

AWARENESS AND ACCEPTANCE OF TEMPORARY METHODS OF CONTRACEPTIVE AMONG PRIMIPAROUS WOMEN

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ABSTRACT

BACKGROUND

Contraceptive advice is a component of good preventive healthcare. Socioeconomic factors, education are a few of factors that play vital role in family planning acceptance. To provide this, understanding the attitude and knowledge of patient towards contraception is very much necessary. Objective of this study is to assess the awareness and acceptance of temporary methods of contraception in postpartum primiparas during their first visit to Family Planning OPD, MCH, Kottayam.

MATERIALS AND METHODS

A hospital-based prospective descriptive study was conducted among the primiparas presented in Family Planning OPD for the first time in postpartum at 6 wks. in MCH during the study period. Informed written consent was obtained from the patients. The study subjects were interviewed with questionnaire to assess the awareness and acceptance of temporary contraceptive methods and the level to which each of them will keep compliance. The questionnaire was to elicit information regarding age, educational status, occupation, knowledge and source of contraceptive methods, attitude of female towards contraception.

RESULTS

In our study, majority include graduates (37%), but most of study population were unemployed (43.2%). Literate people are more conscious about their own health and that of their families and try to limit their families much more effectively than the illiterates do. The awareness of the group about contraception was 80.5%, mostly through health workers, 39.6%. 53.9% of the study population had accepted any of the temporary contraceptive methods; maximum opted being the barrier contraception, 19%. 60.9% had peer group support. 74.5% had antenatal counselling from a healthcare worker regarding the use of temporary contraceptive methods. Acceptance was maximum among the graduated subjects, 66.9%. The type accepted by graduates include mostly barrier. Contraceptives, 23.2%. 48% of the graduates used for the need of spacing. A maximum peer group support of 68.3% was found among the graduates. 81.7% of the graduate people had met and received counselling from healthcare worker regarding the contraceptive usage.

CONCLUSION

Consistent success for the family welfare programme can be ensured only if community demand is generated. Healthcare workers and peer group support plays an important role in improving awareness and acceptance of contraceptive methods.

KEYWORDS

Family Planning, Postpartum, Healthcare Workers.

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BACKGROUND

Lack of knowledge regarding the various methods of contraception is the reason for not practising family planning methods. Contraceptive advice is a component of good preventive healthcare. It is very much necessary to stabilise the population and to conserve natural sources to future

generations. An ideal contraceptive should suit an individual's personal, social and medical characteristics and requirements. Socioeconomic factors, education are a few of factors that play vital role in family planning acceptance.

Emphasis should be made on communication and good counselling to women giving correct information about the availability, source and side effects of contraceptive methods. The major source of knowledge is social circle and media. Mass media plays an important role in promotion and acceptability of contraception.

Family planning can avert nearly one-third of maternal deaths and 10% of child mortality when couples space their pregnancies more than two years apart.¹ Short intervals between births are linked with higher maternal and child mortality and morbidity. Postpartum family planning is the

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prevention of unintended and closely spaced pregnancies through the first twelve months following childbirth. Postpartum women need a range of effective contraceptive methods to be able to prevent an unplanned pregnancy within a short interval.

Postpartum counseling should be planned to be initiated for postpartum women. Sunita Ghike 2005 found out that 67.5% of women were aware about temporary methods of contraception, but the number of women practicing contraception was very low, 35.7% and the main reason of non-practice of contraception was family pressure. It was noted that though knowledge of at least one method of contraception was wide among women, actual practice was very low.

Sarah² conducted a study on postpartum contraceptive use among low income women in Mexico. Overall, 47% of women used a modern contraceptive method. Women who received family planning advice during prenatal care were more likely to use a contraceptive than those who did not receive such advice. Women who received family planning advice had a higher probability of using condoms and IUDs. Integrated family planning advice into prenatal care maybe an important strategy for reaching women when their demand for contraception is high.

Two trials conducted by Huntington and Aplogan demonstrated that integration of family planning service delivery results in increased contraceptive use or uptake.

The focus of the paper, contraceptive knowledge and practice by women attending antenatal clinic in Ilea, Nigeria, by Ogunjuyige et al (1996) was to examine whether attendance at antenatal clinics does increase the knowledge and attitude of women who attend antenatal health clinics and consequently increased their use of modern contraceptives.

K.K. Singh concluded that comparison regarding postpartum contraceptive use between rural and urban women of India shows that rural women are still lagging behind with regard to awareness of postpartum contraceptive use.³

Sebastian⁴ studied that targeted behaviour change communication using community workers is an effective and feasible strategy for promoting postpartum contraception. Stephenson⁵ concluded that education in the postpartum period may increase awareness and even desire to use contraception.

MATERIALS AND METHODS

Fertility Awareness

Periodic abstinence requires avoiding intercourse during the fertile period around the time of ovulation. Various methods are the calendar method, the mucous method (billings or ovulation method) and the symptothermal method, which is a combination of the first two methods.

Breast Feeding

Breastfeeding can be used as a form of contraception. Ovulation is suppressed during lactation. The suckling of the infant elevates prolactin levels and reduces Gonadotropin-

Releasing Hormone (GnRH) from the hypothalamus, reducing Luteinising Hormone (LH) release and thus inhibiting follicular maturation.

Condoms

Condoms usually are made of latex rubber, but condoms made from non-latex materials such as polyurethane or synthetic elastomers that are thin, odourless, transparent are available. Sexually transmitted diseases and Pelvic Inflammatory Disease (PID) are reduced with consistent use of barrier methods.

Vaginal Spermicides

Vaginal spermicides combine a spermicidal chemical, either nonoxynol-9 (N-9) or octoxynol with a base. Nonoxynol-9 is a nonionic surface-active detergent that immobilises sperm.

Vaginal Barriers

Four types of vaginal barriers were used in vaginal diaphragm, cervical cap, vault cap and vimule. When used consistently, vaginal barriers can be reasonably effective. They are safe, and as with condoms, they have the non-contraceptive benefit of relative protection from STDs and cervical neoplasia.

Intrauterine Contraception

15% of married women worldwide use intrauterine contraception. Two IUDs are- The copper T380A Levonorgestrel-releasing T (Mirena). The copper T380A has bands of copper on the cross arms of the T in addition to copper wire around the stem providing a total surface area of 380 mm of copper. It is approved for up to 10 years of continuous use.

Hormonal Contraception

Hormonal contraceptives are female sex steroids, synthetic oestrogen and progestin. They can be administered in the form of OCs, patches, implants and injectables. The most widely used hormonal contraceptive is the combination OC containing both oestrogen and progestin. Progestin-only OCs are taken every day without interruption. Other forms of hormonal contraception include transdermal administration with the patch, injectable progestins, injectable oestrogen-progestin combinations, subdermal implants that release progestin and vaginal rings that release either oestrogen-progestin or progestin alone.

Emergency Contraception

- Levonorgestrel.
- The copper intrauterine device.

Sterilisation

Surgical sterilisation is the most common method of fertility control used by couples, tubal sterilisation or vasectomy.

1. Female sterilisation.

This can be any of these-

- Tubal sterilisation at the time of laparotomy for a caesarean delivery or other abdominal operation.

- Postpartum minilaparotomy soon after vaginal delivery.
 - Interval minilaparotomy.
 - Laparoscopy.
2. Vasectomy.

Vasectomy is usually performed under local anaesthesia. The basic technique is to palpate the vas through the scrotum, grasp it with fingers or atraumatic forceps, make a small incision over the vas and pull a loop of the vas into the incision. A small segment is removed and then a needle electrode is used to coagulate the lumen of both ends.^{6,7}

OBJECTIVE

To study the awareness and acceptance of temporary methods of contraception in postpartum primiparas during their first visit to Family Planning - Outpatient Department, Medical College, Kottayam.

METHODOLOGY

Study Design	Descriptive study
Study Setting	Family Planning - OPD, Department of Obstetrics and Gynaecology, MCH, Kottayam.
Study Duration	1 year, June 2015-June 2016.
Study Population	Primiparas during their first postpartum visit in family Planning OPD, Department of Obstetrics and Gynaecology, MCH, Kottayam.

Inclusion Criteria

1. Postpartum primiparas.
2. Women living with their husbands.
3. Age between 18-45 yrs.
4. Primiparas including history of abortions.

Exclusion Criteria

1. Multiparas.
2. Male partners.

Sample Size Calculation-
Sample size

$$N = Z_{1-\alpha/2}^2 \times P(1-P) / (\epsilon P)^2$$

α = Type 1 error (fixed at 5% level).
 P = Proportion having accepted temporary contraceptive methods among primiparas taken as 50%.
 E = Relative precision taken as 10% of p.
 Sample size, $N = 1.96^2 \times 0.5 \times 0.5 / (10/100 \times 0.5)^2 = 384$.

Study Tool- Questionnaire, record.

Study Procedure

After getting ethical committee clearance and consent from the Department of Obstetrics and Gynaecology, MCH, Kottayam, a hospital-based prospective descriptive study will be conducted among the postpartum primiparas presented in FP-OPD for the first time in MCH. Interviewer herself will visit the study subjects and conduct the study. Informed written consent will be obtained from the patients. The study subjects will be interviewed with questionnaire to assess the awareness and acceptance of temporary contraceptive methods and the level to which each of them will keep compliance. The questionnaire is to elicit information regarding age, educational status, occupation, number of children, knowledge and source of contraceptive methods and attitude of female towards contraception.

OBSERVATIONS AND RESULTS

	Education						Analysis	
	Primary		Higher Secondary		Graduate and Above		Chi-square	p-value
	No.	%	No.	%	No.	%		
Meaning of contraception	7	19.4	86	66.7	216	98.6	146.9	0.000
Benefits known	4	11.1	79	61.2	210	95.9	147.3	0.000
Risks known	0	0	25	19.4	93	42.5	37.9	0.000
Attitude								
Positive	3	8.3	52	40.3	145	66.2	56.4	0.000
Neutral	3	8.3	16	12.4	10	4.6		
Negative	30	83.3	61	47.3	64	29.2		
Advice During ANC by Health Worker								
Yes	24	66.7	87	67.4	175	79.9	7.9	0.019
No	12	33.3	42	32.6	44	20.1		

Table 1. Relationship between Education and Different Aspects of Contraception

Source of information	Education						Total	
	Primary		Higher Secondary		Graduate and Above			
	Count	%	Count	%	Count	%	Count	%
Media	1	2.8	13	10.1	40	18.3	54	14.1
Social circle	3	8.3	30	23.3	72	32.9	105	27.3
Health personnel	3	8.3	43	33.3	106	48.4	152	39.6
Never heard	29	80.6	43	33.3	1	0.5	73	19.0
Total	36	100.0	129	100.0	219	100.0	384	100.0

Table 2. Relationship between Education and Source of Information about Contraception

Chi-square=155.2; p=0.000.

Type Accepted	Education						Total	
	Primary		Higher Secondary		Graduate and Above			
	No.	%	No.	%	No.	%	No.	%
Safe period	0	0.0	1	0.8	17	7.8	18	4.7
Lactational amenorrhoea	1	2.8	5	3.9	13	5.9	19	4.9
Barriers	0	0.0	22	17.1	51	23.3	73	19.0
IUCD	2	5.6	15	11.6	41	18.7	58	15.1
Oral contraceptives	0	0.0	6	4.7	23	10.5	29	7.6
Injectables	0	0.0	6	4.7	4	1.8	10	2.6
Not accepted	33	91.7	74	57.4	70	32.0	177	46.1
Total	36	100.0	129	100.0	219	100.0	384	100.0

Table 3. Type of Contraception Accepted and Education

Chi-square=65.1; p=0.000.

DISCUSSION

There are nearly 40 million women in India who would prefer to avoid becoming pregnant, but not practicing contraception. According to NFHS-3, about 30% of fertility in India is unwanted indicating a huge gap between demand and supply of family planning methods.⁸ The unmet need for the country as a whole is about 13% and this is high among married women aged 15-19 yrs. (25% for spacing and 2% for limiting) and among those aged 20-24 yrs. (15% for spacing and >6% for limiting). 85% of contraceptive users in India are women.⁹ Evidence from a number of small scale studies in various parts of the country indicates that inadequate knowledge of contraceptive methods is a reason for not accepting family planning. In Indian studies, awareness rate is 82.8%. But, in practice, only 55% of women are using contraceptive methods. 55.5% women are not using them due to lack of knowledge about their usage. 29.7% expressed concerns about side effects as the reason for not using.

In our study, majority include graduates (37%), but most of study population were unemployed (43.2%). Literate people are more conscious about their own health and that of their families and try to limit their families much more effectively than the illiterates do. The awareness of the group about contraception was 80.5%, mostly through health workers, 39.6%.

53.9% of the study population had accepted any of the temporary contraceptive methods; maximum opted being

the barrier contraception, 19%. Khawaja¹⁰ found that the main source of information was television (26%) and relatives (24%) and the most common method chosen was the barrier method (15%), followed by IUCD (10%) and the pill (10%).

76.3% were aware of the benefits, 30.7% were aware of the risks, 17.7% had previous history of adverse effects, 42.7% of study population showed approval for the use of temporary contraceptive method; for majority, the need is spacing, 29.7%.

60.9% had peer group support. 74.5% had antenatal counselling from a healthcare worker regarding the use of temporary contraceptive methods. Burgard found that given the important role that health service providers play in women's knowledge and perceptions of contraceptive methods.¹¹

The main reason for subjects not using was the partner opposition, 14.8%. Bhasin found that amongst the subjects who were not using contraceptives, the most common reason for not doing so was the desire for more children (36.4%).¹²

The contraceptive meaning was known to maximum among graduated subjects, 99.3% of whom the major source of information was through the health worker, 51.4%.

Acceptance was maximum among the graduated subjects, 66.9%. The type accepted by graduates include mostly barrier contraceptives, 23.2%. 57.7% of the

graduates showed approval for contraceptive use. 48% of the graduates used for the need of spacing. A maximum peer group support of 68.3% was found among the graduates. A majority of people with higher secondary education were not using contraception due to lack of knowledge, 24%.

81.7% of the graduate people had met and received counselling from healthcare worker regarding the contraceptive usage.

66% of the population aware of the meaning of contraception, had acceptance. The majority showed an attitude of approval of contraception, 53.1%. Among them, the reason for using was maximum for the need of spacing, 35.9%.

Of these subjects, the maximum chose barrier contraception, 23.2%. Bhasin¹² studied that condom was the most common method (33.4%) of contraception followed by tubectomy (27.3%), oral pills (16.6%) and intrauterine device (15.7%). The reason for not using was mainly due to partner opposition, 14.2%.

A majority of people who have met and received contraceptive advice from healthcare workers during the antenatal period, 85.4% had an attitude of approval of the method. Among them, a majority had peer group support 69.5%.

CONCLUSION

Various temporary contraceptive methods are safe and effective. Awareness of these was good among the study population. Majority have heard about these from the healthcare workers. Graduated subjects were more receptive to the acceptance of contraception. Healthcare workers and peer group support plays an important role in improving awareness and acceptance of contraceptive methods. This has to be promoted as temporary contraceptive methods can be used as effective pillars to maintain the spacing need of the population.

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