will be comfortable to clarify queries from their own community people. Community change agent model can be used as IEC model for giving health education in the community.

Nursing Practice

Community health nurse has the sole responsibility to provide comprehensive care for the people especially for the vulnerable populations such as women. It is important to create the self reliance among them towards their health and there is a need for constant source of information. Through the creation of the community care agents the CHN can make it available for the women.

Nursing Administration

Nurse administrator can collaborate with governing bodies in formulating policies to employ such trained community agents for betterment of the service utilization and realizing the target of self reliance of health.

Nurse administrator can arrange many camps and programmes on various health topics to promote their active participation.

Nursing Research

Nursing research is a powerful means of answering questions about health care interventions and finding better ways of promoting health, prevention of illness and providing care and rehabilitation services to people of all ages and in different settings.

Nurse researcher can promote more research in these community change agents approach and disseminate the findings through conferences, seminar, internet, journals, and literature publications in professional national and international journals to promote practice. As because this approach is cost-effective and dissemination of knowledge will be more efficient. The

generalization of the study results can be made by further replication of the study in various settings and larger population.

Nursing research motivates other investigators to conduct further study on aspects from this topic. This is an area inviting further innovative researches, to build sound evidenced based nursing practice.

RECOMMENDATIONS

1. The investigator recommends the utilization of the self instructional module to train all the women residing at the adapted village in order to improve their self reliance towards health of the community.
2. The investigator recommends communicating the information about the effectiveness of community change agents whom they can involve in health care activities.
3. A similar study can be conducted at different setting with larger samples for generalization.
4. Replication of the study can be done for various age groups on need based manner.
5. Comparative study could be conducted to for assess the effectiveness between rural and urban community.

LIMITATIONS

1. As because of the time constraints and poor transportation the researcher was not able to complete the study as planned to do in 5 villages among 100 samples.
2. It was little tedious for the researcher to gain support from the community change agents and women to discuss about sensitive topic like reproductive health aspects initially
3. Researcher found difficulty in getting extensive Indian reviews related to teaching of women by community change agents approach.

APPENDIX – C

LETTER SEEKING EXPERTS' OPINION FOR CONTENT VALIDITY

From

S.Narmatha,
M.Sc (N) II Year student,
Omayal Achi College of Nursing,
Chennai.

To

Respected Sir/ Madam,

Sub : Requisition for expert opinion on suggestion for content validity of the tool regarding the assessment of effectiveness of community change agents on knowledge and attitude regarding reproductive health among the women.

I am a student of M.Sc Nursing II Year at Omayal Achi College of Nursing, Puzhal -66. As a part of my research project to be submitted to the Tamilnadu Dr.M.G.R Medical University, in partial fulfillment of the university requirement for the award of M.Sc (N) degree, conducting a study on, **“A pre experimental study to assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women in selected Villages adopted by Omayal Achi Community Health Centre, Thiruvalluvar district, Chennai 2011.”**

I have enclosed my data collection tool and intervention tool for your expert guidance and validation. Kindly validate the tool and render your expert opinion in this regard.

It will be very kind of you to return it undersigned at the earliest.

Thanking you

Yours sincerely,

(S. NARMATHA)

Enclosures:

- Research Proposal
- Data collection tool
- Intervention tool
- Content Validity form
- Certificate for Content validity

LIST OF EXPERTS FOR CONTENT VALIDITY

MEDICAL EXPERTS:

1. Dr. K.R.RAJANARAYAN

B.Sc.M.B.B.S.,FRSH(LONDON)

Honorary professor in community medicine

Omayal Achi college of Nursing

Puzhal, Chennai – 600 066, Tamil Nadu.

2. Dr.S.Y.Jaganathan

M.D. (Pathology), DPH,

Asst. Professor of Pathology,

Govt. Stanley Medical College & Hospital,

Chennai – 600 001.

NURSING EXPERTS:

3. Dr.Saradha Ramesh, Ph.D.,

Principal,

College of Nursing,

Saveetha University,

Chennai – 600 077.

4. Mrs.Rajeshwari Vaidyanathan, M.Sc., Ph.D.,

Principal,

Sri Ramachandra University,

Porur, Chennai.

5. Dr.Dinesh, Ph.D.,

HOD,

Padmashree Institute of Nursing,

Bangalore – 560 060

APPENDIX – D

CERTIFICATE OF ENGLISH EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify the dissertation work “**A pre experimental study to assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women in selected Villages adopted by Omayal Achi Community Health Centre, Thiruvalluvar district, Chennai 2011.**” done by Ms.Narmatha, II year M.Sc(N) student of Omayal Achi College of Nursing, Chennai, is edited for English language appropriated by

Signature :

Seal:

APPENDIX – E

CERTIFICATE OF TAMIL EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify the dissertation work “**A pre experimental study to assess the effectiveness of community change agents on knowledge and attitude regarding reproductive health among women in selected Villages adopted by Omayal Achi Community Health Centre, Thiruvalluvar district, Chennai 2011.**” done by Ms.Narmatha, II year M.Sc(N) student of Omayal Achi College of Nursing, Chennai, is edited for Tamil language appropriated by

Signature :

Seal:

APPENDIX – F

INFORMED CONSENT – REQUEST FORM

Good morning.

I am Narmatha.S, II year student from Omayal Achi College of Nursing, Puzhal, Chennai, conducting a study to evaluate the effectiveness of community change agents on knowledge and attitude of the women on reproductive health, as a part of fulfillment of the requirement for the degree of M.Sc Nursing under the Tamilnadu Dr.M.G.R.Medical University. The women will be assessed by using structured interview schedule and 5point Likert attitude scale for knowledge and attitude. Then they will be educated by their own community women through the structured training module, Pamphlets, posters and flashcards.

So I request you to cooperate with me to conduct this study effectively and successfully. I assure you that the information obtained will be kept confidential.

Thank you.

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 «Ççi, çŞËý.

¿ýÈç...

INFORMED CONSENT FORM

I understand that I am being asked to participate in a research study by Ms. Narmatha.S. M.Sc(N) II Year student of Omayal Achi College of Nursing. This study will evaluate the "Effectiveness of community change agents on knowledge and attitude of the women on reproductive health". If I agree to participate in the study, I will be interviewed and it will take place in privacy. I understand that there is no risk associated with this study.

I realize that the knowledge and attitude gained from the study may help either me or other people in the future. I realize that my participation in this study is entirely voluntary, and I may withdraw from the study at any time I wish. If I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary fashion.

I understand that all study data will be kept confidential. However, this information may be used in nursing publications or presentations. If I need to I can contact Ms. Narmatha.S M.Sc(N) II year student of Omayal Achi College of Nursing, Puzhal, Chennai any time during the study.

The study has been explained to me. I have read and understood this consent form, all of my questions have been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form.

Signature of the Participant

Date:

Signature of the Investigator

Date:

Óý «ÈçÁçòÒ ´òÀó¼ ÀÈÁõ

–“ÁÁî ñç òÁçÄçÄ÷ ðæÄçÄçø ÓÐç“Ä Àð¼òÀÈòÒ ÀÄçÖò òÁç.ç÷Á¼ Æ Æ÷Çç ÷¼ð¼!ÁÜò þó¼ –òÁçø ±ý“É Áí§,ü, §,ðí!;ñ¼“¼ çíý òüÜ!;ü,ç§Èý. þó¼ –ÁîïçÄíÉÐ ¼Áçúçí ¼çÖÁüé÷ ÁíÄð¼ð¼çüì –ðÀð¼ §¼÷ó¼!;òÀð¼ çÄíÁíÇçø Áçèìò !ÄñÇçý «Èçx ÁüÜò ÁÉòÁíý“Á §ÁðÁìðÄ¼çø «òÁ¼çÄçø Áçèìò òá, çÄ –÷ÁÄçý Áì ÌÈçð¼¼ìò. þó¼ –òxì çíý ´òò!;ñ¼!ø «¼“ÉìÈçò¼ §ç÷Ó, –“ÁÁ¼Äçø Áí§,ü, §Áñìò ±ýÄ“¼ «Èç§Áý. ±ý“ÉòÀüÈç §,Äçò¼ ÍÁ¼,Áø,ü «“ÉòÐò !ÁÇçÄç¼ð¼!¼Áø ÀíÐ,ì,òÁìò ÁüÜò þ¼ý äÁÁ, ±Èì ±ó¼ À¼¼çòÒò þ“Ä ±ýÄ“¼Öò «ÈçóÐ !;ñ¼¼ý.

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–ÁîïçÄíÇÄçý“,!ÁíòÀò §¼¼ç :

APPENDIX – G

DATA COLLECTION TOOL

SECTION –A**DEMOGRAGHC VARIABLES****I.DEMOGRAPHIC DETAILS****Please select the appropriate option**

1) Age of the mother in years

- a) 18-25
- b) 26-35
- c) 36-45
- d) 46 and above

2) Educational status

- a) Primary
- b) High school
- c) Higher secondary
- d) Graduate
- e) Non literate
- f) Others

3) Occupation

- a) Skilled
- b) Semiskilled
- c) Unskilled
- d) House wife
- e) Professional

4) Monthly family income in Rs.

- a) < 1500

b) 1501-3000

c) 3001-5000

d) > 5000

5) Religion

a) Hindu

b) Christian

c) Muslim

d) Others

6) Type of the family

a) Nuclear family

b) Joint family

c) Extended family

d) Others

7) Sources of reproductive health information

a) Mother and Siblings.

b) Relatives.

c) Health personnel.

d) Mass media (TV, Radio, News paper).

8) Member of voluntary group

a) Self help group

b) Mahila mandal

c) Others

d) Nil significance

II.FAMILY HISTORY

9) Family history of reproductive tract infection or sexually transmitted infection

a) Yes

b) No

If yes means specify

a) Mother

b) Siblings

c) Father

10) Family history of cervical cancer

a) Yes

b) No

If yes means specify

a) Mother

b) Siblings

11) Family history of breast cancer

a) Yes

b) No

If yes means specify

a) Mother

b) Siblings

III. OBSTETRIC AND GYNECOLOGICAL HISTORY

12) Marital status

a) Married

b) Unmarried

c) Widow

d) Separated

13) Age at menarche

- a) Below 13 years
- b) 13-15 years
- c) Above 15 years

14) Menstrual history

- a) Regular
- b) Irregular
- c) Treatment taken to menstrual problem

15) Age at marriage

- a) Below 18 years
- b) 18-21 years
- c) Above 21 years

16) Years of married life

- a) 1 year
- b) 2 years
- c) 2-5 years
- d) Above 5 years

17) Do you have children?

- a) Yes
- b) No

If yes means specify

- a) 1
- b) 2
- c) More than 2

18) Mode of delivery

a) Normal vaginal delivery

b) Caesarean section

19) Place of delivery

a) Institutional delivery

b) Hospital delivery

20) Previous Abortion or stillbirth

a) Yes

b) No

If yes means specify

a) 1

b) 2

c) More than 2

21) Previous exposure to reproductive tract infection or gynaecological problem

a) Yes

b) No

If yes means specify the problem

Time and duration of the problem

SECTION -B
STRUCTURED INTERVIEW SCHEDULE TO ASSESS THE
KNOWLEDGE ON REPRODUCTIVE HEALTH

I.REPRODUCTIVE TRACT INFECTION

- 1) Reproductive tract infection means
 - a) Infection of genital tract
 - b) Infection of urinary tract
 - c) Infection of pelvic floor muscles
 - d) Infection of alimentary tract
- 2) Infection and inflammation of uterus and uterine tubes is known as
 - a) Peritonitis
 - b) Ascitis
 - c) Polycystitis
 - d) Pelvic inflammatory disease.
- 3) Reproductive infection during adolescence and in early childhood is caused by
 - a) Repeated childbirth
 - b) Protected sexual intercourse
 - c) Poor menstrual hygiene
 - d) Ingestion of contaminated food or fluids
- 4) The main feature of RTI is
 - a) Vomiting
 - b) Genital ulcer and vaginal discharge
 - c) Diarrhea
 - d) Abnormal tissue growth

- 5) Sexually transmitted infection means
- a) Infection caused due to unhygienic health practices.
 - b) Infection of genital tract follows genital injury
 - c) Infection of genital tract follows intercourse with infected person
 - d) Infection of genital tract which persist from the time of birth.
- 6) Under the following which is not a STD
- a) Gonorrhoea
 - b) Syphilis
 - c) Osteo arthritis
 - d) Lymphogranuloma venereum
- 7) Human immune deficiency virus causes
- a) AIDS
 - b) Syphilis
 - c) Chancroid
 - d) Lymphogranuloma venerium
- 8) AIDS and Sexually transmitted infections are common among the age group of
- a) Below 15 years
 - b) 16- 45 years
 - c) 46-60 years
 - d) Above 60 years
- 9) The main feature of AIDS includes
- a) Headache and vomiting
 - b) Weight loss and lowering of immunity
 - c) Abdominal pain
 - d) Constipation

10) Safe sex practice includes

- a) Use of condoms and having single sex partner
- b) Having multiple sex partners
- c) Using intrauterine devices.
- d) Using spermicides.

II. LIFE THREATENING CANCERS AFFECTS WOMEN

11) The common cancer which affect female is

- a) Cancer of cervix
- b) Cancer of stomach
- c) Cancer of bone
- d) Cancer of rectum

12) The common risk factors of cervical cancer are

- a) Nullipara
- b) High parity
- c) Sexual promiscuity
- d) High socio economic status

13) The age which has increased risk for developing breast cancer

- a) Less than 20 years
- b) 20-30 year
- c) 30- 40 years
- d) More than 40 years

14) Risk factor for breast cancer is

- a) Age below 25 years
- b) Family history
- c) Infection

- d) Birth of first child after 30 years and menarche before 12 years
- 15) Untreated sexually transmitted infection may cause the cancer of
- a) cervix
 - b) Stomach
 - c) Breast
 - d) Bone
- 16) The clinical features of breast cancer are
- a) Discharge from nipple, change in color and retraction of nipple and unequal breast size
 - b) Shrinking of breast
 - c) Bilateral breast tissue enlargement
 - d) Itching, Irritation and tenderness
- 17) Pap smear helps to detect
- a) Breast cancer
 - b) Lung cancer
 - c) Bone cancer
 - d) Cervical cancer
- 18) Breast self examination can be done
- a) Once a day
 - b) Once in a month
 - c) Once in a year
 - d) Once in 6 month
- 19) An effective tool to confirm breast cancer is
- a) Self breast examination
 - b) Clinical breast examination

c) Mammography

d) Urine test

20) The healthy life style which prevents the risk of development of Breast cancer is except

a) Regular monthly self breast examination

b) Maintain healthy weight

c) Intake of diet rich in plant source and low in fat

d) Sedentary life style

SECTION – C

ASSESS THE ATTITUDE OF THE WOMEN REGARDING REPRODUCTIVE HEALTH WITH MODIFIED 5 POINT LIKERT SCALE

S.NO.	DIMENSIONS	SA	A	UC	DA	SDA
	I.GENERAL ASPECTS					
1.	Early marriage deteriorates women's reproductive health.					
2.	Dietary factors are not having an important role in promoting women's health.					
3.	Education about reproductive health is important for women					
4.	The husband is not having an important role in improving women's reproductive health.					
5.	It will be sufficient for the women to concentrate on her reproductive health only after her marriage.					
	II.REPRODUCTIVE TRACT INFECTION					
6.	It is necessary to seek treatment for sexually transmitted disease in its early stage.					
7	It is not necessary to wash genital area before and after intercourse.					
8.	The women can use same napkin or pad for 24 hours during her menstrual period.					
9.	The women should wear clean inner clothes which are washed and dried in sun light.					

10	AIDS can spread only through sexual contact.					
	III.LIFE THREATENING CANCERS OF WOMEN					
11	Monthly self breast examination is necessary for the women.					
12	It is necessary for the women to consult the gynecologist after 40 years to improve the reproductive health.					
13	Chronic exposure of genital tract infection won't cause cervical cancer.					
14.	Nulliparous woman have more risk of developing breast cancer.					
15	Vaccines can help to prevent the development of cervical cancer.					

Key:**SA - Strongly agree****A - Agree****UC - Uncertain****DA - Disagree****SDA - Strongly disagree**

DEMOGRAPHIC DATA COLLECTION TOOL FOR COMMUNITY CHANGE AGENTS

1) Age of the women in years

- a) 18-25
- b) 26-35
- c) 36-45
- d) 46 and above

2) Educational status

- a) Primary
- b) Higher secondary
- c) Graduate
- d) Non literate
- e) Others

3) Occupation

- a) Skilled
- b) Semiskilled
- c) Unskilled
- d) House wife
- e) Professional

4) Monthly family income in Rs.

- a) < 1500
- b) 1501-3000
- c) 3001-5000
- d) > 5000

5) Religion

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

6) Type of the family

- a) Nuclear family
- b) Joint family
- c) Extended family
- d) Others

7) Sources of reproductive health information

- a) Mother and Siblings
- b) Relatives
- c) Health personnel
- d) Mass media (TV, Radio, News paper).

8) Member of voluntary group

- a) Self help group
- b) Mahila mandal
- c) Others
- d) Nil significance

9) Have you attended any health camp

- a) yes
- b) No

If yes specify

10) Have you attended any health programmes

a) Yes

b) No

If yes specify

II.FAMILY HISTORY

11) Family history of reproductive tract infection or sexually transmitted infection

a) Yes

b) No

If yes means specify

a) Mother

b) Siblings

c) Father

12) Family history of cervical cancer

a) Yes

b) No

If yes means specify

a) Mother

b) Siblings

13) Family history of breast cancer

a) Yes

b) No

If yes means specify

a) Mother

b) Siblings

III. OBSTETRIC AND GYNECOLOGICAL HISTORY

14) Marital status

- a) Married
- b) Unmarried
- c) Widow
- d) Separated

15) Age at menarche

- a) Below 13 years
- b) 13-15 years
- c) Above 15 years

16) Menstrual history

- a) Regular
- b) Irregular
- c) Treatment taken to menstrual problem

17) Age at marriage

- a) Below 18 years
- b) 18-21 years
- c) Above 21 years

18) Years of married life

- a) 1 year
- b) 2 years
- c) 2-5 years
- d) Above 5 years

19) Do you have children?

- a) Yes

b) No

If yes means specify

a) 1

b) 2

c) More than 2

20) Mode of delivery

a) Normal vaginal delivery

b) Caesarean section

21) Place of delivery

a) Institutional delivery

b) Hospital delivery

22) Previous Abortion or stillbirth

a) Yes

b) No

If yes means specify

a) 1

b) 2

c) More than 2

23) Previous exposure to reproductive tract infection or gynaecological problem

a) Yes

b) No

If yes means specify the problem

Time and duration of the problem

CONTACT NUMBER:

ADDRESS:

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¾Éç çÀ÷ ¾, Åø §°, ÃçòÒì, ÕÅç

1. !Àñ½çý ÁÂÐ (ÁÕ¼í, Ççø)

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- ¬) 26-35
- þ) 36-45
- ®) 46 ÁüÚõ «¾üì §Áø

2. ÀÊòÒò¾ì¾ç

- «) ¬ÃòÀì, øÅç
- ¬) §Áøçç"Ä
- þ) Àð¾òÀÊòÒ
- ®) ÀÊì, í¾Å÷
- ¬) ÁüÈ"Á

3. !¾íÆçø ¾ì¾ç

- «) «ÖÄÄ, À½ç
- ¬) ÍÂ !¾íÆçø
- þ) !¾íÆçø °íÄì, øÅç
- ®) þøÄò¾Ä°ç
- ¬) !¾íÆçø °í÷ó¾, øÅç

4. ÌõÀ Áí¾ ÁÕÁíÉõ

- «) <1500
- ¬) 1500-3000
- þ) 3001-5000
- ®) >5000

5. Á¾õ

- «) þóÐ
- ¬) ,çÈçò¾Å÷

ρ) ÓŠĂĒõ

Ⓜ) ÁüĒ"Ă

6. ĪĩõÀõ

«) ¼ÉçĭĪĩõÀõ

→) ÜðĭĭĪĩõÀõ

ρ) ĂçĂçĂĭÉ ĪĩõÀõ

7. ρÉðĭĂŌĭ, ĭĂõ ĩĒçð¼ ĩ°ð¼ç, ũ §°, Ăçð¼ Ăç¼õ

«) ¼ĭõ ÁüÜõ °§, ĭ¼Ăç, Çç¼ĂçŌóð

→) ĩĒĂçÉ÷, Çç¼ĂçŌóð

ρ) ÁŌððĂõ ÁüÜõ ÁŌððĂõ °ĭ÷¼Ă÷, ũ äĂõ

Ⓜ) ĩ¼ĭ"Ăĭ, ĭð°ç, ĂĭĭÉĭĂç ÁüÜõ ĩ°ð¼çð¼ĭü

8. ¼ĭĭ, ũ ±ó¼ «"ĂðĂçø ¼ĭýÉĭ÷Ăðĭ¼ĭĭĭ ĩ" ŰóĂçÉ÷

«) ĭĂ" ¼Ăçĭø

→) Ă, çĂĭĂó¼ø

ρ) ÁüĒ"Ă

Ⓜ) ±ð×Ăçø"Ă

ĪĩõÀõ ÀüĒçĂ ĂçÉĭ, ũ

9. ĪĩõÀ ĩ" ŰóĂçÉ÷, Ççø ĂĭŌĭ, ĭĂð ρÉðĭĂŌĭ, ðĂĭ"¼ ĩ¼ĭüŰ («) ĂĭĂçĂø §ĭĭõ ĩ" ũÇ¼ĭ?

«) ĩõ

→) ρø"Ă

ĩõ ±Ēçø ĩĒçðĂç¼×õ

«) ¼ĭõ

→) ĩ" ¼ý ĂçĒó¼ °§, ĭ¼Ăç

ρ ¼ó"¼

10. ĪĩõÀ ĩ" ŰóĂçÉ÷, Ççø ĂĭŌĭ, ĭĂð, Ōð"ĂĂĭõ ÒüŰ §ĭĭõ ĩ" ũÇ¼ĭ?

«) ĩõ

→) ρø"Ă

ĩõ ±Ēçø ĩĒçðĂç¼×õ

«) ¼jö

→) ¼ý ÀçÈó¼ °§,¼¼Ãç

b) ¼ó¼

11. ÌïðÀ - ÚóÀçÉ÷, Ççø Á, Õi, j, ÅÐ Á, ÷À, ÒüÚ §ç, jö - ùÇ¼j?

«) -ð

→) þø"Ä

-ð ±Éçø ìÈçðÀç¼xð

«) ¼jö

→) ¼ý ÀçÈó¼ °§,¼¼Ãç

Á, ó§ÀÚ ÁüÚó !Àñ, Ççý §ç, jö, ù

12. ¼çÕÁ½ÁjÉÁÃj

«) ¼çÕÁ½ÁjÉÁ÷

→) ¼çÕÁ½ÁüÈÁ÷

b) Áç¼"Ä

Ⓜ) ½Ä"ÄðÀçÃçó¼Ä÷

13. âðÀ"¼Õð §Ä, ð ÁÄÐ

«) 13ÄÄ¼çüì, £ú

→) 13-15 ÄÄÐ

b) 15 ÄÄÐì §Áø

14. Á, ¼¼Áç¼jö

«) ´Øí, jÉÐ

→) ´Øí, üÈÐ

b) Á, ¼¼Áç¼jö ÀçÃí°ç"É, Ùì °ç, çí"° ±íð¼Ä÷

15. ¼çÕÁ½ð¼çý §Ä, ð ÁÄÐ

«) 18ÄÄ¼çüì, £ú

→) 18-21 ÄÄÐ

b) 21 ÄÄÐì §Áø

16. $\frac{3}{4}\phi\tilde{O}\tilde{A}\frac{1}{2}\tilde{A}_i, \phi \pm \delta\frac{3}{4}\tilde{E} \tilde{A}\tilde{O}\frac{1}{4}\tilde{i}, \hat{u} \neg, \phi\tilde{E}\tilde{D}$

«) $\tilde{O} \tilde{A}\tilde{O}\frac{1}{4}\tilde{o}$

¬) $2 \tilde{A}\tilde{O}\frac{1}{4}\tilde{i}, \hat{u}$

þ) $2-5 \tilde{A}\tilde{O}\frac{1}{4}\tilde{i}, \hat{u}$

Ⓣ) $5 \tilde{A}\tilde{O}\frac{1}{4}\tilde{i}, \hat{u}$ ì §Áø

17. \neg, \hat{i}, \hat{u} ì ìÆó³ $\frac{3}{4}, \hat{u} \neg \hat{u}\zeta\tilde{E}\tilde{A}_i?$

«) $\neg\tilde{o}$

¬) þø³Ä

$\neg\tilde{o} \pm \tilde{E}\phi\phi \text{ ì } \tilde{E}\phi\delta\tilde{A}\phi\hat{i},$

«) 1

¬) 2

þ) $2 \text{ ì } \tilde{A}\tilde{E}\delta\frac{3}{4}, \hat{u}$ ì §Áø

18. $\pm \hat{u}\tilde{A}_i \hat{U} \tilde{A}\phi\tilde{A}^o\tilde{A}\tilde{o} \zeta \frac{1}{4}\delta\frac{3}{4}\tilde{D}?$

«) $\hat{i}, \delta\tilde{A}\phi\tilde{A}^o\tilde{A}\tilde{o}$

¬) $^o\phi\tilde{S}^o\tilde{A}\phi\hat{A}_y$

19. $\tilde{A}\phi\tilde{A}^o\tilde{A}\tilde{o} \zeta \frac{1}{4}\delta\frac{3}{4} \text{ þ}\frac{1}{4}\tilde{o}$

«) $\tilde{A}\tilde{O}\delta\tilde{D}\tilde{A}\tilde{A}^3\tilde{E}$

¬) Ä£Í

20. $\text{þ}\frac{3}{4}\hat{u}$ ì ÓýÖ, $\tilde{O}\hat{i}^o\phi\frac{3}{4}\times$ («) ìÆó³ $\frac{3}{4}$ þÈó§ $\frac{3}{4}$ ÀçÈóðÛç $\frac{3}{4}_i?$

«) $\neg\tilde{o}$

¬) þø³Ä

$\neg\tilde{o} \pm \tilde{E}\phi\phi \text{ ì } \tilde{E}\phi\delta\tilde{A}\phi\hat{i},$

«) 1

¬) 2

þ) $2 \text{ ì } \tilde{A}\tilde{E}\delta\frac{3}{4}, \hat{u}$ ì §Áø

21. $\text{þ}\frac{3}{4}\hat{u}$ ì Óý þÈó:ÄÖì, ò:¼ \hat{i} üÜ «ðÄð Ä \hat{i} ÄçÄø ì¼ \hat{i} üÜ §ç \hat{i} öì ñç \hat{i} , çÄçÖì, çÈ£÷, ç \hat{i} ?

«) $\neg\tilde{o}$

¬) þø³Ä

~õ ±Éçø §çj"À ÀüÈç ÌÈçôÀç¼xõ

±ô§ÀjÐ ²üÀð¼Ð ±ò¼"É ÁÕ¼í,û þÕð¼Ð ?

ÀçÃçx-~: þÉð:ÀÕì, çÃõ ÀüÈçÀ §ç÷Ó, ÁçÉjð¼jû

1. þÉð:ÀÕì, Àj"¼ ¼¼jüÜ

1) þÉð:ÀÕì, Àj"¼ ¼¼jüÜ ±ýÀÐ

«) ÀçÈðÕóÀçø ²üÀíð ¼¼jüÜ

~) °çÚç£÷ Àj"¼Àçø ²üÀíð ¼¼jüÜ

þ) ÀçÈðÕóðò ÁÆçÁçý, £§Æ - ùç ¼"º, Ççø ²üÀíð ¼¼jüÜ

®) - ½xðÀj"¼Àçø ²üÀíð ¼¼jüÜ

2) ,Õð"À ÁüÓð ,Õð"À ÌÆjð ~,çÃÁüÈçø ²üÀíð ¼¼jüÜ

,£ú,ñ¼ÁjÜ

«ÈçÃðÀj,çÈÐ.

«) ÁÃçüÜ - "È «Æü°ç

~) ç£÷ ,ðí¼ø ,jÃ½Áj, ÁÃçÚ ÁÉj,çð§Àj¼ø

þ) «ñ¼ð"ÁÀçø ç£÷j,ðÈ- ÕÁj¼ø

®) «ÉÁÃçüÈçø - ùç - ù - ÓðÒ,Ççø ²üÀíð «Æü°ç

3) ÁÇÃççõ ÌÃñ,û ÁüÓð þçð ÁÃÐ ÌÃñ,Ùì þÉð:ÀÕì, Àj"¼ ¼¼jüÜ ²üÀ¼ Óì,çÃ ,jÃ½õ

«) «Íð¼Íð¼ ÌÆó"¼ ÀçÈðÒ

~) ÀjÐ,jðÀjÉ - ¼ÖÈx

þ) Áj¼Áç¼jð ,jÀð¼çø Íð¼õ Í,j¼jÃÁçýÈç þÕð¼ø

®) - ½x ÁüÓð ç£÷ «ÕðÐÁ¼jð

4) þÉð:ÀÕì, Àj"¼ ¼¼jüÈçý Óì,çÃ «ÈçÌÈç

«) Ájó¼ç

~) ÀçÈðÕóÀçø Òñ ÁüÓð «¼ç, 'Øì

þ) ÁÃçüÜð§Àjì

®) ÁÆì,ð¼çü ÌÁjÉjÉ ¼çÍ ÁÇ÷í°ç

5) ÀjÃçÃø §çjð ±ýÀÐ

«) Í, j ¼ i Ã Ä ü È À Æ ï, Å Æ ï, í, Ç ø É ð ² ü À ï ð

þ É ð ï À Õ ï, ð À ï ³ ¼ i ü Ú

→) À ø È ð Ò Ú ð À ø ² ü À ï ð, j Æ ð ³ ¼ ø É ð ² ü À ï ð þ É ð ï À Õ ï, ð

À ï ³ ¼ i ü Ú

þ) i ¼ i ü Ú ˆ ù Ç ¿ À Õ ¼ ý À ð, j ð Ä ü ˆ ¼ Ö È ×

í, j ù Ä ³ ¼ i ø ² ü À ï ð þ É ð ï À Õ ï, ð À ï ³ ¼ i ü Ú

®) À ø È ð ³ ¼ ð Ó ³ ¼ ø þ Õ ï ð þ É ð ï À Õ ï, ð À ï ³ ¼

6) , £ ú ï, ñ ¼ Ä ü È ø ø ± ð À ï Ä ø Ä ø § ¿ j ö « ø Ä

«) ! Ä ð ³ ¼ § ¿ j ö (!, j § É Ä ø Ä j)

→) , ø Ä ó ³ ¼ ø (° ø À ø Ä ø Š)

þ) ± Ö ö Ò Á ü Ú ö ã ð í « Æ ü ° ø

®) Ä ø ö § Ä ï, ø Ä ï Ù § Ä ï Á ï ! Ä § É Ä ø Ä ö

7) ± í f Ä ø ˆ ñ í Ä ø Ä ø ² ü À ï ð ð ö § ¿ j ö

«) ± ö ð Š

→) , ø Ä ó ³ ¼ ø (° ø À ø Ä ø Š)

þ) §, ñ, ø Ä ï ö í

®) Ä ø ö § Ä ï, ø Ä ï Ù § Ä ï Á ï ! Ä § É Ä ø Ä ö

8) ± ö ð Š Á ü Ú ö À ï Ä ø Ä ø i ¼ i ü Ú § ¿ j ö ± ó ³ ¼ Ä Ä ³ ¼ ø É ˆ Ä ! Ä ð Ä ï, Ä ï ³ ¼ ø ï, ø È ð

«) 15 Ä Ä ³ ¼ ø ù ì , £ ú

→) 16 -45

þ) 46-60

®) 60 Ä Ä ³ ¼ ø ù ì § Ä ø

9) ± ö ð Š § ¿ j Ä ø ý Ó ï, ø Ä « È ø ì È ø

«) ³ ¼ ˆ Ä Ä ø Á ü Ú ö Á ï ó ³ ¼ ø

→) ± ˆ ¼ í ˆ È ³ ¼ ø Á ü Ú ö § ¿ j ö ± ³ ¼ ø ð ö ï ò ï ³ ¼ ø ì ˆ È ×

þ) « È Ä Ä ø ü È ø ø Ä Ä ø

®) ÁÄ°çì,ø

10) À;Ð, ðÀ;É À;ÄçÄø ÀÆì, ÁÆì, í, ù ±ÉðÀÌ"Á

«) -Ì"È - ÀŞÁì, çð¾ø ÁüÚð 'ÖÁÛì 'Öð¾ç ±É Á;ú¾ø

-) ÄŞÄÖ¼ý - ¼ÖÈ× !, ìÛ¾ø

þ), Öð"ÁÄçø !À;Öð¾ðÀÌð, Öð¾"¼ °ì¾Éí, ù - ÀŞÁì, çð¾ø

®) Áçð¾ç"É «Æçì, ÁðÄ ŞÁ¾çÄø !À;Ö"Ç - ÀŞÁì, çð¾ø

2. !Àñ, Ûì ²üÀÌð «À;Á, ÄÁ;É ÒüÚ Ş;ì, ù

11) !Àñ, "Ç À;¾çì, ìÛÈÁ Óì, çÄ ÒüÚ Ş;ì, ò

«) , Öð"Á Á;ö ÒüÚ Ş;ì, ö

-) þ"Äð"Á ÒüÚ Ş;ì, ö

þ) ±ÖðÒ ÒüÚ Ş;ì, ö

®) ÁÄð"Á ÒüÚ Ş;ì, ö

12) , Öð"Á Á;ö ÒüÚ Ş;ì, ö ²üÀ¼ Óì, çÄ , Ì½ç

«) !Æó"¾ !ÀüÛì !, ìÛç; "Á

-) «¾ç, ±ñ½çì", ÁçÄ;É !Æó"¾ ÄçÈðÒ

þ) ÄÄÖ¼ý - ¼ÖÈ× !, ìÛÁÐ

®) - Á÷Á;É °ã, !À;Öç;¾;Ä çç"Ä

13) Á;÷À, ÒüÚ Ş;ì, ö ±ó¾ ÁÄ¾çÉÄç"¼ŞÄ «¾ç, Áì, , Ì½ðÀÌ, çÈÐ

«) 20 ÁÄÐì !, £ú

-) 20-30 ÁÄ¾çüì

þ) 30-40 ÁÄ¾çüì

®) 40 ÁÄ¾çüì ŞÁø

14) Á;÷À, ÒüÚ Ş;ì, ö ²üÀ¼ Óì, çÄ , Ì½ç

«) 25 ÁÄÐì !, £ú - ùçÁ÷, Ûì

-) !ÌðÀ !;ÄðÄÄçÄð (¾ì, °Ş, Ì¾Äç («) !çÖì, çÄ - ÈÄçÉöì !;÷À, ÒüÚ Ş;ì, ö)

p) ¼üÜ

®) 12 Å¼çššâÀ¼, 30 Å¼üì šÁø Óø ÌÆó¼

ÀøÈø¼ø

15) ÀøÀøÉ šžjø, û Óøøç, çî°Àççì, ô¼;Àøð¼;ø ÀçýÀÕø ÒüÜšžjø ²üÀîð
Åjøðø, û «¼ç, õ

«) , ÆøÀ Åjø ÒüÜ šžjø

→) ÅçüÜðøüÜ šžjø

p) Å;À, ôøüÜ šžjø

®) ±øøøüÜ šžjø

16) Å;À, ÒüÜ šž;Àçý Óì, çÅ «ÈøÈø

«) ÓÀì, øÀççøøøø¼çÅø, øç¼ø, Å;À, ð¼çý çøÈø Å;Ü¼ø,

ÓÀì, øø - üšžì, ççøøø¼ø ÅüÜø Å;À, «ÇÀøø Å;üÈø

→) Å;À, õ ÍŒì, çøšÅ;¼ø

p) øø Å;À, í, Üø «ÇÀøø ÌÀçç¼ì¼ø

®) Å;À, ð¼çø «Àçøø, ±ççîø ÅüÜø «Óìø šÀ;ð Åçç

17) Åjø Åççšø¼É ±ó¼ šž;ÀççÉì, ñ¼ÈçÅ - ¼ç, çÈø

«) Å;À, ÒüÜ šžjø

→) ™Àçççø ÒüÜ šžjø

p) ±øøø ÒüÜ šžjø

®) , ÕøÀ Åjø ÒüÜ šžjø

18) ÍÅ Å;À, Àççšø¼É"Å ÌøöÅ šÅñÈÅ, ;Ä p¼;Àçç

«) ¼çÉø ´Œ Ó"È

→) Å;¼ø ´Œ Ó"È

p) ÅŒ¼ø ´Œ Ó"È

®) 6 Å;¼ì, Üì ´Œ Ó"È

19) $\hat{A}_i \div \hat{A}, \hat{O} \hat{u} \hat{U} \hat{S} \hat{z}_i \hat{A} \hat{c} \hat{E} \hat{i}, \hat{n} \frac{1}{4} \hat{E} \hat{c} \hat{A} \hat{=} \frac{3}{4} \hat{x} \hat{o} \hat{A} \hat{c}, \hat{i}^{\circ} \hat{c} \hat{E} \hat{o} \frac{3}{4} \hat{A} \hat{A} \hat{c} \hat{S} \hat{o}_i \frac{3}{4} \hat{E}$

«) $\hat{I} \hat{A} \hat{A}_i \div \hat{A}, \hat{A} \hat{A} \hat{c} \hat{S} \hat{o}_i \frac{3}{4} \hat{E}$

→) $\hat{A} \hat{O} \hat{o} \hat{D} \hat{A} \hat{A} \hat{E} \hat{A} \hat{c} \hat{o} \hat{i}^{\circ} \hat{o} \hat{A} \hat{o} \hat{A} \hat{i} \hat{o} \hat{A}_i \div \hat{A}, \hat{A} \hat{A} \hat{c} \hat{S} \hat{o}_i \frac{3}{4} \hat{E}$

b) $\hat{A}_i \hat{o} \hat{S} \hat{A}_i, \hat{c} \hat{A}_i \hat{A} \hat{c}$

®) $^{\circ} \hat{c} \hat{U} \hat{z} \hat{E} \div \hat{A} \hat{A} \hat{c} \hat{S} \hat{o}_i \frac{3}{4} \hat{E}$

20) $\hat{z} \hat{u} \hat{i}, \hat{j} \hat{i} \hat{o} \hat{A} \hat{E} \hat{i}, \hat{A} \hat{E} \hat{i}, \hat{i}, \hat{c} \hat{c} \hat{o} \hat{\pm} \hat{D} \hat{A}_i \div \hat{A}, \hat{O} \hat{u} \hat{U} \hat{S} \hat{z}_i \hat{A} \hat{c} \hat{E} \hat{o} \frac{3}{4} \hat{i},$

$\hat{=} \frac{3}{4} \hat{A}_i \hat{D}$

«) $\hat{O} \hat{i}, \hat{j} \hat{E} \hat{A}_i \frac{3}{4} \hat{o} \hat{O} \hat{O} \hat{E} \hat{I} \hat{A} \hat{A}_i \div \hat{A}, \hat{A} \hat{A} \hat{c} \hat{S} \hat{o}_i \frac{3}{4} \hat{E} \hat{i}^{\circ} \hat{o} \hat{A} \hat{D}$

→) $^{\circ} \hat{A} \hat{c} \hat{A}_i \hat{E} \hat{\pm} \frac{1}{4} \hat{A} \hat{A} \hat{A}_i \hat{A} \hat{A} \hat{c} \hat{o} \frac{3}{4} \hat{o}$

b) « $\frac{3}{4} \hat{c}, \frac{3}{4} \hat{i} \hat{A} \hat{A} \hat{=} \frac{1}{2} \hat{x}, \hat{C} \hat{A} \hat{u} \hat{U} \hat{o} \hat{i}, \hat{j} \hat{o} \hat{o} \hat{i} \hat{E} \hat{A}_i \hat{E} \hat{=} \frac{1}{2} \hat{x}$

$\hat{=} \hat{o} \hat{i}, \hat{j} \hat{u} \hat{U} \frac{3}{4} \hat{o}$

®) $\hat{i} \hat{E} \hat{A}_i \hat{E} \hat{=} \frac{1}{4} \hat{o} \hat{=} \hat{A} \hat{E} \hat{o} \hat{O}$

ÀçÃçx-p : pÉô!ÀÕi, çÄò¼ç"Éô ÀüÈçÂ «ÀçôÃjÂ ÀÊÂõ

<p>ÀÃç"º ±ñ</p>	<p>Àjì,çÂí,ù</p>	<p>ÁÉôá-ÁÁj, ºõÁ¾¼çì,ç\$Éý</p>	<p>ºõÁ¾¼çì,ç\$Éý</p>	<p>!¾¼ÃçÂÁçø"Ä</p>	<p>ÁÚì,ç\$Éý</p>	<p>ÁÉôá-ÁÁj, ÁÚì,ç\$Éý.</p>
<p>1.</p> <p>2.</p> <p>3</p> <p>4.</p> <p>5.</p> <p>6.</p> <p>7.</p>	<p>1. !ÀjÐÄjÉ \$,ùÄç,ù ºçÚ ÁÁ¾¼ç\$Ä\$Ä¾¼çÕÁ½õ ÒÃçÁÐ !Àñ,ù pÉô!ÀÕi, çÄ"É Àj¾¼çì,çÈÐ. !Àñ,ççý pÉô!ÀÕi, çÄ"É 2. \$ÁõÀ!òÐÄ¾¼çø - ½Áçüì ±ó¾¼ç¾¼çÁjÉ Óì,çÂÁíõ pø"Ä pÉô!ÀÕi,õ !Èçò¾¼ç,øÁç !Àñ,ùì «Áºçõõ. !Àñ,ççý pÉô!ÀÕi, çÄ"É \$ÁõÀ!òÐÄ¾¼çø, ½ÁÕìì ±ó¾¼ç¾¼çÁjÉ Óì,çÂÁíõ pø"Ä !Àñ,ù¾¼çÕÁ½õð¾¼çüìòÀçÈì¾¼ç,ù pÉô!ÀÕi, çÄ"É !ÈçòÐ «ì,È ±!òÐì !,jñ¾¼ç\$Ä \$ÄjÐÁjÉÐ. 2. ÀjÄçÂø \$çjï,ù ÀjÄçÂø \$çjïì «¾¼çý -ÃõÄ,ð¾¼ç¾¼ç\$Ä\$Äºç,ç"º «Ççì,õ À¾¼ç \$Äñ!õ. -¾¼çÕÈxìì ÓýÕõ ÀçýÕõ ÀçÈõÒÚõ"Ä !ò¾¼ç !ºõÄ \$ÄñÈõ «ÁºçÂõ pø"Ä. Áj¾¼çÁç¾¼çjï,çÄò¾¼çý \$ÄjÐ ' \$Ä Ð¾¼ç («) çjõ,ç"É 24 Á¾¼ç \$çÄò¾¼çüìò</p>					

	<p>ÀÁÿÀÏò¼Äjõ. çÿì «Ä°ç ÌÂÂçÄçø - Ä÷ò¼çÂ àÂ ùÇj¼, ÇŞÂ ÌÂñ, ù «½çÂ ŞÂñÏõ.</p>					
8.	<p>ÀjÐ, jôÄüÈ - ¼ÖÈÄçý ãÄõ ÁðÏŞÁ ±öðŞ ÀÃ×õ.</p>					
9	<p>3.ÌÂñ, Çò Àj¼çìõ «ÀjÂ, ÃÁjÉ ÒüÚ Şziö, ù</p>					
10	<p>Áj¼j¼j¼õ ¼ÄÈj¼Äø ÍÂ Áj÷Â, ÄÃçŞj¼É ÌöÐ Ì, jùÇ ŞÂñÏõ.</p>					
11	<p>40 ÁÂÐì ÑÁø ÌÂñ, ù ¼j, ù þÉð:ÀÏj, çÄ"É ŞÁöÁÏò¼ ÌÂñ, ù çÄ ÁÏðÐÄ"Ä «Ï, ç, Äó¼j ŞÄj°çì, ŞÂñÏõ. çËñ¼, jÄ ÀçÈðÒÚðÒò Àj¼ Ì¼jüÚ , Õð"À Ájö ÒüÚ Şzi"Ä ²üÄÏðÐÄÐ þø"Ä.</p>					
12	<p>ÌÆó"¼ ÌÄÈ¼ ÌÂñ, ùì Áj÷Â, ÒüÚ Şziö ÁÏõ ÁjöðÒ «¼ç, õ. , Õð"À Ájö ÒüÚ Şzi"Äò ¼Ïj, ¼ÏðÒ ÁÏóÐ, ù - ¼×, çýÈÈ.</p>					
13						
14						
15						

APPENDIX – I
CODING FOR DEMOGRAPHIC VARIABLES

Demographic variables	Code No
I) Age of the mother in years	
a) 15-25	1
b) 26-35	2
c) 36-45	3
d) 46 and above	4
2) Educational status	
a) Primary	1
b) High school	2
c) Higher secondary	3
d) Graduate	4
e) Non literate	5
f) Others	6
3) Occupation	
a) Skilled	1
b) Semiskilled	2
c) Unskilled	3
d) House wife	5
e) Professional	6

4) Monthly family income in Rs.

- | | |
|--------------|---|
| a) < 1500 | 1 |
| b) 1501-3000 | 2 |
| c) 3001-5000 | 3 |
| d) > 5000 | 4 |

5) Religion

- | | |
|--------------|---|
| a) Hindu | 1 |
| b) Christian | 2 |
| c) Muslim | 3 |
| d) Others | 4 |

6) Type of the family

- | | |
|--------------------|---|
| a) Nuclear family | 1 |
| b) Joint family | 2 |
| c) Extended family | 3 |
| d) Others | 4 |

7) Sources of reproductive health information

- | | |
|--|---|
| a) Mother and Siblings. | 1 |
| b) Relatives. | 2 |
| c) Health personnel. | 3 |
| d) Mass media (TV, Radio, News paper). | 4 |

8) Member of voluntary group

- | | |
|---------------------|---|
| a) Self help group | 1 |
| b) Mahila mandal | 2 |
| c) Others | 3 |
| d) Nil significance | 4 |

II.FAMILY HISTORY

9) Family history of reproductive tract infection or sexually transmitted infection

- a) Yes 1
- b) No 2

If yes, specify

- a) Mother 1
- b) Siblings 2
- c) Father 3

10) Family history of cervical cancer

- a) Yes 1
- b) No 2

If yes, specify

- a) Mother 1
- b) Siblings 2

11) Family history of breast cancer

- a) Yes 1
- b) No 2

If yes, specify

- a) Mother 1
- b) Siblings 2
- c)Father 3

III. OBSTETRIC AND GYNECOLOGICAL HISTORY

12) Marital status

a) Married	1
b) Unmarried	2
c) Widow	3
d) Separated	4
13) Age at menarche	
a) Below 13 years	1
b) 13-15 years	2
c) Above 15 years	3
14) Menstrual history	
a) Regular	1
b) Irregular	2
c) Treatment taken to menstrual problem	3
16) Age at marriage	
a) Below 18 years	1
b) 18-21 years	2
c) Above 21 years	3
17) Years of married life	
a) 1 year	1
b) 2 years	2
c) 2-5 years	3
d) Above 5 years	4
18) Do you have children?	
a) Yes	1
b) No	2
If yes, specify	

a) 1	1
b) 2	2
c) More than 2	3
19) Mode of delivery	
a) Normal vaginal delivery	1
b) Caesarean section	2
c) Both	3
20) Place of delivery	
a) Institutional delivery	1
b) Hospital delivery	2
c) Both	3
21) Previous Abortion or stillbirth	
a) Yes	1
b) No	2
If yes, specify	
a) 1	1
b) 2	2
c) More than 2	3
22) Previous exposure to reproductive tract infection or gynaecological problem	
a) Yes	1
b) No	2
If yes, specify the problem	
Time and chronicity of the problem	

SCORING KEY

SECTION B:

Section B consisted of interview schedule to assess the knowledge of women on reproductive health which comprised of 20 questions in two components (reproductive tract infection and life threatening cancers among women) were formulated.

All of the 20 questions were objective and closed ended items. Scoring for correct answer was “1” mark and for wrong answer “0” marks was given.

Maximum score -20 marks.

Minimum score - 0.

The scoring for the level of knowledge was distributed as follows:

SCORE	LEVEL OF KNOWLEDGE
<50%	Inadequate knowledge.
50–75%	Moderate adequate knowledge
>75%	Adequate knowledge.

SECTION – C

A modified 5 point Likert scale consisting 15 statements were used to assess the attitude of women regarding reproductive health. Out of 15 statements, 8 were positively worded statements and 7 statements were negatively worded statements.

Each statement had 5 responses to select.

S.No	Statements	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1	POSITIVE STATEMENT	5	4	3	2	1
2	NEGATIVE STATEMENT	1	2	3	4	5

Maximum score – 75.

The scoring for the level of attitude was distributed as follows:

SCORE	LEVEL OF ATTITUDE
<50%	Unfavourable attitude.
50–75%	Moderately favourable attitude.
>75%	Favourable attitude.

APPENDIX – J

BLUE PRINT

S.No.	Content	Item	Total items	Percentage
1	Demographic variables	21	21	
2	Knowledge			
	a) Reproductive tract infection	10	35 (20+15)	28.58%
	b) Life threatening cancers of women	10		28.58%
3	Attitude			
	a) General aspects	5		14.28%
	b) Reproductive tract infections	5		14.28%
	c) Life threatening cancers of women	5		14.28%
	Total	35		100%

APPENDIX – K

INFORMATION, EDUCATION, COMMUNICATION

PACKAGE

- Education through Structured training module on reproductive health for community change agents

Communication women through

- Pamphlets (Reproductive tract infections, STIs, cervical cancer and breast cancer)
- Poster (reproductive tract infection) and
- Flashcards (Life threatening cancers of women).