

**KNOWLEDGE AND PRACTICE ON TOILET TRAINING
AMONG MOTHERS OF TODDLER IN SELECTED AREA AT
MANAMADURAI, SIVAGANGAI DISTRICT, TAMIL NADU**

BY

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

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ABSTRACT

STATEMENT OF THE PROBLEM

“A study to determine the knowledge and practice on toilet training among mothers of toddler in selected area at Manamadurai”. It was conducted in partial fulfillment of the requirement for the degree of Master of Science in Nursing at Matha College of Nursing, Manamadurai which is affiliated to the TamilNadu Dr M.G.R Medical University, Chennai during the year 2010.

THE OBJECTIVES OF THE STUDY

- To assess the level of knowledge on toilet training among mothers of toddler in selected area at Manamadurai.
- To assess the toilet training practice among mothers of toddler in selected area at Manamadurai.
- To relate the knowledge and practice of toilet training among mothers of toddler and its selected demographic variables.
- To associate the knowledge on toilet training among mothers of toddler and its selected demographic variables.
- To associate the practice on toilet training among mothers of toddler children and its selected demographic variables.

HYPOTHESES

1. There will be a significant relationship between knowledge and practice on toilet training among mothers of toddler in selected area at Manamadurai.
2. There will be a significant association between knowledge of mothers of toddler on toilet training and its selected demographic variables.
3. There will be a significant association between practice of mothers of toddler on toilet training and its selected demographic variables.

The research approach adopted for this study was descriptive approach and the design used in this study was a descriptive design. The tools used for this study was structured knowledge questionnaire and practice questionnaire. Manamadurai was selected for this study; convenient sampling method was used for samples selection. A sample size was 100 mothers of toddler were taken for the study according to the inclusion criteria.

THE MAJOR FINDINGS OF THE STUDY

- Most (36%) of the mothers were belong to the age group of 21-25 years
- Majority (52%) of the mothers were Hindus.
- Majority (59%) of the mothers had High School Education
- Most (59%) of the mothers had two children.
- Most (65%) of the mothers were from nuclear family.
- Majority (49%) of the child were second child.
- Most (39%) of the mothers were house wife.

- Most (61%) of the family income is below Rs.5000/- (Rupees Five Thousand) per month.
- Most (64%) of the mothers were got information on toilet training from Elders, Relatives of the family and Friends.
- The co-relation between knowledge and practice on toilet training was tested by Karl Pearson's "r". The outcome showed that there was a significant positive co-relation in knowledge and practice among mothers of toddler children.

Among the mothers of toddler, 19% of the mothers had inadequate knowledge, 59% of mothers had moderately adequate knowledge and only 19% of the mothers having adequate knowledge on toilet training.

Among the mothers of toddler, 32% of the mothers having good practice, 41% of mothers having average and 27% of the mothers having poor practice on toilet training

The computed 'r' value is +0.197. The positive correlation was found between knowledge and practice. Hence it was interpreted that mother who had adequate knowledge, followed good practices.

There is a significant association exist between the knowledge and the age of the mother, educational status, Birth order of children, occupation of mother, Type of family, family income, and source of information on toilet training.

There is a significant association between Practice and the age of the mother, Religion, Educational status, Number of children, Birth order, Occupation and source of information on toilet training among mothers of Preschool children.

RECOMMENDATIONS:

From the findings of the presents study it can be recommended as follows.

- A comparative study can be carried out to find out the knowledge and practice of mothers on toilet training in urban and rural areas.
- Study can be conducted for the fathers separately as they are also responsible for the childcare as per the present trend.
- A similar study can be conducted by using large samples to generalize the findings at national or state level.
- A study can be conducted among the same population after introducing a health education programme.

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CHAPTER – I

INTRODUCTION

“Children are a gift from the LORD; they are a reward from Him.”

Today’s society is complex and ever changing. Children are blooming buds. They are important asset of nation. As children grow, they must learn not only to care with current demands but also to prepare for the many unexpected events, they will face in their tomorrows changes brought by new techniques and technologies. Children are expected to grow and learn to their fullest potential. Parents serve as advocates for children in order to meet needs of all children for access to education and health care process.

All the stages in human life are exposed to challenges, difficulties and success as a gain. One such stage is the toddler period. It is the magical time of childhood. It is a different exciting and interesting period of life. Fundamental learning process develop in the child as the child begins to seek autonomy explores the world. It learns how things mostly begin to tolerate, express desires and develop relationships.

Toilet training, or potty training, is the process of training a young child to use the toilet for urination and defecation, though training may start with a smaller toilet bowl-shaped device (often known as a potty). In Western countries it is usually started and completed between the ages of 12 months and three years with boys typically being at the higher end of the age spectrum.

In some countries, childrearing is considered protective nurturing. Children are not rushed into new experiences like toilet training or being in school. In other countries, children are commonly treated in a harsh, strict manner, using shame or corporal punishment for discipline. In Central American nations, toilet training may begin as early as when the child can sit upright.

Most advise that toilet training is a mutual task, requiring cooperation, agreement and understanding between child and the caregiver, and the best potty training techniques emphasize consistency and positive reinforcement over punishment - making it fun for the child. There are articles suggesting that it is easier to toilet train a child when he/she is at least 18 months old, and for boys it is better to wait even longer since they usually lack the necessary language and fine motor skills. This time frame is much easier to use because of the child wanting to please his/her parents.

Toilet training is the process of teaching a young child to control the bowel and bladder and use the bathroom for elimination. A child is considered to be toilet trained when he or she initiates going to the bathroom and can adjust clothing necessary to urinate or have a bowel movement. Toilet training is sometimes called toilet learning or potty training. The average age at which children complete toilet training in the United States is approximately three years old. In some cases children learn bladder control first others learn bowel control before bladder control. Control is generally first achieved during the daytime, well before a child is able to stay dry at night. Some children achieve some control over bladder and/or bowel movements as early as nine months of age and are able to cooperate in controlling themselves to some degree by the age of 12 to 15 months.

Most experts agree, however, that toilet training should only be initiated when a child exhibits certain signs of readiness that usually appear between the ages of two and three years of age. Unlike infants, toddlers know when they are urinating or defecating and may assume certain postures or become quiet when they are about to move their bowels. They have also learned the vocabulary their family uses for elimination. Another sign is a sense of fastidiousness and desire for order that appears at this stage of development. Children are likely to ask parents to change their dirty diapers right away, and they show a general interest in orderliness that can be harnessed for purposes of toilet training. A child this age also has a pronounced desire to imitate the parent of the same sex, a trait that can be used to advantage in enticing her to use the toilet. Lastly, the child will begin to show signs of being able to delay urination or bowel movements such as waking from sleep still dry or refraining from urinating or defecating for longer periods of time while not wearing a diaper.

Toilet training can be considered a progressive process that consists of several stages for which the child must acquire both physical and cognitive self control. It includes discussing, undressing, going, wiping, dressing, flushing and hand washing. It is an individualized task for each child. It should begin and be completed according to the child's ability to accomplish it, not according to a set schedule.

One potential negative effect of resistance is that the child can hold back bowel movements, resulting in constipation. This in turn makes elimination uncomfortable and even painful, creating even greater reluctance and resistance on the part of the child. Severe cases of constipation can cause painful anal fissures, faecal soiling (encopresis), or rectal enlargement. Unusual delays in toilet training normal children or regressions to soiling generally indicate family stress and/or underlying emotional problems and may require counselling to be effectively resolved.

The correct knowledge and awareness among parents or caregivers is very essential to the success of the child. Sometimes they may have either inadequate or inappropriate knowledge regarding initiation readiness process and hazards of toilet training. It is essential to find a success in each child, it becomes essential for the parents to be aware of proper guidelines.

NEED FOR THE STUDY

A child's development encompasses many aspects including the physical, social, emotional and cognitive/mental. In order for children to develop in all aspects, they must be supported in all areas and the one person most often responsible for this encouragement is the mother. Mothers tend to be the primary caregiver in both traditional and single parent families and thus are with their children more than anyone else. Mothers, therefore, are in the unique position of influencing their children's growth in all areas of development, beginning with the bonding and attachments that they usually develop with their children.

When babies become toddlers they know that their mothers are the primary individuals to meet their needs and so the initial cycle of bonding has been completed. At this time, however, toddlers are beginning to realise that

they are their own individuals and now have the mobility to test the boundaries that their mothers have set for them.

Child care experts generally recommend a strategy that uses praise as a motivator, has little pressure from the parents, and is fun for the child. It has been found that when parents wait until their toddler has attained the greatest possible degree of readiness, the process is easier, faster, and accompanied by fewer lapses. The emphasis is on letting the child proceed at his own pace, motivated by the desire to be a "big boy" or "big girl" and imitate his parents. Measures that may cause pressure and anxiety need to be avoided.

Parents play a key role in toilet training. The ways in which the parents approach the process of toilet training are more important than the actual procedure itself. Their relaxed and positive attitudes and behaviours can influence the way children feel about themselves and others. The correct knowledge and awareness among parents or caregiver is very essential for the success of the child. Sometimes they may have either inadequate or inappropriate knowledge regarding initiation, readiness process and hazards of toilet training. For the total success in each child parents should be aware of proper guidelines. To avoid hazards, at primary level health professionals especially nurses can provide the perspectives needed to help children, parents and families, so as to build healthier life and personality.

Children learn to care for themselves initially by attempting to imitate the actions of their parents and siblings. Achieving control of the bodily functions of defecation and urination is one of the major tasks of the toddler period. The control of bladder and bowel functions involves a complex integration of neuromuscular pathways at the peripheral and central levels. The 50% of the girls and boys are toilet trained at 35 and 39 month respectively. Toilet training is often a dreaded and frustrating task for parents. The process can go more smoothly for parent and child if parents are educated on training techniques that emphasize waiting until a child shows signs of readiness before initiating training and taking a child-oriented approach.

Toilet training is affected by a child maturation level and intellectual capacity, cultural attitude and the psychological make up of each parent child level. Bowel and bladder control usually develops gradual and sub sequential. The normal sequence of attaining their milestones is (a) the development of

nocturnal faecal incontinence (b) the development of diurnal faecal incontinence (c) the development of diurnal bladder control and (d) the development of nocturnal bladder control.

Enuresis is manifested as the repetitive and inappropriate passage of urine. The voiding may be voluntary or involuntary. A minimum chronological age of 3 years and minimum mental age of 4 are regarded. There is sharply decreasing prevalence up to age 4 and gradually declines thereafter 82% of 2 years old, 49% of 3 years old, 20% of 4 years old, 7% of 5 years old, 3% of 10 years old and 11.2% of 19 years old are enumerated. Adult's prevalence is about 1% approximately. Most children are toilet trained by age of 30 months, although 2% to 10% of children are not toilet trained by age of 4 years. Problems of toilet training have become a common behavioural concern for parents of school going children.

The enuresis and encopresis in children from Kerala were noted among 18.6%. These episodes were associated with parent's education, lax attitude to toilet training and other symptoms in the child. Toilet training earlier is not recommended as it may lead to toilet training problems.

In developed countries, bowel control is estimated to be more than 95% of children by fourth birthday & 99% of children by fifth birthday frequently decrease to virtual absence by age sixteen. At age four the functional encopresis at all ages is 3-4 times as common in boys as in girls by age 7 to 8, frequency is 2.3% in boys and 7% in girls by age 10-12, once in a month soiling occurs in 1.3% of boys and in 0.3% in girls.

Lack of appropriate toilet training or inadequate training may delay the child's attainment of continence. There is also evidence that some encopresis. Children suffer from life long inefficient and ineffective gastrointestinal motility. Either of these factors alone but especially two in combination offers an opportunity for a power struggle between the child and the parent over issue of autonomy and control.

Potty training focuses, after called toilet errors, are common among toddlers and small children look at things from child's perspective. He is giving up the security of a diaper. He didn't have to control himself until an opportunity is available. He could go anytime and anywhere, knowing that

someone would always be there to change his diapers. Mothers should know that child's fear need is to be addressed as real and serious fear, your child knows that you understand and are being to help; he will feel more relaxed and comfortable while potty training. .

Parents want to toilet train their children as soon as possible, however do not start toilet training until both (parent and child) are ready usually; child is ready by the age of 18 to 24 months. We try to rush it, we will have more problems and toilet training will take a longer time. The variety of distinctive, cultural practices like tucking cloth or urgency to catch the urine and open field defecation lowers to the success in children. Thus it is important to assess the parent's knowledge about their child development and prime concerns in accomplishing their duties.

Above literature and discussion with the guide and self-experience of the child toilet training, the researcher felt the need to explore this area and thus it is necessary to assess the level of knowledge and practices of mothers regarding the bowel and bladder control. The investigator's aim is to improve the knowledge and practices of mothers so that successful mastery of the child over toilet training can be ensured.

STATEMENT OF THE PROBLEM

A study to determine the knowledge and practice on toilet training among mothers of toddler in selected area at Manamadurai.

OBJECTIVES OF THE STUDY

- To assess the level of knowledge on toilet training among mothers of toddler in selected area at Manamadurai.

- To assess the toilet training practice among mothers of toddler in selected area at Manamadurai.
- To relate the knowledge and practice of toilet training among mothers of toddler and its selected demographic variables.
- To associate the knowledge on toilet training among mothers of toddler and its selected demographic variables.
- To associate the practice on toilet training among mothers of toddler and its selected demographic variables.

HYPOTHESES

1. There will be a significant relationship between knowledge and practice on toilet training among mothers of toddler in selected area at Manamadurai.
2. There will be a significant association between knowledge of mothers of toddler on toilet training and its selected demographic variables.
3. There will be a significant association between practice of mothers of toddler on toilet training and its selected demographic variables.

OPERATIONAL DEFINITION

Knowledge

In this study, it refers to the verbal responses of mothers on toilet training as measured by the structured knowledge questionnaire.

Practice

In this study, it refers to the activities done by the mothers during toilet training, as measured by the structured practice questionnaire.

Toilet training

In this study, it is a process by which mother systematically helps for their children to promote physiological and psychological readiness over his or her bowel and bladder movement.

Mother

women those who are having toddler residing in selected area at Manamadurai.

Toddler

Children between the age group of 1-3 years.

ASSUMPTIONS

- Mothers of toddler will have some knowledge on toilet training.
- Mothers of toddler will have knowledge on toilet training but they may not practice properly.
- Demographic variables of mother may influence the knowledge and Practice on toilet training.

LIMITATIONS

- The study was limited to women those residing in selected area at manamadurai like railway colony, marakadai street and Vellanthoppu.

- The sample of the study is limited to 100
- Study limited to only 6 weeks

PROJECTED OUTCOMES

- The present study would help the nurses to understand the level of knowledge and practice on toilet training.
- The findings of the study will motivate nurses to do more research on similar types of studies in different areas.

CONCEPTUAL FRAME WORK

Conceptual framework for a particular study is the abstract and logical structure that enables the researcher to link finding to a body of knowledge in nursing. It is developed from the existing theory and helps in identifying and defining the concept of interests and proposing relationships among them. The model gives direction for planning research design, data collection and interpretation of findings. The present study is based on Rosenstock's (1974) and Becker's health belief model.

The first component in this model involves the individual perception. In this study the individual is the mother of toddler. The individual perceptions are influenced by the demographic variables such as age of the mother, religion, education, occupation, number of child, birth order of child, type of family, family income and source of information on toilet training.

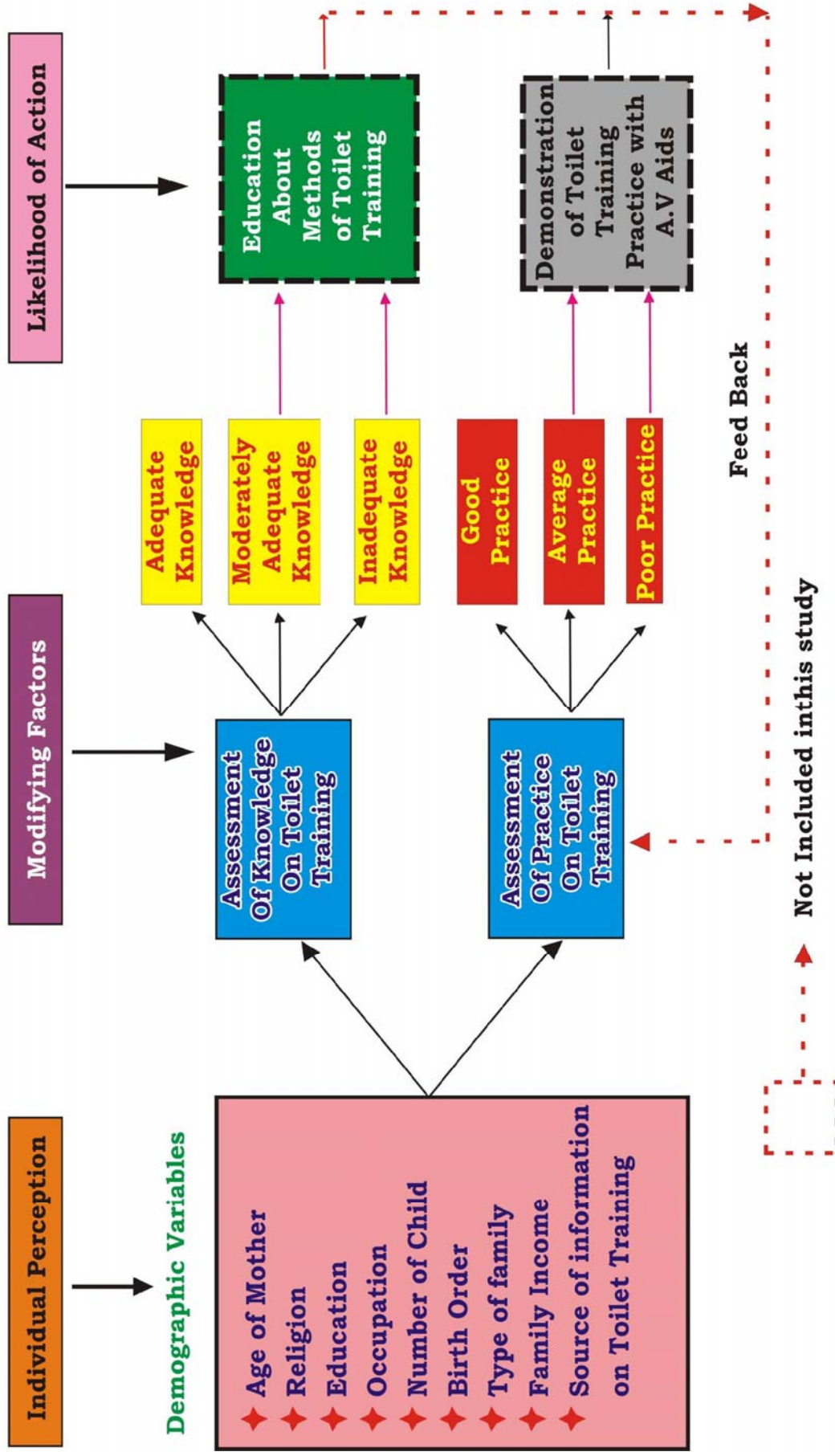
The second component of the model consists of modifying factors. It includes assessing the knowledge on toilet training among mothers with toddler and grading it as adequate, moderately adequate and inadequate. To identify the practice on toilet training it is classified as good, average, poor Practice level. The cues to action is to adopt by mothers to gain adequate knowledge and practice on toilet training.

According to the model the third factor is the likelihood of taking action which includes likelihood of taking recommended preventive health action.

In this study the likelihood of taking action includes education about toilet training methods and of demonstration of practice on toilet training with Audio visual aids helps the mother to improve their knowledge and practice on toilet training.

Seeking guidance and knowledge on time and by proper practicing of toilet training methods will help to achieve the ultimate goal, which in turns results in healthy nation.

Fig 1 : CONCEPTUAL FRAME WORK. HEALTH BELIEF MODEL (Rosenstock (1974) and Becker)



CHAPTER – II

REVIEW OF LITERATURE

Best (1982) describes a brief summary of previous research findings and writings of recognized experts provides evidence that the researcher is familiar with what is already known and with what is still unknown and interested.

The review of literature plays a key role in the research process. It refers to an extensive, exhaustive and systematic examination of publication relevant to the research projects.

In this study, the review of literature is presented under the following headings:

The literatures related to:

- Knowledge and practice guidance for parent on toilet training.
- Child's readiness for toilet training.
- Toilet training and associate variables.
- Untoward effects of toilet training.

LITERATURES RELATED TO KNOWLEDGE AND PRACTICE GUIDANCE FOR PARENT ON TOILET TRAINING, WHICH FORMS THE FOUNDATION AND IMPORTANT COMPONENT OF WELL CHILDCARE.

Paediatric Society (1990) presented a descriptive study to find out Toilet Training: Parent guidance with a child oriented approach. Contents of this study included timing, assessing a child's readiness for toilet training, child oriented toilet learning techniques and toileting refusal children with special needs. Parent's handouts were issued. Study concluded that the process of toilet training has changed significantly over the years and with the difference culture. A child-cantered approach where the timing and methodology of toilet learning is individualized as much as possible is recommended.

National Survey of Early Childhood Health (2000), describes the content of parent guidance on toilet training provided to parents of toddlers and preschool. Sample was parents of 2068 US children aged 4 to 35 months. Results shows that the parent reported discussion of these topics include reading (discussed for 61% of children 19-35 months) and child care (discussed for 26% of children 19-35months) Parent reports of same unmet need affect 36% of children aged 0 to 9 months and 56% of children aged 10 to 35 months and are highest far the topics of discipline strategies and toilet training parents and paediatricians report high rates of discussion on many topics that are critical to health development in the first years of life.

Curtis, Kanji, et al., (2001) conducted a study to determine whether parents are receiving knowledge guidance on toilet training in developing countries. Analysis of data was based on 25 minutes telephonic interview consisting if 2017 respondents. A stratified random digit dealing design was used to obtain sample of parents with children between 3-5 years. Discussion with a nurse on about 6 parental guidance topics revealed varied results on not using the information. New born (35%), crying (65%), sleep pattern (59%), encouraging (77%), discipline (36%), and toilet training (66%). Among total 37% parents had not discussed on any of theses topics. About 39% of parents had discussion on toilet training and 37% had not discussed on toilet training, needed more information on toilet training.

A National Survey (2001) of parents with young children was conducted to determine the child rearing needs and paediatrics health experiences of parents and children regarding toilet training. A stratified random digit dial sample design was used to obtain a nationally representation sample of 2017 parent using a 25 minutes structured telephonic questionnaire. The results

revealed excellent health among 76% of children, 88% had regular source of paediatrics health care, 79% of parents reported that they could use more information in at least one of six areas of child rearing; new born care, sleep patterns, crying baby, toilet training discipline and encouraging early learning. About 41% of parents wanted more specific information on toilet training. However less than one third of parents talked to the physician or nurse about toilet training. The study shows that toilet training is least discussion topic and yet parents wanted more specific information on it.

LITERATURES RELATED TO CHILD'S READINESS FOR TOILET TRAINING.

Corranino Walsh and Nodal (2001) conducted a research on Assisted Infant Toilet Training in a Family Setting. Independent toilet training usually starts at age 18 months or later. In developing countries and in Asia, assisted toilet training traditionally starts between one and three months and is completed within approximately one year. This research reports a male infant who started assisted toilet training at age 33 days, in a family setting. During the first days, the mother made observations of the infant's bowel movement schedule and the cues he provided, from which she learned when to assist him to eliminate in the bathroom. During this process, the infant was held in an "in arms" position. Successful toilet training was completed at five months. This case reported that early infant toilet training is possible in a family setting if the mother properly learns the infant's natural elimination timings and signals.

Shailen Nandy et al., (2005) conducted a prospective study to examine the incidence and age at onset of hiding while defecating in children before they have completed toilet training. Study conducted in suburban private paediatric practice. Subjects were 378 children aged 30-42 months. They were followed up by telephonic interviews with parents every 2-3 months, until they completed daytime toilet training. Results shown that 263 children (69.6%) met criteria for hiding groups. 38 began hiding before toilet training was initiated and 64 started hiding after intensive toilet training had begun. The non-hiders 115 (30.4%) were significant. They completed toilet training at an earlier age than hidings (34.5 vs.38.1; $P < 0.001$) these behaviour may make toilet training more difficult.

Mammen et al, (2006) conducted a prospective study to determine the relationship between age at initiation of toilet training, age at completion of toilet training, and duration of toilet training. A total of 406 children at suburban private paediatric were enrolled in the study between 29 and 38 months of age, and 378 (93%) were enrolled by telephonic interview with parents every 2 to 3 months until the child completely toilet trained. Age of initiation of toilet training correlated with the age of completion of toilet training. ($r=0.275$). The correlation between age at initiation of intensive training and age at completion was even stronger ($r=0.459$). However age at initiation of intensive toilet training was negatively correlated with the duration of toilet training ($r=-0.48$). Completion of toilet training was not significant for those who began intensive training before 27 months of age ($r=0.197$). Earlier toilet training is not associated with constipation, stool withholding, or stool toileting refusal. Initiation of intensive toilet training before 27 months does not correlate with earlier completion of toilet training, suggesting little benefit is beginning intensive training before 27 months of age in most children.

K Srinivasan, G R Prabhu (2006) conducted a longitudinal study to compare the age, by gender, at which normally developing children acquire individual toilet training skills". A survey of children 24 to 42 months of age. Study included 126 girls and 141 boys. 88% were white. Parents submitted a total of 10,741 weekly surveys (range: 1-73; median: 49 per child). Median ages of staying dry during the day were 32.5 months (95% confidence interval: 30.9-33.7) and 35.0 months (95% confidence interval: 33.3-36.7) for girls and boys respectively. In addition, the inter quartile ranges of the toileting skills varied from 6.9 to 11.4 months in girls and from 7.5 to 14.6 months in boys. Study population concluded that girls achieve nearly all toilet training skills earlier than boys, including successful completion.

Taffa N, Cheangeno, G Amuyurizu et al., (2005) conducted a longitudinal study on secular trends and individual differences in toilet training progress from Stanford University. A group of 71 children between 33 and 46 months old for the age of onset and completion of mature toileting behaviour, physiological maturity and maternal pressure for toilet training. Onset occurred between 33 and 35 months, with girls finishing sooner than boys. Girls who start sooner finish sooner. Mature boys (as measured by sleep patterns) finish sooner.

The unexpected sex differences may be due to differences in the relationship of sleep maturity to overall maturation for boys and girls.

K Gupta et al., (2004) conducted a study to determine the bladder capacity in children, its relationship to toilet training and frequency of micturation. Bladder capacity was measured prospectively at voiding by cystourethrography in 274 consecutive healthy infants and children. Bladder volume index (BVI) was then calculated. Bladder capacity increased dramatically after 24 months and reached a plateau between 6-10 months of age thereafter. This sharp increase indicates increase in bladder capacity in toddler and childhood. The study also revealed that the bladder capacity would be regularized after completion of toilet training.

LITERATURES RELATED TO TOILET TRAINING AND ASSOCIATE VARIABLES.

Schulenburg D et al., (2003) conducted a study to determine the effectiveness of a reinforcement based toilet training intervention on three children with diagnosis of enuresis. This includes a combination positive reinforcement, graduated guidance, schedule practice trials and forward prompting. Results indicated that all procedures were implemented in response to urination accident. All three participants reduced urination and accidents to zero and learned to spontaneously request the use of bathroom within 7-11 days of training. Findings suggested that proposed procedure is an effective and rapid method of toilet training, which can be implemented within a structured school setting with generalizations of home environment.

B Banerjee, et al., (2005) conducted a study to determine the increasing independence through effective toilet training. Reinforcement based strategies. Focus of this study was to introduce the parents to effective toilet training procedures that are based on prompting strategies found in toilet training literature included urination training package for parents and professionals. This was done successfully into a variety of community based setting. (Eg. classroom, day programmes, and the home). Time also spent on the bowel training procedures; schedule training and night toilet training. Intervention strategies led to successful self initiated toilet training with both children and parents

Al Malik, M Holt R D (2000) did a study in developing Asian country regarding cultural relativity of toilet training readiness. Ideas about toilet training practice have changed in the developed country following cultural trends and the advice of childcare experts. The different expectations of the infant behaviour of the Asian produce a markedly different toilet training approach than the current maturational readiness method recommended in developed country. Asian believes that the infant can learn soon after birth and begin motor and toilet training in the first weeks of life. The success of early Asian training suggests that the socio cultural factors are more important determinants of toilet training readiness than is currently thought.

Chaveepoj Kamjorm W et al (2002) did a prospective study to determine the incidence of toileting refusal for bowel movement and its outcome. Healthy children between 35 and 40 months with no signs of developmental delay were enrolled in the study. Parents were given questions regarding the child's toilet training and behaviour. A total of 482 children (255 males) completed the study. Stool toileting refusal occurred among 1 in 5 children. There was an association between the presence of a younger sibling ($P=0.23$) and parental ability to set limits for the child ($P=0.017$) and stool toileting refusal ($P<0.001$). If the problem of stool with holding is not resolved, it can result in primary encopresis, which is very complicated to medical treatment.

Vaswani V (2004) conducted a study to determine the toilet habits and incontinence in children. Sample of 1192 children was assessed on basis of toilet training and elimination status by an interview and questionnaire. Toilet training age ranged from 0.75 to 5 years, with a mean of 2.4 ± 0.6 years. There was a general linear relationship between age and reported age at toilet training. ($r=-0.183$; $P<0.01$). Voiding frequency was inversely related to age. Bowel movements per week ranged from 1 to 21 with a mean of 6.8 ± 2.5 . This information is useful in evaluation and toilet training of children with voiding dysfunction or constipation.

Gielen et al., (2001) did a study to determine the effect of toilet training on achievements of bladder and bowel control and also control of enuresis in SSKM Hospital, Calcutta. A total of 170 children were studied for effect of toilet training and the age at which bladder and bowel control is achieved. 50 children were toilet trained and followed up. 100 children of one to five years of

age belong to trained and untrained groups were studied. Toilet training was given to ten enuresis children. About 60 % of the trained infants between six months to one year acquired control by 10 months. 65% by one and half year, 88 % of trained children acquired bladder control by two and quarter year, whereas 70 % of untrained children did not acquire even till age of three and half years.

LITERATURES RELATED TO UNTOWARD EFFECTS OF TOILET TRAINING.

A cross sectional population based survey was done including 580 children in urban state “investigation of voiding dysfunction in a population based sample of children aged 3 to 9 years”. Voiding and faecal patterns were investigated using, score, created by Farhet, modified by addition of high frequency urine (more than 8 times a day). Boy’s scores above eight and girls above five were clinically investigated, results shown nocturnal (60.4%) urinary urgency (49.7%) and holding manoeuvres 42.1% prevalence of enuresis was 20.1% in boys 15.1% in girls. Urinary dysfunction was 22.8% only 10.5% of the parents of the children with voiding dysfunction consult a doctor. The voiding symptoms studied presented high prevalence rates.

Fukunishi K (2000) conducted a study to determine the precipitants to constipation during childhood related to toilet training. Study conducted in 125 families with a child aged between 2 and 7 years with a complaint of constipation were compared with findings from 95 children between 2 and 7 years without any history of constipation. Parents answered questions concerning family history, toilet training and bowel habits. The age and sex who did not suffer from constipation were comparable ($P > 0.3$). When compared with control children, constipated children were no more likely to have a parent (30% vs. 40%, $P = 0.14$) or sibling (17% vs. 14%, $P = 0.54$) with a history of constipation. Constipated children did not begin toilet training earlier than 27 did control children (28 ± 7 vs 27 ± 6 months, $P = 0.30$). Parents of constipated children indicated their children had more difficult and more painful defecation experiences than did the parents of control children ($P < 0.001$), and constipated children were more likely to express worry about

future painful defecation than were control children ($P < 0.001$). Results show that toilet training is precipitant of constipation.

Mukerjee G (2001) conducted a retrospective study to assess the frequency of predisposing factors for encopresis before and during toilet training. Questionnaires from the initial evaluation at encopresis clinic at a tertiary care paediatric hospital were received for the presence or absence of factors in the first three years of life, for toilet training practices. Reports shown that in 11 children with encopresis the reported frequency of predisposing factors included constipation in 35% and previous treatment for constipation in 24% toilet training was initiated before age two years in 26% and after age 3 years in 14% Interruption of toilet training and punishment were seen more in primary encopresis than in secondary encopresis (50% vs. 28% $P < 0.05$) and (52% vs. 26%; $P < 0.05$) respectively constipation (30% vs. 18%; $P < 0.05$) and abdominal pain (23% vs. 9% $P < 0.05$) during toilet training were more common in primary encopresis was fear of the toilet (47% vs. 10% $P < 0.05$). However children with primary encopresis did have more difference and disruptive toilet training experiences.

Kumar (2003) conducted a study on a rapid method of toilet training the institutionalized retarded. Incontinence is a major unsolved problem in the institutional care of the profoundly retarded. Study conducted in the ward setting of mentally retarded. 9 profoundly retarded children given intensive training (median of 4 days per patient) the distinctive features are increase in frequency of urinations, 28 positive reinforcement of correct toileting, shaping of independent toileting, cleanliness training and reinforcement procedures. Incontinence was reduced by 90% and decreased to near 0. Results indicates the present procedures is an effective, rapid, enduring and feasible solution to the problem of incontinence.

Tiagi (2000) conducted a study to determine constipation in childhood: toilet training, patient characteristics, treatment, and long-term follow up. The symptoms of 174 children ≤ 4 years of age, are reported in the study with long term outcome in 90 of them. Initial symptoms were infrequent bowel movements in 58 %, painful bowel movements in 77 % and severe stool withholding manoeuvres in 97 %. The long-term outcome could be evaluated in 90 patients (52%) [Mean SD 6.9 (2.7)] years after initial evaluation. The

recovery rate of children < or = 2 years of age was significantly higher than in children > 2 to 4 years of age. Thirty-three children (37%) had not recovered. The treatment of chronic constipation consisted of education and finally toilet training of the preschool child.

Mock et.al; (2004) conducted a case study was conducted on 27 children between 36-46 months of age who had achieved bladder control but not bowel control. There were 27 matched controls. Behaviour characteristics of children with stool toileting refusal were assessed. The children with stool toileting refusal did not have more behavioural problems than children who were toilet trained, but children with stool toileting refusal tended to have more different temperament than controls and had more problems with constipation and painful bowel movements.

The reviewed literature indicates that mothers and caregivers were anxious to know toilet training, which is the least discussed topic by the health personnel even though it is important. Proper training of children based upon their readiness to attain toileting control can prevent untoward effects of toilet training.

CHAPTER - III

RESEARCH METHODOLOGY

This chapter compress the methodology for the study, the research approach, and design for the study, study setting, sample size, sampling technique of data collection, the pilot study and plan for analysis of the data. The study was done with the purpose to determine the knowledge and practice on toilet training among mothers of toddler in selected area at Manamadurai.

RESEARCH APPROACH

A descriptive approach was used in this study.

RESEARCH DESIGN

Descriptive design is very explorative and it description the phenomena in real life situations. It provides accurate account of the characteristics of particular individuals, situations of groups. So, a research design adapted for this study is descriptive in nature.

SETTING OF THE STUDY

The place selected for this study was Railway Colony, Vellayanthopu, and Marakadai Street, in Manamadurai. It is situated 5 Kilometres away from Matha College of Nursing. Manamadurai is a panchayat and had a total population of 26,253 in that 13,000 males and 13,253 females, 12% of the population is under 6 years of age. Manamadurai had 172 streets and each street there are number of children under five years of age, in that I have selected three streets like railway colony, Marakadai Street, vellayanthoppu.

Manamadurai was selected for the study because of the availability of subjects and feasibility of conducting the study.

POPULATION

The target population in the present study included mothers of toddler in selected area at Manamadurai.

SAMPLE

The mothers who fulfilled the inclusion criteria residing at Manamadurai

SAMPLE SIZE

The Sample consists of 100 mothers of toddler in selected area at Manamadurai.

SAMPLING TECHNIQUE

Convenient sampling technique was used to select the subjects.

CRITERIA FOR SAMPLE SELECTION

Inclusion Criteria

- ❖ Mothers having children between 1-3 years of age.
- ❖ Mothers who understands Tamil or English.

Exclusion Criteria

- ❖ Mothers who were not willing to participate in the study
- ❖ Mothers who were not present at the time of data collection
- ❖ Children who were having infection of bowel and bladder.

DESCRIPTION OF TOOL

Tool was Prepared after reviewing the related Literature such as books, Journals, Past experience and also from experts opinion.

PART- I

It deals with background information items included was Age, Religion, Education ,Occupation, Number of child, Birth Order, Type of family, Income of Family and sources of information on toilet training.

PART-II

It was developed to determine the knowledge on toilet training among mothers of toddler. It included twenty multiple choice questions, which were divided into four items on physiological readiness, four items on psychological readiness, two items on parental readiness and ten items related to toilet training process.

PART- III

Structured questionnaire on assessment of practice of toilet training consisting of twenty items that were divided into four aspects, four items on physiological readiness, three items on psychological readiness, seven items on parental readiness and six items related to toilet training process.

SCORING PROCEDURE

Knowledge questionnaire consist of 20 multiple choice questions. Each correct answer was given one score and zero score for wrong answer. The maximum score was 20 and minimum score was 0. The subjects were classified as follows as based on their scores.

The score was interpreted in the following manner;

Less than 50% - inadequate knowledge

50-75%-moderately adequate knowledge

More than 75%- adequate knowledge

Practice questionnaire consist of 20 dichotomous questions. Each correct response was given one mark. The maximum possible score was twenty. The subjects were classified into three group based on their scores.

The score was interpreted in the following manner;

Good Practice - Above 75%

Average Practice	-	50- 74%
Poor Practice	-	Below 50%

TESTING OF THE TOOL

VALIDITY

In Order to ensure content validity; the tool was submitted to six experts in the field of child health nursing, community health nursing and department of maternity nursing. Based upon the expert's suggestion the items were modified and tool got its final form. After establishing the validity, the tool was translated into Tamil and again translated into English to validate the language.

RELIABILITY

Structured questionnaire was tried out with ten mothers of toddler children in Anbunagar, Manamadurai. Test and Retest method was used to find out the reliability of the instrument. Co-efficient of correlation was found to be $r=0.9$, which indicate the degree of reliability.

PILOT STUDY

Polit and Hungler (1999) defined pilot study as a small-scale version on trial run on the major study. Its function is to detain information for upbringing the project or for assessing its feasibility. The principal focus was the assessment of the adequacy of measurement.

Pilot study was conducted in Anbunagar, Manamadurai. The study was carried out on ten mothers those who fulfil the criteria for sample selection were selected by using convenient sampling method. It was carried out in the same way as the final study would be done. In order to test the feasibility and practicability, it was conducted after obtaining permission from the department. Pilot study was conducted by using knowledge questionnaire and practice questionnaire. The results were analyzed based on the scores obtained by the mothers. These subjects were excluded from the final study.

DATA COLLECTION PROCEDURE

Data collection is the process of acquiring subjects and collecting the information needed for the study (Burns and Grooves).

Before collecting the data, formal administrative permission was obtained from the principal, Matha College of nursing as well as from the village panchayat officer and also from the participants. The confidentiality of the information given by them was assured. The investigators, before the data collection, ensured that mothers included in the study have toddler in the selected area at Manamadurai. The area was selected by using lottery method.

The data was collected for a period of 6 weeks [03.09.2010 to 13.10.2010] at Manamadurai. Before administering the questionnaire, the purpose of study was explained to the mother with self introduction and privacy was maintained, Mothers were made comfortable and relaxed. The data was collected from Monday to Saturday (10 AM to 4 PM). The time taken for each mother was 35-40 minutes. Every day 3-4 mothers were selected based on inclusion criteria and questions were distributed, asked the mother to follow the instructions written on top of the questions. During the data collection period the mothers were very co-operative. On completion of the questionnaire each one was given time to clarify her doubts and ask questions.

DATA ANALYSIS

The data will be analyzed based on the objectives. Descriptive statistics such as mean, median, standard deviation was used to describe the knowledge and practice of the mothers. Frequency and percentage were computed for describing the sample characteristics. Chi - square tests were computed to describe the association between knowledge, practice and demographic variables. Spearman correlation 'r' was computed to find out the relationship between knowledge and practice on toilet training among mothers of toddler.

PROTECTION OF SUBJECT RIGHTS

The research proposal was approved by dissertation committee prior to the pilot study and main study permission was obtained from head of the department of Paediatric Nursing, Matha College of Nursing. The oral consent

of each subject was obtained at the time of data collection. Assurance was given to the study subjects. The anonymity of each individual would be maintained.

CHAPTER – IV

ANALYSIS AND INTERPRETATION OF THE DATA

This chapter dealt with the analysis of the sample and interpretation of data to find out knowledge and practice on toilet training among mothers of toddler.

According to Polit (1999) analysis helps a research make sense of quantitative information, Statistical procedure enable researchers to summarize, organize, evaluate, interpret and communicate numeric information.

The obtained data has been classified, Grouped and analysed statistically based on the objectives of the study.

OBJECTIVES OF THE STUDY

- To assess the level of knowledge on toilet training among mothers of toddler in selected area at Manamadurai.
- To assess the toilet training practice among mothers of toddler in selected area at Manamadurai.
- To relate the knowledge and practice on toilet training among mothers of toddler and its selected demographic variables.
- To associate the knowledge on toilet training among mothers of toddler and its selected demographic variables.
- To associate the practice on toilet training among mothers of toddler and its selected demographic variables.

During the analysis the data were reduced to an interpretable form to summarize the findings, test the hypothesis and establish the relationship between variables.

Organization of study findings

Section I

Distribution of samples according to the demographic variables of mothers of toddler.

Section II

Distribution of the samples according to the level of knowledge on toilet training.

Section III

Distribution of the samples according to the level of practice on toilet training.

Section III

Relationship between knowledge and practice on toilet training among mothers of toddler.

Section IV

Association between knowledge and the selected demographic variables such as age, religion, education, occupation, family income, type of family, number of children, birth order of child and sources of information on toilet training.

Section V

Association between practice and the selected demographic variables such as age, religion, education, occupation, family income, type of family, number of children, birth order of child and sources of information on toilet training.

SECTION 1

DISTRIBUTION OF SAMPLES ACCORDING TO THE DEMOGRAPHIC VARIABLES.

TABLE 1**N=100**

S.No	Demographic Variables		Frequency (n=100)	Percentage (%)
1	Age	Less than 20 Years	18	18
		21-25 Years	36	36
		26-30 Years	31	31
		31-35 Years	15	15
2	Religion	Hindu	52	52
		Christian	31	31
		Muslim	17	17
		Other	0	0
3	Education	Illiterate	25	25
		High School	59	59
		Graduate	11	11
		Professional	5	5
4	Number of Child	One	29	29
		Two	59	59
		Three	12	12
		Above 4	0	0
5	Birth Order	1 st	45	45
		2 nd	49	49
		3 rd	6	6
		After 4 th	0	0
6	Occupation	Unemployed	12	12
		Self	29	29
		Professional	20	20
		House Wife	39	39

7	Type of Family	Nuclear	65	65
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		Joint	27	27
		Extended	8	8
8	Income of Family	Less than Rs.5000	61	61
		5001-10000	37	37
		Above Rs.10000/-	2	2
9	Source of Information	Friends and Relations	64	64
		Health Officials	25	25
		Radio	2	2
		Newspaper/Books	9	9

The data on Table 1 shows that the 36% mothers were between the age group of 21-25 years, 31% were between the age group of 26-30 years, 18% were below the age of 20 years and 15% were between the age group of 31-35 years.

The data on the religion of the mothers shows that 52% were Hindus, 31% were Christians and 17% were Muslims.

The educational status of the mothers shows that 59% had High School Education, 25% were illiterate, 11% had Degrees and 5% were professional degrees.

Number of children shows majority of the mothers 59% had two children, 29% had one child, 12% of mothers had three children and none of the mothers had four and more than four children. They were 65% were living as nuclear families, 27% were joint families and 8% were extended families.

The data on the birth order of child shows that 49% were second child, 45% were first child and 6% were third child.

Occupation status revealed that 39% were house wife, 29% were self employed, 20% were professionals and 12% were unemployed. Considering the family income 61% were getting below Rs.5000/- (Rupees Five Thousand), 37% were getting between Rs.5000/- to Rs.10,000/- and 2% were only getting more than Rs.10,000/- (Rupees Ten Thousand).

The Table 1 shows that 64% of the mothers were got information on toilet training from Elders, Relatives of the family and Friends. And 25% were from Health Personnel and 9% were Newspaper/Books and Magazines. 2% of the mothers were got from Electronic Gadget like Radio, Television etc.,

Fig 2 : Distribution of samples according to Age

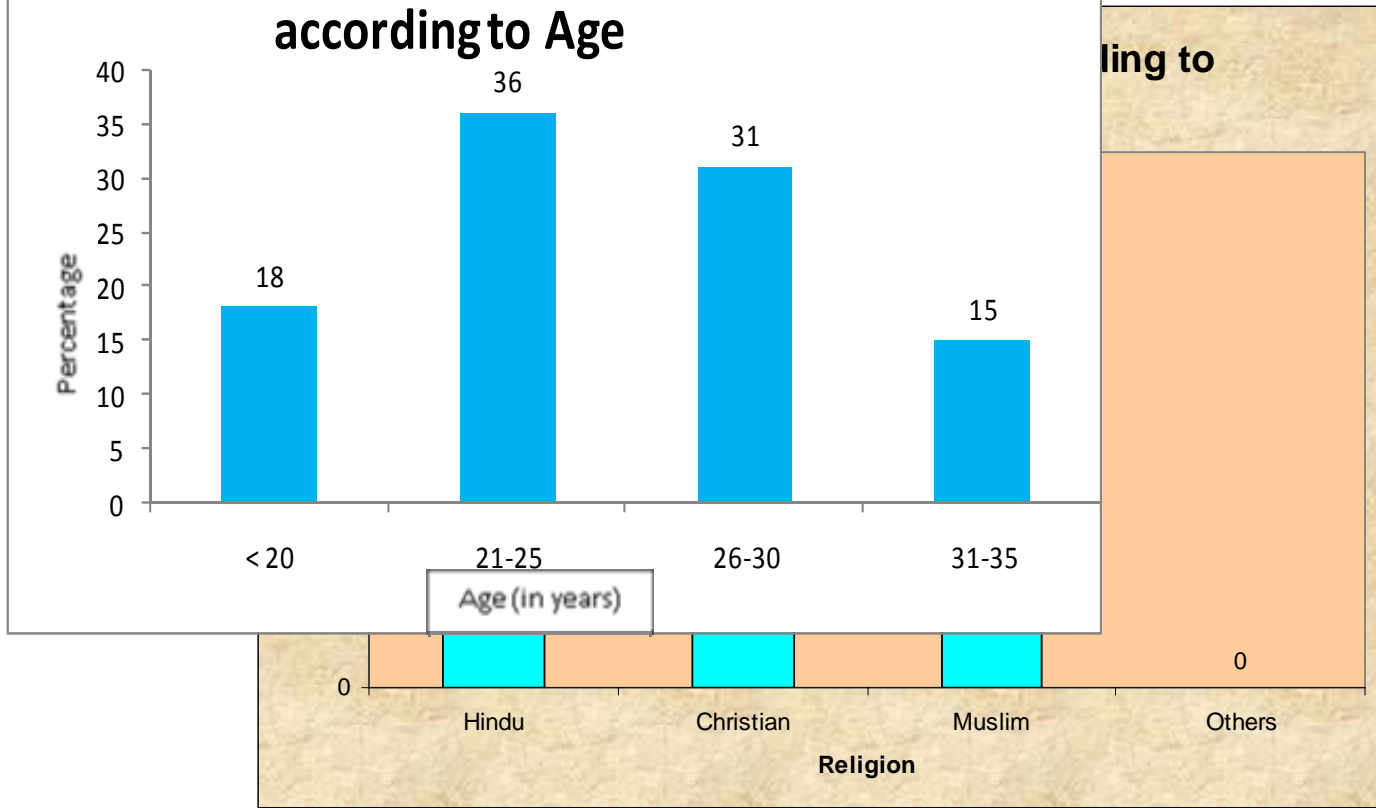


Fig 4: Distribution of samples according to Education

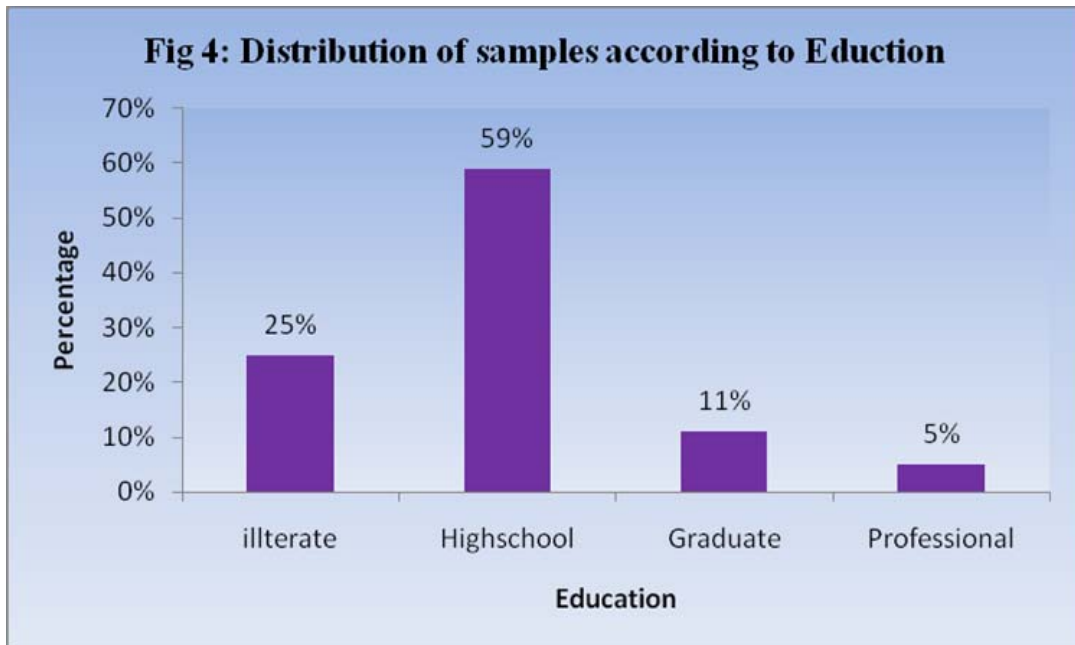


Fig 5. Distribution of samples according to Number of Child

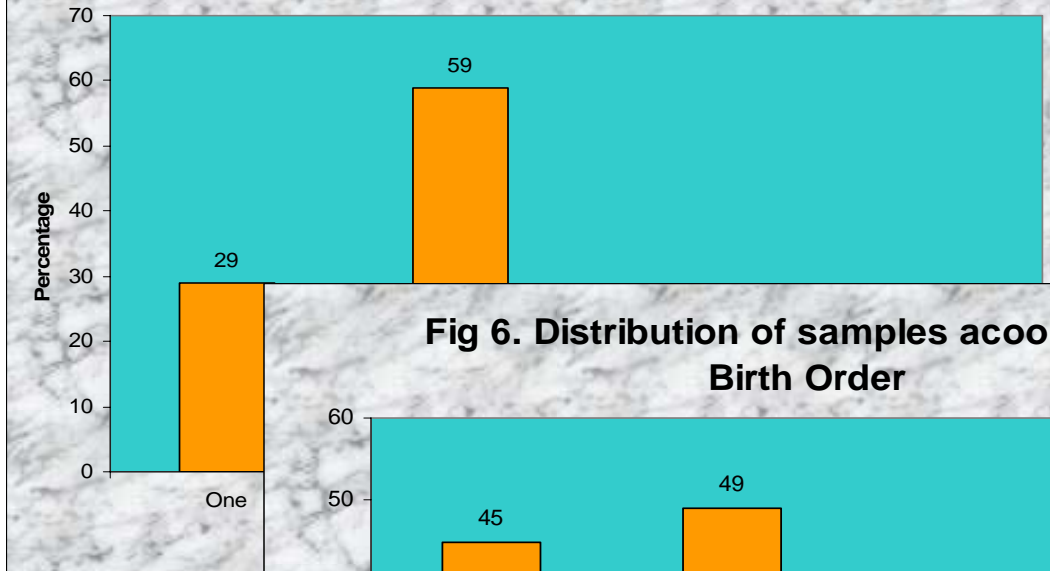


Fig 6. Distribution of samples according to Birth Order

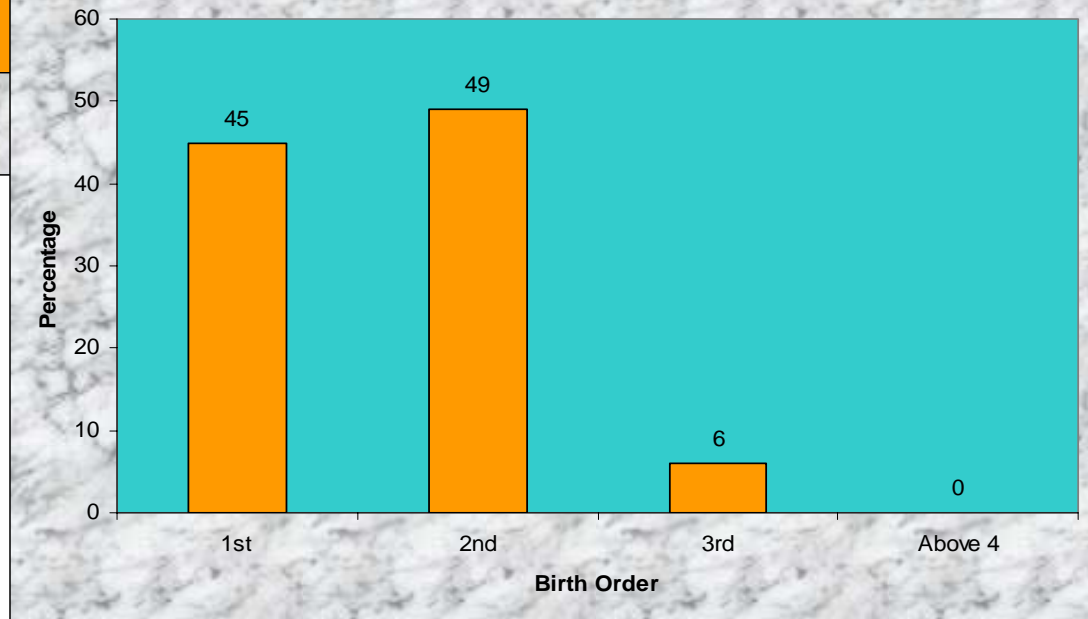


Fig 7 : Distribution of samples according to Occupation of Mothers



Fig 8: D

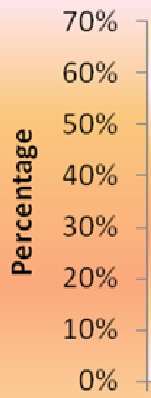


Fig 9: Distribution of samples according to Family Income

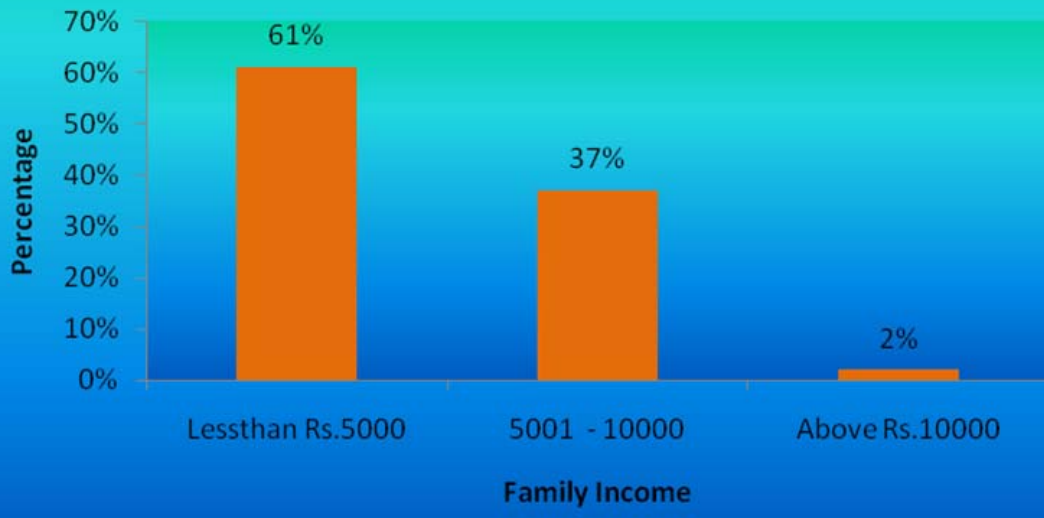
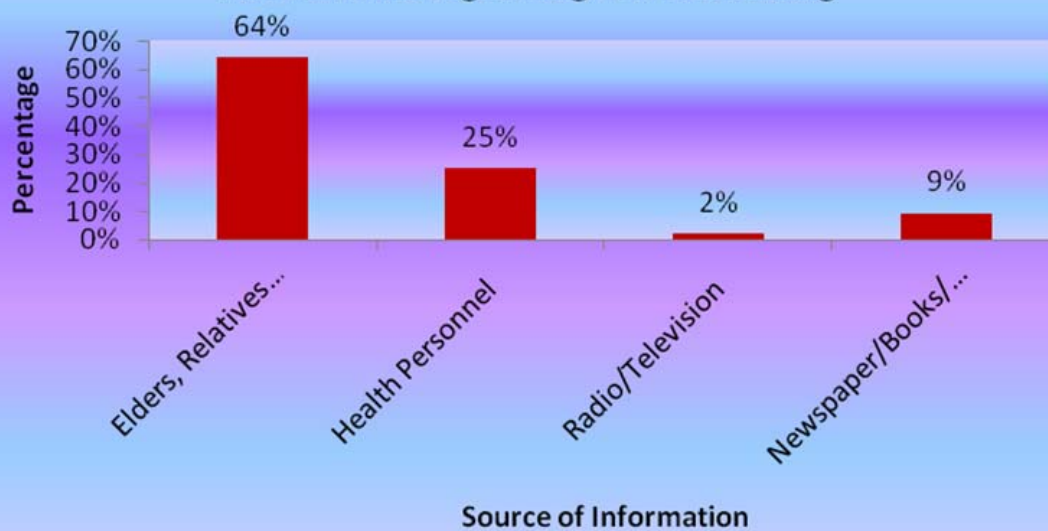


Fig 9: Distribution of samples according Source of information regarding Toilet Training



SECTION – II

DISTRIBUTION OF SAMPLES ACCORDING TO THE LEVEL OF KNOWLEDGE ON TOILET TRAINING

TABLE 2

N=100

S.No.	Level of Knowledge	Frequency (n=100)	Percentage (%)
01	Adequate	22	22
02	Moderately Adequate	59	59
03	Inadequate	19	19

Table 2 shows that 19% of the mothers had inadequate knowledge on toilet training, 59% of mothers had moderately adequate knowledge and only 19% of the mothers having adequate knowledge on toilet training.

SECTION – III

DISTRIBUTION OF THE SAMPLES ACCORDING TO THE LEVEL OF PRACTICE ON TOILET TRAINING.

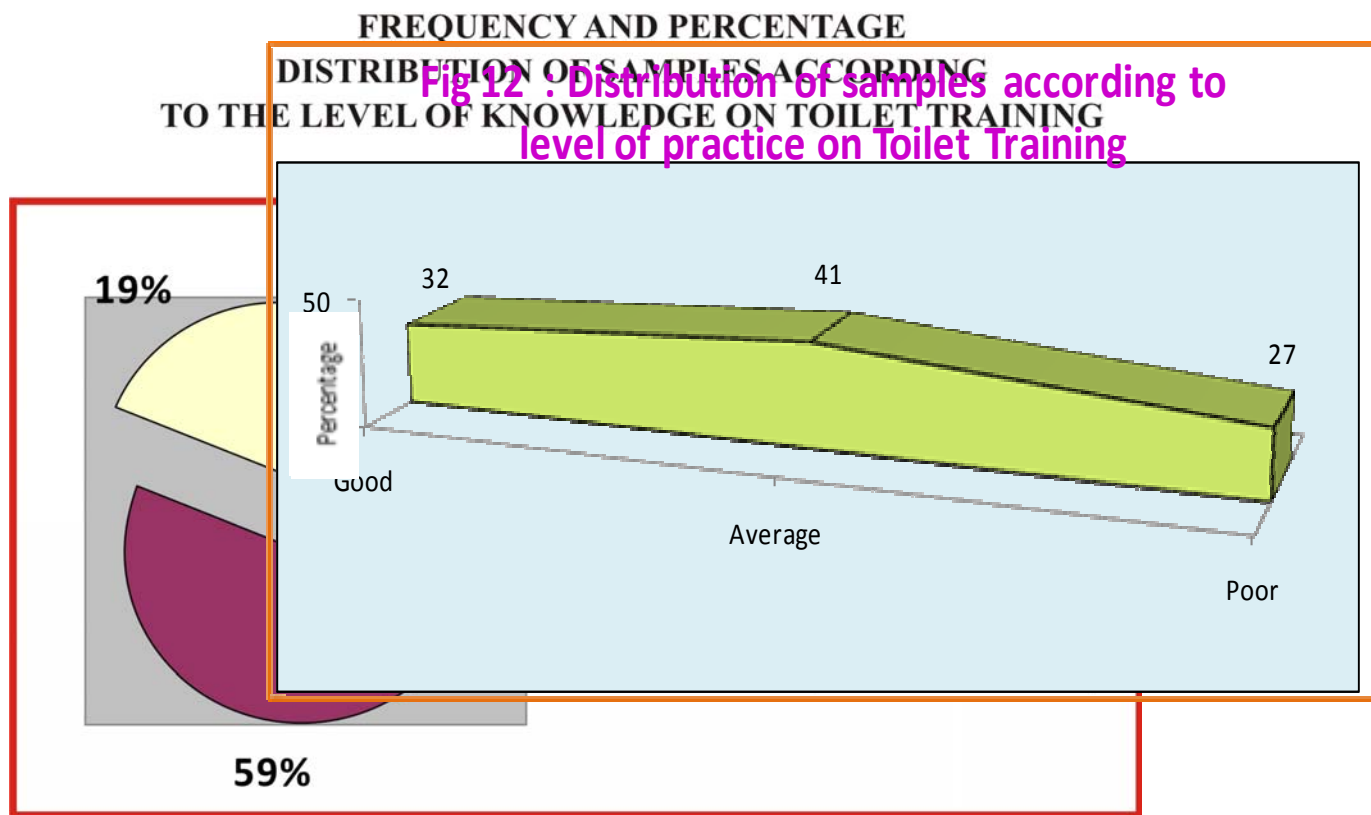
TABLE 3:

N= 100

S. No.	Level of practice	Frequency (n=100)	Percentage (%)
01	Good Practice	32	32
02	Average Practice	41	41
03	Poor Practice	27	27

The data (shown in Table 3) shows that 32% of the mothers had good practice regarding toilet training, 41% of mothers had average and 27% of the mothers having poor practice on toilet training.

Fig : 11



SECTION -IV

RELATIONSHIP BETWEEN KNOWLEDGE AND PRACTICE ON TOILET TRAINING AMONG MOTHERS OF TODDERS.

TABLE 4

N=100

S. No.	Particular	“r” value
01	Relationship between the level of knowledge on toilet training	+0.197
02	Relationship between the level of practice on toilet training	

To find out the relationship between knowledge and practice co-efficient correlation was used. The computed ‘r’ value is +0.197. The positive correlation was found between knowledge and practice. Hence it was interpreted that mother who had adequate knowledge, followed good practices.

SECTION V

ASSOCIATION BETWEEN THE KNOWLEDGE ON TOILET TRAINING AMONG MOTHERS OF TODDLER AND THE SELECTED DEMOGRAPHIC VARIABLES.

TABLE 5

N=100

No	Demographic Variables	Inadequate		Moderate		Adequate		Chi-square
		No	%	No	%	No	%	
1	Age of the Mother							8.17 ^S
	Less than 20Years	3	16.6	13	72.2	2	11.1	
	21-25 Years	8	22.2	17	47.2	11	30.6	
	26-30 Years	10	32.2	18	58	3	9.7	
	31-35 Years	2	13.3	10	66.6	3	20	
2	Religion							2.01 ^{NS}
	Hindu	13	25.0	28	53.9	11	21.2	
	Christian	5	16.1	20	64.5	6	19.4	
	Muslim	5	29.4	10	58.8	2	11.8	
	Others	0	0	0	0	0	0	
3	Educational Status							3.87 ^S
	Illiterate	8	32	13	52	4	16	
	High school	12	20.3	37	62.7	10	16.9	
	Graduate	2	18.9	5	45.5	4	36.3	
	Professional	1	20	3	60	1	20	
4	Number of Children							0.83 ^{NS}
	One	6	20.7	17	58.6	6	20.7	
	Two	15	25.4	34	57.6	10	16.9	
	Three	2	16.6	7	58.3	3	25	
	Above Four	0	0	0	0	0	0	

5	Birth Order							
	First	11	24.4	25	55.6	9	20	4.69 ^s
	Second	11	22.4	31	63.3	7	14.3	
	Third	1	16.7	2	33.3	3	50	
	Above Four	0	0	0	0	0	0	
6	Occupation							
	Unemployed	3	25	7	58.3	2	16.7	2.55 ^s
	Self employed	6	20.7	19	65.5	4	13.8	
	Professional	4	20	10	50	6	30	
	Housewife	10	25.6	22	56.4	7	17.8	
7	Type of Family							
	Nuclear	15	23.1	36	55.4	14	21.5	5.33 ^s
	Joint	4	14.8	19	70.4	4	14.8	
	Extended	4	50	3	37.5	1	12.5	
88	Income of Family							
	Less than Rs.5000	16	26.2	36	59	9	14.8	3.90 ^s
	Rs.5001 – 10,000	6	16.2	21	56.7	10	27	
	Above Rs.10,000	1	50	1	50	0	0	
99 9	Source of Information							
	Elders / Relatives/Friends	9	14.1	38	59.4	17	26.6	15.8 ^s
	Health Personnel	9	36	15	60	1	4	
	Radio/TV	1	50	1	50	0	0	

	Newspaper/Books	5	15.5	3	33.3	1	11.1	
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S – Significant at 0.05 levels

NS – Not Significant at 0.05 levels

Mothers with Christian religion possess with adequate knowledge (64.5%) on toilet training.

High school mothers found (62.7%) had adequate knowledge on toilet training.

Knowledge level of mothers possessing number of children indicates mothers with one child (58.6%) had adequate knowledge on toilet training.

Birth order of children and knowledge on toilet training shows that (63.3%) of mothers with second child had adequate knowledge on toilet training.

Employed mothers (65.5%) had adequate knowledge on toilet training.

Higher percent of mothers with joint family (70.4%) found with adequate knowledge on toilet training.

Family income of the mothers less than Rs. 5000 (59%) had adequate knowledge on toilet training.

Mothers received information from elders/ relatives/friends (59.4%) had adequate knowledge on toilet training.

To find out the association between knowledge and the demographic variables chi-square test were computed. In the Present study the calculated value is greater than the table value. So the null hypothesis is rejected, and a research hypothesis is accepted. Hence there is a significant association exist between the knowledge and the age of the mother, educational status, Birth order of children, occupation of mother, Type of family, family income, and source of information on toilet training. Hence there is no significant association between the Religion of mother and Number of children on toilet training among mothers of toddler.

SECTION – VI

ASSOCIATION BETWEEN PRACTICE ON TOILET TRAINING AMONG MOTHERS OF TODDLER AND THE SELECTED DEMOGRAPHIC VARIABLES.

No	Demographic Variables	Poor		Average		Good		Chi-square
		No	%	No	%	No	%	
1	Age of the Mother							6.27 ^s
	Less than 20Years	2	11.1	14	77.8	2	11.1	
	21-25 Years	5	13.9	22	61.1	9	25	
	26-30 Years	7	22.6	19	61.3	5	16.1	
	31-35 Years	4	26.7	6	40	5	33.3	
2	Religion							2.01 ^s
	Hindu	10	19.2	32	61.5	10	19.2	
	Christian	3	9.7	18	58.1	10	32.3	
	Muslim	5	29.4	11	64.7	1	5.9	
	Others	0	0	6	0	0	0	
3	Educational Status							3.03 ^s
	Illiterate	5	20	17	68	3	12	
	High school	11	18.6	34	57.6	14	23.7	
	Graduate	2	18.1	6	54.5	3	27.3	
	Professional	0	0	4	80	1	20	

4	Number of Children							7.93 ^S
	One	5	17.2	22	75.9	2	6.9	
	Two	9	15.3	33	55.9	17	28.8	
	Three	4	33.3	6	50	2	16.7	
	Above Four	0	0	0	0	0	0	
5	Birth Order							3.57 ^S
	First	7	15.6	30	66.7	8	17.8	
	Second	11	22.4	26	53.1	12	24.5	
	Third	0	0	5	83.3	1	16.7	
	Above Four	0	0	0	0	0	0	
6	Occupation							7.21 ^S
	Unemployed	4	33.3	7	58.3	1	8.3	
	Self employed	7	24.1	14	48.3	8	27.6	
	Professional	1	5	15	75	4	20	
	Housewife	6	15.9	25	64.1	8	20.5	
7	Type of Family							2.30 ^{NS}
7	Nuclear	10	15.4	41	63.1	11	16.9	
	Joint	7	26	14	51.9	10	37	
	Extended	1	12.5	6	75	1	12.5	
88	Income of Family							
	Less than Rs.5000	12	19.7	38	62.3	11	18.0	

	Rs.5001 – 10,000	6	16.2	21	56.8	10	27	2.46 ^{NS}
	Above Rs.10,000	1	50	1	50	0	0	
Source of Information								
99 9	Elders / Relatives/Friends	10	15.6	38	59.4	16	25	7.90 ^S
	Health Personnel	4	16	17	68	4	16	
	Radio/TV	0	0	1	50	1	50	
	Newspaper/Books	4	44.4	5	55.6	0	0	

S – Significant at 0.05 levels

NS – Not Significant at 0.05 levels

Higher percent of mothers in the age group of less than 20 years (77.8%) had good practice on toilet training.

Mothers with Muslim religion (64.7%) had good practice on toilet training.

The result shows that (80%) of professional mothers had good practice on toilet training.

Mother with one child (75.9%) shows that good practice on toilet training.

The result shows that mother with three children (83.3%) had better practices regarding toilet training.

Professional mothers had good practice (75%) on toilet training.

Table 6 indicated that association between type of family and practice level shows that, mothers belongs to extended family (75%) had good practice on toilet training.

Higher the family income Rs.10, 000[100%] noticed better toilet training practices.

Mothers received information from health personal shows higher toilet training practices.

To find out the association between practice and the demographic variables chi-square test were computed. Present study shows that the calculated value is greater than the table value. So the null hypothesis is rejected, and a research hypothesis is accepted. Hence there is a significant association between Practice and the age of the mother, Religion, Education, Number of children, Birth order, Occupation and source of information on toilet training and there is non significant association between type of family and family income of mothers of toddler.

CHAPTER V

DISCUSSION

Toilet training is affected by a child maturation level and intellectual capacity. Lack of appropriate toilet training or inadequate training may delay the child attainment of continence.

Hence, the investigator is of the opinion to improve the knowledge and practice of mothers so that successful mastery of the child over toilet training can be ensured.

The present study is a descriptive survey to determine the knowledge and practice of mothers so that successful mastery of the child over toilet training can be ensured.

The first objective was to assess the level of knowledge on toilet training among mothers of toddler in selected area at Manamadurai.

Table 2 shows that 19% of the mothers had inadequate knowledge on toilet training, 59% of mothers had moderately adequate knowledge and only 19% of the mothers having adequate knowledge on toilet training.

These findings were supported by T. Berry Brazelton, author of toilet training conducted a study on educational level of mothers and their knowledge concerning toilet training. Parent's goal is to train the child in the first year by responding to her body signals with a race to the toilet, even though the child isn't yet aware that she needs to urinate (or) move her bowels, when the baby began to walk in the second year, she was already conditioned to respect the inside of the hut. She toddles outside to try to urinate (or) defecate.

These findings was supported by John A. Martin, David, Eleanor and Jacklin and T.Berry Brazelton who reported that sex differences is most common factor of toilet training. Girls achieve sooner than boys. Mostly toilet training depends upon the physiological and psychological readiness.

The second objective was to assess the level of practice on toilet training among mothers of toddler in selected area at Manamadurai.

The Table 3 shows that 32% of the mothers had good practice on toilet training, 41% of mothers had average and 27% of the mothers having poor practice on toilet training.

A comparative analysis on parents and child care professional's toilet training an attitudes and practices result shows that, increasingly, toilet training as a developmental milestone is being negotiated by Parents and child care professionals. The study examines the differences in attitudes and Practices of 89 Parents and 97 child care professionals from San Diego country regarding toilet training. The result indicate that Parents and child care professional hold significantly different beliefs about when to initiate training, readiness cues, toileting practices and response to accidents. Professional sought guidance from books other staff members and children's parents when difficulties in training arose Parents, alternatively, sought toileting advice from family members and friends.

These findings were supported by Schuster, Duan, Regaldo and Klein and Kempe, Dempsey and Poole, and Young Davis, Schoen and Parker who

reported that toilet training topic was least discussed and parents wanted more specific information on knowledge and practice on toilet training.

The third objective was to relate the knowledge and practice of toilet training among mothers of toddler and its selected demographic variables.

To find out the relationship between knowledge and practice co-efficient correlation was used. The computed 'r' value is +0.197. The positive correlation was found between knowledge and practice. Hence it was interpreted that mother who had adequate knowledge, followed good practices (Table No. 4).

Taubman B, Blum NJ, Nemeth N (2006) conducted a prospective study to determine the relationship between age at initiation of toilet training, age at completion of toilet training, and the duration of toilet training. A total of 406 children seen at a suburban private Paediatric practice were enrolled in a study of toilet training between 17 and 19 months of age, and 378 (93%) were followed by telephone interviews with the parents every 2 to 3 months until the child completed daytime toilet training. Age of initiation of toilet training correlated with age of completion of training ($r = 0.275$). The correlation between age at initiation of intensive training and age at completion was even stronger ($r = 0.459$). Younger age at initiation of intensive toilet training was not associated with constipation, stool withholding, or stool toileting refusal. However, age at initiation of intensive toilet training was negatively correlated with duration of toilet training ($r = -0.481$), indicating that initiation of training at younger ages was associated with a longer duration of training. In addition, the correlation between age at initiation of intensive toilet training and age at completion of training was not significant for those who began intensive training before 27 months of age ($r = 0.107$).

The fourth objective was to associate the knowledge on toilet training among mothers of toddler and its selected demographic variables.

Higher percent of mothers in the age group of less than 20 years (72.2%) had adequate knowledge on toilet training.

Mothers with Christian religion possess with moderate knowledge (64.5%) on toilet training.

High school mothers found (62.7%) had moderate knowledge on toilet training.

Knowledge level of mothers possessing number of children indicates mothers with one child (58.6%) had moderate knowledge on toilet training.

Birth order of children and knowledge on toilet training shows that (63.3%) of mothers with second child had moderate knowledge on toilet training.

Employed mothers (65.5%) had moderate knowledge on toilet training.

Higher percent of mothers with joint family (70.4%) found with moderate knowledge on toilet training.

Family income of the mothers less than Rs. 5000 (59%) had moderate knowledge on toilet training.

Mothers received information from elders/ relatives/friends (59.4%) had adequate knowledge on toilet training.

Sumeetha Khurana et al., (2001) conducted a cross sectional study to determine the association of toilet training with child parent and environmental factors. Descriptive design was used to study children age 24-42 months attending paediatric clinic. Total 496 children comprising 219 that have not started training, 70 were not on current training, 148 were in training and 59 were completely trained. The ages at which 50 % of children were predicted to be toilet trained were 36-39 months for girls and boys respectively. Significant factors predicting toilet training completion were older age, non Caucasian race, female gender and single parenthood.

The fifth objective was to associate the practice on toilet training among mothers of toddler and its selected demographic variables.

Higher percent of mothers in the age group of less than 20 years (77.8%) had adequate practice on toilet training.

Mothers with Muslim religion (64.7%) had good practice on toilet training.

The result shows that (80%) of professional mothers had good practice on toilet training.

Mother with one child (75.9%) shows that good practice on toilet training.

The result shows that mother with three children (83.3%) had better practices regarding toilet training.

Professional mothers had good practice (75%) on toilet training.

Table 6 indicated that association between type of family and practice level shows that, mothers belongs to extended family (75%) had good practice on toilet training.

Higher the family income Rs.10, 000[100%] noticed better toilet training practices.

Mothers received information from health personal shows higher toilet training practices.

IOM, Maharajgunj (2007) conducted a small research study determining the mother's awareness and practice of toilet training to their children was conducted in Guntur V.D.C of Bhaktapur district. The total samples were 50. This study was descriptive and of exploratory in nature. The objective were to find out the mothers awareness and practice towards the toilet training in two ethic group to find out the age of toilet training to the child, and to find out hand washing practices after defecation. The findings of the study show that illiteracy, ignorance, low income, agriculture by occupation and mother's carelessness are the main cause of their bad habits of their children in toilet training. Both educated and uneducated mothers were not aware of toilet training of their children. Result shows that mothers were given toilet training to their child but they do not complete it.

CHAPTER VI

SUMMARY, FINDINGS, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSIONS

This chapter dealt with the summary of study and the conclusion drawn. It clarifies limitation of the study. The implication and recommendations are given for different aspect in nursing practice, nursing education, nursing research and general education.

SUMMARY

The present study was under taken to assess the knowledge and practice on toilet training among mothers of toddler.

OBJECTIVES

- ☆ To assess the level of knowledge on toilet training among mothers of toddler in selected area at Manamadurai.
- ☆ To assess the toilet training practice among mothers of toddler in selected area at Manamadurai.
- ☆ To relate the knowledge and practice of toilet training among mothers of toddler and its selected demographic variables.
- ☆ To associate the knowledge on toilet training among mothers of toddler and its selected demographic variables.
- ☆ To associate the practice on toilet training among mothers of toddler and its selected demographic variables.

HYPOTHESES

- There will be a significant relationship between knowledge and practice on toilet training among mothers of toddler in selected area at Manamadurai.
- There will be a significant association between knowledge of mother of toddler on toilet training and its selected demographic variables.
- There will be a significant association between practice of mothers of toddler on toilet training and its selected demographic variables.

Children are the potential sources of nation. They are the citizens of tomorrow and hence the child health care is rightly called custodians tomorrow.

The review of literature enabled the investigator to develop the conceptual framework, methodology for the study and plan for analysis of data in an effective and efficient way. The conceptual frame work adopted for this study was based on.

The research approach adopted for this study was descriptive approach and the design used in this study was a descriptive design. The tools used for this study was structured knowledge and practice questionnaire. Manamadurai was selected for this study. Convenient sampling method was used for sample selection. A sample size was 100 mothers of toddler were taken for the study according to the inclusion criteria.

The Major Findings of the Study:

- Most (36%) of the mothers were belong to the age group of 21-25 years
- Majority (52%) of the mothers were Hindus.
- Majority (59%) of the mothers had High School Education
- Most (59%) of the mothers had two children
- Most (65%) of the mothers were living as nuclear families
- Majority (49%) of the child were second child.
- Most (39%) of the mothers were house wife.
- Most (61%) of the families income is below Rs.5000/- (Rupees Five Thousand) per month.
- Most (64%) of the mothers were got information on toilet training from Elders, Relatives of the family and Friends.
- The co-relation between knowledge and practice on toilet training was tested by Karl Pearson's "r". The outcome showed that there was a significant positive co-relation in knowledge and practice among mothers of toddler.

Among the mothers of toddler, 19% of the mothers had inadequate knowledge, 59% of mothers had moderately adequate knowledge and only 19% of the mothers having adequate knowledge on toilet training.

Among the mothers of toddler, 32% of the mothers having good practice, 41% of mothers having average and 27% of the mothers having poor practice on toilet training

The computed 'R' value is +0.197. The positive correlation was found between knowledge and practice. Hence it was interpreted that mother who had adequate knowledge, followed good practices.

NURSING IMPLICATIONS:

The findings of the study have implication on the field of nursing education, nursing practice, nursing administration and nursing research.

NURSING EDUCATION:

- Nurse educators should encourage student nurses to educate toilet training practices and insist the mothers to practice in home.
- Demonstration on toilet training must be included in paediatric procedure.
- The nursing curriculum should have in depth content regarding sphincter control on toilet training.

NURSING PRACTICE

- . Different AV aids can be used in imparting knowledge on toilet training to various categories of people.
- Nurse should act as a facilitator to educate mothers regarding toilet training.
- Misconceptions related to toilet training can be eliminated based on the findings to improve mother's knowledge and practice for better care of the child.

NURSING RESEARCH

- Research studies should be conducted to assess toilet habits and untoward effects of toilet training.
- Prevention and intervention programme can be conducted regarding toilet training.

NURSING ADMINISTRATION

- Nursing administration should implement outreach programmes to make the people aware about the process of toilet training
- Mass media and health education programme should be arranged to educate mothers regarding toilet training.
- Necessary administration support should be provided to conduct several activities regarding toilet training.

RECOMMENDATION

- A comparative study can be carried out to find out the knowledge and practice of mothers on toilet training in urban and rural areas..
- Study can be conducted for the fathers separately as they are also responsible for the childcare as per the present trend.
- A similar study can be conducted by using large samples to generalize the findings at national or state level.
- A study can be conducted among the same population after introducing a health education programme.

LIMITATIONS

- Generalization of findings is limited as sample was restricted to selected urban community in Manamadurai.
- Lack of random sampling technique hinders the generalization of results.
- Structured knowledge and practice questions used for the data collection, which restricts the amount of information that can be obtained from the respondents.
- The study is limited to 6 weeks only.

CONCLUSION

The family is the central focus in the life of toddler children. The most important societal demand made on the child during this period is the control of elimination. There are many developmental tasks to be achieved during this period. Among them toilet training is the most important task to be attained by each child. In this study, mothers of toddler had inadequate knowledge and practice on toilet training. The correct knowledge and awareness among parents (or) caregiver is very essential for the success of the child. In order to improve their knowledge and practice of toilet training, educate the mothers about toilet training methods and Demonstration are to be encouraged between the individual and society through mass media (or) the awareness programme to lead a healthy life.

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APPENDIX- I

Letter Seeking Expert's Opinion for Content Validity of Tool

From

Kavitha S

M.Sc., Nursing II year

Matha College of Nursing

Manamadurai

To

Through : The Proper Channel

Respected Madam / Sir,

Sub : Requesting opinion and suggestion of experts for content validity of knowledge questionnaire & Practice Questionnaire.

I am a final year student / Master of Science in Nursing in the Matha College of Nursing, Manamadurai. In partial fulfilment of Master Degree in Nursing. I have selected the topic mentioned below for the research project to be submitted to the Dr M.G.R Medical University, Chennai.

Problem Statement

A study to determine the knowledge and practice on toilet training among mothers of toddler in selected area at Manamadurai.

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

Enclosing

Demographic Profile

Knowledge Questionnaire & practice questionnaire

Thanking You,

Yours Sincerely,

Place : Manamadurai

Date :

(KAVITHA S)

APPENDIX- II

LIST OF EXPERTS CONSULTED FOR THE CONTENT VALIDITY OF RESEARCH TOOL

Dr. Mr.PRABAKAR NAVAMANI ,M.D., D.C.H

Navamani Child speciality Hospital

Madurai.

Prof.Mrs.ROSE RAJESH M.Sc.,(N) Ph.D

HOD of Pediatric Nursing

CSI Jeyaraj Annapackiam College of Nursing,

Madurai.

Prof.Mrs.N.SARASWATHI, M.Sc (N)

Associate Professor

Department of Pediatric Nursing

Matha College of Nursing,

Manamadurai.

Prof.Mrs.HELAN RAJAMANICKAM.,M.Sc (N)

HOD of Community Health Nursing

Matha College of Nursing

Manamadurai.

Prof.Mrs.THAMARAI SELVI ., M.Sc (N)

Vice Principal, HOD of Maternity Nursing

Matha College of Nursing

Manamadurai.

APPENDIX III

TOOL

STRUCTURED QUESTIONNAIRE ON TOILET TRAINING

Instruction:

Tick mark (✓) against the items as per the responses given by the participant.

PART-I DEMOGRAPHIC DATA

1. Age of mother in years

- a) Below 20 years
- b) 21 – 25 years
- c) 26 – 30 years
- d) 31 – 35 years

2. Religion of mother

- a) Hindu
- b) Christian
- c) Muslim
- d) Any other

3. Education of mother

- a) Illiterate
- b) Secondary
- c) High School
- d) Graduate
- e) Professional

4. Number of children

- a) One
- b) Two
- c) Three
- d) Four and above

5. Birth order of child

- a) First

- b) Second
- c) Third
- d) Fourth and above

6. Occupation of mother

- a) Unemployed
- b) Self employed
- c) Professional
- d) Housewife

7. Type of family

- a) Nuclear
- b) Joint
- c) Extended

8. Income of family per month (Rs.)

- a) Below Rs 5000/-
- b) Rs.5001/- to 10,000/-
- c) Above Rs.10,000/-

9. From where you receive information on toilet training.

- a) Elders/ Relatives/ Friends
- b) Health personnel
- c) Television / Radio
- d) Newspaper/ Books/ Magazine

PART II : KNOWLEDGE QUESTIONNAIRE ON TOILET TRAINING

Instruction:

Tick mark (✓) against the items as per the responses given by the participant

1. What do you mean by toilet Training?
 - a. Toilet training is the acquisition of skills necessary for urinating and defecating in a toilet at a socially acceptable time and age.
 - b. Toilet training is the acquisition of skills necessary for urinating in a toilet at a socially acceptable time and age.
 - c. Toilet training is the acquisition of skills necessary for defecating in a toilet at a socially acceptable time and age

2. Why toilet training is necessary?
 - a. Control emotions.
 - b. Control over urine and stool evacuation.
 - c. Control future complications.

3. When the child will gain the bowel control?
 - a. 2 years – 2 ½ years
 - b. 2 ½ years – 3 years
 - c. above 3 years

4. When the child will gain the bladder control?
 - a. 1 year – 1 ½ year

- b. 1 ½ years – 2 years
 - c. Above 2 years
5. When will be the child physically ready for bladder control?
- a. The child wets panty or diaper.
 - b. The child is able to walk.
 - c. The child is able to sit upright for sometime.
6. When the child will be ready for stool control (bowel control)?
- a. Bladder control is attained.
 - b. Child passes regular stool.
 - c. The child refuses to go to toilet.
7. What would be the psychological sign of getting ready for toilet training?
- a. The child wakes up at the same time
 - b. The child verbalizes or non -verbalizes the urge.
 - c. The child feels guilty for bed- wetting.
8. Which is the appropriate time for the parents to start the process of toilet training?
- a. Parents are willing to spend time required.
 - b. Parents are tensed about the child.
 - c. Parents want to take the child outside.

13. What is time duration required to complete the toilet training process?
 - a. Depends upon child.
 - b. Depends upon parent.
 - c. Depends upon toileting equipments.

14. Which is the most stressful situation faced by the child during Toilet training?
 - a. Child's needed to master the task within the suitable period.
 - b. Child's needed to meet the expectation of the peers.
 - c. Child's needed to please parents.

15. What is the indication of successful toilet training?
 - a. Child will verbalize of attaining toileting control.
 - b. Child will pass stool at a regular time.
 - c. Child will control bowel and bladder voluntarily.

16. Child should be taught to clean the perineal area from?
 - a. Front to back.
 - b. Back to front.
 - c. Side to side.

- c. Child experiences stronger sensation of playing with stool than to pass.

PART: III QUESTIONNAIRE ON TOILET TRAINING PRACTICE

Instruction:

Tick mark (✓) against the response as given by the respondent

SRL. NO.	CONTENT	YES	NO
1	Have you given potty training to your child?		
2	Do you used to scold your child when he/ she wets panty?		
3	Will you take your child to bathroom only when the child verbalizes the urge?		
4	Do you compel your child to sit on potty?		
5	Do you spend the time required to start the process of toilet training?		
6	Do you allow child's participation in selection of a potty?		
7	Have you taken your child to toilet to get familiar with the toileting equipments?		
8	Do you praise your child in continuing the toileting habits?		
9	Do you taught your child to wash hands with soap and water after toilet use?		
10	Do you show anger and strict discipline to your child during initial toilet training process?		
11	Do you spend 5-10 minutes during practice session in training child to evacuate the stool?		
12	Do you engage your child with play while sitting in potty?		
13	Do you give fluids to your child while going to bed?		
14	Do you teach your child to clean the perineal area after potty or toilet?		
15	Do you accompany your child during potty sitting?		
16	Do you allow your child to empty the bladder before going to bed?		
17	Do you prepare a schedule for toilet trained your child?		

18	Do you take the help of another sibling in toilet training?		
19	Do you show bad expression or make faces when the child evacuates the stool?		
20	Do you scold your child when he/she takes long time to pass the potty?		

APPENDIX -IV

RônUôoL [óÅ TWm

1. YVÇ (YÎ PeLÇp)

- A) 20 YV¾tá ; r
- B) 21-25 YVÇ YûW
- C) 26-30 YVÇ YûW
- D) 31-35 YVÇ YûW

2. URm

- A) CkÇ URm
- B) ÷ Èv ÇY URm
- C) êv m URm
- D) Ut\ UReLs

3. LpÅJ Rá¾

- A) LpÅVÈY A t\Y0
- B) B WmTd LpÅ
- C) ThPRôÃ
- D) ùRôÆp LpÅ

4. À\kR áZkûRLÇu Gi ½dûL

- A) Juñ

- B) CWi ả
- C) Øuñ
- D) Sôu á ARtá úUí m

5. áZkûRÃu YÃûN

- A) Juñ
- B) CWi ả
- C) Øuñ
- D) Sôu á ARtá úUí m

6. ùRôÆp

- A) úYûX YônI Tt\Yo
- B) ãV ùRôÆp
- C) T½ éÃTYôó
- D) CpXj RW°

7. ReLÇu áâmT AûUI é

- A) RÉ dáâmTm
- B) Í hãd áâmTm
- C) ùTÃV áâmTm

8. áâTj ¾u UôR Yî Uô] m

- A) 5000 ÚTôndá j r
- B) 5001 – 10,000 YûW
- C) 10,000dá úUp

9. LÆYÛ\ITÂt° TtÈV RLYÛX ``eLs GRu ØXm AÈk\$oLs?

- A) Øj RYôLs/E\Å] oLs/Si ToLs
- B) āLôRôW Aí YXoL[ó
- C) úW¾úVô
- D) ùNn¾j Rôs / éj RLeLs

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LÆYÛ\ITÂt° TtÈV ùNVpêÛ\ Å] ôdLs

j úZ ùLôâdLI Thás [Å] ôdLô dá B m ApXç CpûX GuT¾p HúRò m JuÈp ✓ áÈ«â CPî m.

Y.Gi	Å] ôdLs	B m	CpûX
1	EeLs áZkûRLô dá LÆYÛ\I TÂt° YZeLI Thás [Rô?		
2	°ñ``o LÆj ç B ÛPLÛ [SÛ] j çd ùLôsô m úTôç EeLs áZkûRÛV ``eLs L¾kç ùLôs@oL[ô?		
3	EeLs áZkûR UXm LÆdám AYNWj ùR Ī ñm úTôç UhâúU LÆYÛ\dá AûZj çf ùNp@oL[ô?		
4	EeLs áZkûRÛV LÆYÛ\Âp UXm LÆdL		

	LhPôVI Táj ç®oL[ô?		
5	áZkûRdá LÆYÛ\I TÂt°ûV AÇITRtLô] úSWj ûR ``eLs Jçdá®oL[ô?		
6	LÆYÛ\ úLôTôTûV úRokûRâI T¾p EeLs áZkûRÂu Teá CpmùT\ A U¾ AÇI ©oL[ô?		
7	LÆYÛ\d Li ÁLû[TtÈj ùRÃkç ùLôs[EeLs áZkûRûV LÆYÛ\dá AûZj çf ùNuñ Cì d, ±oL[ô?		
8	LÆYÛ\I TZdLj ûRj ùRôPokç LûPI Â¼dL EeLs áZkûRûV ``eLs F dLI Táj ç®oL[ô?		
9	LÆYÛ\ ETúVôLj ¾tá Âu] o, EeLs áZkûR úNôI é, Ri o ùLôI â ùLLû[f ãj Rm ùNnYRtá LtÂj ç Es° oL[ô?		

10	BWmT çûX LÆYÛ\I TÂt°Âu útôç EeLs áZkûRÂPm ``eLs úLôTm Utñm LâûUVô] LhâI TôâLû[Lôhâ®oL[ô?		
11	LÆYÛ\Âp áZkûR UXm LÆdám útôç ``eLs 5 êRp 10 çÁPeL[YûW ùNXÂâ, ±oL[ô?		
12	LÆYÛ\Âp UXm LÆdám útôç EeLs áZkûRûV Âû[VôhâLs HúRò m DâTP Aò U¾ AÇI ©oL[ô?		
13	EeLs áZkûR TâdûLdáf ùNpí m útôç AYoLõ dá ``o B LôWm HúRò m ùLôâI ©oL[ô?		
14	LÆYÛ\dáf ùNuñ YkR Âu] o UXm LÆj R EPtTá¾ûV ãj Rm ùNnV EeLs áZkûRdá Ltñd ùLôâj çs° oL[ô?		
15	áZkûR LÆYÛ\dá ùNpí m útôç EeLs áZkûRêPu ``eLs ùNp, ±oL[ô?		
16	EeLs áZkûR TâdûLdá ùNpí m êu °ñ``o LÆdL Aò U¾I ©oL[ô?		
17	EeLs áZkûRdá LÆYÛ\I TÂt° AÇdL HúRò m LôX AhPYûQ RVôo ùNnçs° oL[ô?		
18	EeLs áZkûRÂu LÆYÛ\I TÂt°dá, Utù\ôi áZkûRÂu ERÂûV ùTñ, ±oL[ô?		

19	áZkûR UXm LÆdám ùTôî ç, LâûUVô] ùNôtLû [úVô, (ApXç) Cì LXô] êLj ûRúVô Lôhã®oL [ô?		
20	EeLs áZkûR UXm LÆdL A¾LúSWm Gáj çd ùLôi Pôp AYôLû [d L¼kç ùLôs®oL [ô?		

பிரிவு-ஆ

LÆYÛ\ITÂt° TtÈV AÈî j ¾\ü Å] ôdLs

¡ úZ ùLôádLI Thás[Å] ôdLõ dá NÁVó] ÅúPúV úRokùRáj ç HÚRò m
JuÈp ✓ áÈ«å CPî m.

1. LÆYÛ\ TÂt° TtÈ "eLs AÈYç Gu] ?

✓

- A) NêRôVj Rôp Htñd ùLôs[I ThP CPj ¾p, áÈI ÀhP YV¾p
LÆYÛ\Âp °ñ"o, UXm LÆj Rp
- B) NêRôVj Rôp Htñd ùLôsI ThP CPj ¾p, áÈI ÀhP YV¾p
LÆYÛ\Âp °ñ"o LÆj Rp
- C) NêRôVj Rôp Htñd ùLôs[I ThP CPj ¾p, áÈI ÀhP YV¾p
LÆYÛ\Âp UXm LÆj Rp

2. LÆYÛ\I TÂt° áZkùRdá Hu úRÛYITâ, \ç?

- A) EQ oî Lû[d LhâI Táj R
- B) °ñ"o, Utñm UXm LÆj RÛX LhâI Táj R
- C) Àu] ôp Yi m ÀWfNû] Lû[G¾o ùLôs[

3. UXm LÆj RÛX áZkùR GkR YV¾p LhâI Táj R ùRÃkç ùLôs, \ç?

- A) 2 - 2 1/2 YVç
- B) 2 1/2 - 3 1/2 YVç
- C) 3 YV¾tá úUp

4. °ñ''o LÆj RÛX áZkÛR GKR YV¾p Lhál Táj R ùRÁkç ùLôs, \ç?
- A) 1 – 1 1/2 YVç
- B) 1 1/2 – 2 YVç
- C) 2 YV¾tá úUp
5. °ñ''o LÆj RÛX Epp-¾VôL Jì áZkÛR GI útôç Lhál Táj R RVô, \ç?
- A) áZkÛR _h¼ûV ApXç EËgã ç½ûV SÛ] dám útôç
- B) áZkÛR Rô] ôL SPdLj çYeám ùTôï ç
- C) ¿Áokç áZkÛR EhLôWj ùRôPeám ùTôï ç
6. áZkÛR GI útôç Rô] ôL UXeLÆj Rj RVô, \ç?
- A) °ñ''o LÆj RÛX Lhál Táj R AËëm útôç
- B) UXm LÆdám úLôl ùTûV Rô] ôL ETúVô, dL ùRÁKR ùTôï ç
- C) áZkÛR LÆYû\dáf ùNpX Uñdám ùTôï ç
7. áZkÛR LÆYû\ TÂt° ùTñYRtá RVô, u\ôo GuTÛR AËkç ùLôs [I TVuTám E[ÁVp AËáËLs VôûY?
- A) áZkÛR JúW úSWj ¾p ÕdLj ¾Äì kç Gi méRp
- B) LÆYû\dáf ùNpX úYi ám Gu\ AYNWj ùR Yôoj ùRLs, ùNûLVôp ùYÇI Táj çYç
- C) TádûLÂp °ñ''o LÆI TRôp át\ EQ oî HtTâRp
8. áZkÛRdá, ùTtú\ôoLs LÆYû\ TÂt° YZeL úYi ¼V NÁVô] úSWm Gç?

- A) ùTtú\òoLs LÆYÙ\I TÂt° dLô] úSWj ùRd ùNXÁP RVòWòL
Cì dám ùTòì ç
- B) áZkùRùVI TtÈV U] I TVm HtTámúTôç
- C) áZkùRùV ùYÇÂPeLõ dá AùZj çf ùNpí m úTôç

9. LÆYÙ\I TÂt° Âp ùTtú\òoLÇu B WmTdLhP ùTòñl éLs Gu] ?

- A) LÆYÙ\ TÂt° ùLòáI TRtLô] LôX AhPYùQ ùVj RVòo ùNnRp
- B) LÆYÙ\Âp TVuTáj R úYi ¼V ùTòì hLù[áZkùRdá AÈV
ùYj Rp
- C) LÆYÙ\ùV ETúVò, dL áZkùRùVd LhPòVI Táj çRp

10. LÆYÙ\ TtÈV B WmTLhP TÂt° ùVd ùLòá dám ùTòì ç ùTtú\òoLs
áZkùRÂPm GqYòñ SPKç ùLòs[úYI ãm?

- A) LảùUVô] NhP¾hPj ùRèm, úLòTj ùRèm ùYÇI Táj çRp
- B) AùU¾Vô] , ãRk¾WUò] Yòoj ùRLù[ETúVò, j Rp
- C) Bj ¾WØhãm LảgùNòtLù[ETúVò, j Rp

11. LÆYÙ\I TÂt° ùV Ltám ùTòì ç áZkùR GKR Uò¾ÁVò] YÃùN
éù\ùV ÀuTtñm?

- A) TLp úSWj ¾p ° ñ"o, UXm LÆj RùX LhảI Táj çRp
- B) CWì úSWj ¾p ° ñ"o, UXm LÆj RùX LhảI Táj çRp
- C) UXm LÆj RùXd LhảI Táj Rp, TLp úSWj ¾p ° ñ"o LÆj RùXd
LhảI Táj Rp

12. LÆYÙ\I TÂt° Âu úTôç UXm LÆj Rp GqY[↑ úSWm SùPùTñm

A) 5 ħÁPj ¼tá áû\YôL

B) 5 – 10 ħÁPeLs

C) 10 – 30 ħÁPeLs

13. LÆYÛ\I TÂt°d ùNVpTôâLÛ[ê¼dL GqY[î LôXm úRÛYITá, \ç?

A) JqùYôi áZkÛRÛVI ùTôñj Rç

B) ùTtú\ôûWI ùTôñj Rç

C) LÆYÛ\d Li ÁûVI ùTôñj Rç

14. LÆYÛ\I TÂt°Âu úTôç áZkÛRLs NK¼dám A¼L U] Aï j R ÑrçûX Gç?

A) áËj R LôXj ¼tás TÂt°ûV ê¼dL úYi ¼V ÑrçûX HtTám ùTôï ç

B) áámT AeLj ¼] oLçu G¼oTôol ùT xoj ¼ ùNnV CVXôûU

C) ùTtú\ôoLÛ[U, rf°ITáj R CVXôûU

15. ùYtÈLWUôL ê¼dLI ThP LÆYÛ\I TÂt°Âu AÈáÈLs Gu] ?

A) áZkÛR LÆYÛ\ ETúVôLj ùR ùRĀkç ùLôi PRôL ùNôp, \ç

B) NĀVô] úSWj ¼p áZkÛR LÆYÛ\ûVI TVuTáj ç, \ç

C) Rô] ôLúY °ñ'o, UXm LÆj RÛX NĀTáj ç, \ç

16. UXm LÆj R Âu áZkÛR AkRI Tá¼ûV GqYôñ áj Rm ùNnV úYI ám?

- A) êuÉ ì kç ÀuTôL
- B) ÀuTá¾ÄÄì kç êu] ôL
- C) TdLYôh¼p

17. LÆYÛ\ÛVI TVuTáj ¾V Àu áZkÛRdá Ru āj Rj ÛRI TtÈ AËYñj çYç Gu] ?

- A) ÛLLÛ[úNôl , Ri | Wôp āj Rm ùNnRp
- B) êZeLôp ; r Tá¾ÛV úNôl é, Ri | Wôp āj Rm ùNnRp
- C) EPmé êi Yçm úNôl é, Ri | Wôp āj Rm ùNnRp

18. LÆYÛ\I TÂt°ÛV ùRôPøkç ÀuTt\ áZkÛRdá GqYôñ "eLs ERÍ @o?

- A) áZkÛRÛV éLrkç úTâRp
- B) Ut\ áZkÛRúVôâ JI ÀâRp
- C) áZkÛRÂPm G¾oUÛ\Vô] ùNôtLÛ[ETúVô, j Rp

19. áZkÛR LÆYÛ\I TÂt°ÛV ùTtñd ùLôs[UñdámùTôì ç RôeLs Gu] ùNn@o?

- A) áZkÛR LhPôVI Táj Rp
- B) LÆYÛ\ÛVI TÂt°ÛV çñj çRp
- C) áZkÛRÛV F dLI Táj çRp

20. ; rdLi PYtÈp áZkÛR GkR EQ of°ÛV A¾Lm Að TÂd, \ç?

- A) áZkûR °ñ''o LÆITûR ÅP UXm LÆdám úTôç A¾L
EQ of° ûV Aò TÅd, \ç.
- B) áZkûR LÆITûR ÅP °ñ''o LÆdám úTôç A¾L EQ of° ûV
Aò TÅd, \ç.
- C) áZkûR UXm LÆITûR ÅP ARò Pu Åû[Vôâm úTôç A¾L
EQ of° ûV Aò TÅd, \ç.

APPENDIX –V

KEY ANSWER

Srl. No.	Knowledge Questionnaire
1	A
2	B
3	A
4	B
5	B
6	B
7	B
8	A
9	B
10	B
11	C
12	B
13	A
14	C
15	B
16	B
17	A

Srl. No.	Practice Questionnaire
1	Yes
2	No
3	No
4	No
5	Yes
6	Yes
7	Yes
8	Yes
9	Yes
10	No
11	Yes
12	No
13	No
14	Yes
15	Yes
16	Yes
17	Yes

18	A
19	B
20	A

18	No
19	No
20	No