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A Study of the Impact of Structured Counselling in Women's Selection of Postpartum Contraception in Rural Tertiary Care Centre

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Abstract

Introduction: *Women's reproductive rights, including control over childbearing, are vital for empowerment. Postpartum family planning (PPFP) is essential, as many women want to avoid pregnancy but lack contraception. Effective counselling during the postpartum period can reduce maternal and child mortality and address unmet family planning needs, particularly in rural areas.*

Methods: *This cross-sectional interventional study at Dr. Rajendra Prasad Government Medical College assessed contraceptive counselling for women aged 18-40 during pregnancy and postpartum. Inclusion criteria focused on antenatal and immediate postpartum women, while ethical counselling addressed efficacy, misconceptions, and side effects. Follow-ups evaluated compliance one month after method initiation*

Results: *Counselling sessions were beneficial for 96.36% of participants, leading 95% to choose a contraceptive method. Pre-counselling, 23.76% were undecided; post-counselling, this dropped to 4.96%. Notably, acceptance of the Copper T and DMPA injections increased. The calendar method usage decreased significantly by 66.6%. Reasons for selecting methods included ease of use (56.94%), reduced need for frequent visits (22.91%), and avoidance of hormones (6.25%). These findings highlight the positive impact of counselling on women's contraceptive decision-making and method acceptance.*

Conclusion: *We concluded from our study that effective structured family planning counselling is one of the cornerstones for increasing contraceptive acceptance and use during the post-partum period.*

Keywords: Contraception, Antenatal, Postpartum, Counselling, Family Planning.

Introduction

Reproductive rights and family planning play pivotal roles in empowering women and ensuring equality. Acknowledgment of these rights has grown globally, underscoring benefits such as improved health, economic prosperity, and social welfare for women and families[1]. Postpartum Family Planning (PPFP), defined by the World Health Organization (WHO) as preventing unintended and closely spaced pregnancies in the first 12 months post childbirth, is crucial[2]. WHO recommends a minimum 2-year gap between childbirth and subsequent conception to mitigate risks to maternal and child health[3].

The need for PPFP counselling is essential as,

- Ninety five percent of women who are 0–12 months postpartum want to avoid a pregnancy in the next 2 years but 70% of them are not using contraception[4].

- PPFP can prevent more than 30% of maternal deaths and 10% of child mortality if pregnancy is spaced for more than 2 years [5].
- Risk for mother and baby increases if pregnancy is closely spaced within the first year of postpartum [6].
- Risk of child mortality is highest for very short birth-to-pregnancy intervals (<12 months)[7].

Despite the clear benefits of PPFP, many postpartum women express a desire to delay or avoid pregnancy, yet a significant proportion do not use contraception effectively. Furthermore, data from various studies, including the National Family Health Survey (NFHS) and Demographic and Health Surveys (DHS), highlight suboptimal birth intervals in many regions, including India, where challenges such as unmet contraceptive needs persist due to service limitations, lack of information, and social barriers [8],[9].

Structured counselling sessions on PPFP aim to provide comprehensive information, address concerns, and support decision-making, thereby enhancing contraceptive acceptance and usage.

Despite advancements in contraceptive awareness and utilization in regions like Himachal Pradesh, significant gaps in knowledge persist, particularly regarding less commonly known methods[10].

Therefore, this study aims to evaluate the impact of structured counselling on decision-making among postpartum women, promoting the adoption of effective contraceptive methods to achieve optimal birth spacing and reduce unintended pregnancies.

Material and Methods

This study was conducted in the department of Obstetrics and Gynaecology at of a tertiary care centre over one year and 303 women were counselled.

Inclusion Criteria

1. Age 18-40 years.
2. Antenatal women visiting outpatient department in third trimester.
3. Women in immediate postpartum period.
4. Postpartum women within 8 weeks of delivery during (a) their post-natal check-up (b) while attending clinic for vaccination of the infant.

Exclusion Criteria

1. Postpartum women choosing permanent method of contraception.
2. Postpartum women more than 8 weeks post-delivery.
3. Women not willing to participate in study.
4. Age >40 years.

c) Counselling

Counselling employed best practices including effective communication of contraceptive efficacy, addressing misconceptions, discussing side effects and risks, and optimizing decision-making. Ethical standards were upheld with a patient-centred approach guided by the Medical Eligibility Criteria for Contraceptive use by WHO[11]. Sessions occurred in dedicated counselling rooms and at bedside for immediate postpartum women, utilizing educational materials to explain government-provided and market-available methods impartially.

d) *Questionnaires*

Questionnaires were administered pre- and post-counselling, with data analysed using a study proforma. Chosen contraceptive methods were noted on antenatal or discharge cards, with interval IUCD recipients scheduled for insertion at 6-7 weeks postpartum.

Statistical analysis involved frequencies, percentages, and associations using Chi-square and Fisher's exact tests for qualitative variables, and t-tests or Mann-Whitney tests for quantitative data. SPSS 26.0 and Excel 2021 facilitated analysis and graphical representation.

Results

The study revealed that the majority of participants, primarily aged 24-29 years (56.11%) and predominantly literate (93.4%) with high school education (57.24%), were largely unemployed

(57.76%) and Hindu (79.21%). Most had one live child (56.77%). Table 1 shows awareness about family planning. A majority of women were aware of family planning prior to counselling. Awareness of natural contraceptive methods was significant: withdrawal (33.66%), Lactational amennorhea method (LAM, 21.78%), and the safe period (34.65%). For temporary methods, barrier methods were known by 80.20%, oral contraceptives and progestin-only pills by 65.68%, Copper T by 46.86%, and Depot-medroxy progesterone acetate (DMPA) by 49.83%. Awareness of implants was very low at 1.98%. Regarding permanent methods, tubectomy was recognized by 19.80%, while vasectomy had a lower recognition rate of 9.98%. Half of the women understood the ideal interpregnancy interval should be at least two years, and 87.12% believed family planning benefits both mother and child, compared to 12.87% who did not.

Table 1: Awareness about family planning

Awareness about family planning (n=303)			**Percentage (%)**
Yes	258		85.15
No	45		14.85
Awareness about types of contraceptive methods			
Natural			
a) Withdrawal	102		33.66
b) Safe period (Calendar method)	105		34.65
c) Lactational Amenorrhoea	66		21.78
Temporary			
Copper T	142		46.86
DMPA (Injections)	151		49.83
Pills (OCPs/POPs)	199		65.68
Barrier	243		80.20
Implants	6		1.98
Permanent			
Tubectomy	60		19.80
Vasectomy	30		9.98
Attitude regarding birth spacing			
Ideal interpregnancy interval	1 year	150	49.50
	2 years	105	34.65
	3 years	48	15.84
Family planning is good for mother and child	Yes	264	87.13
	No	39	12.87

Table [2] shows practice of contraceptive methods prior to counselling. Contraceptive methods were used by 76.23% of women, while 23.76% were not using any method. Among those using contraception, 21.11% relied on natural methods. Temporary methods included barrier methods used by 31.68%, Copper T by 11.22%, and oral contraceptives by 13.63%, with only 0.33% using DMPA. Reasons for not using contraception included spouse disapproval (28.71%), fear of potential complications (5.28%), and cultural or religious factors (0.99%).

Table 2: Practices about contraceptive methods: Pre-Counselling

Use of contraceptive methods among women(n=303)	**No. of women**	**Percentage (%)**
Yes	231	76.23
No	72	23.76
Type of contraceptive methods being used		
Natural		
a) Withdrawal	37	12.21
b) Safe period	27	8.9
Total	64	21.11
Temporary		
a) Copper T	34	11.22
a) DMPA (Injections)	1	0.33
b) Pills	36	3.63
c) Barrier	96	31.68
Total	167	55.11
Reason of not using any contraception		
Husband doesn't allow	87	28.71
Religion/Culture doesn't allow	3	0.99
Fear of Complications	16	5.28
Wanted Child	50	16.50

After counselling [Table 3], The counselling sessions were considered helpful by 96.36% of participants. Post-counselling, 95% opted for a contraceptive method, a significant increase from the 23.76% undecided before counselling, which decreased to 4.96% afterward. The use of natural methods saw notable declines: withdrawal use dropped by 18.91% and the calendar method by 66.6%. There was a substantial increase in Copper T usage from 11.22% to 37.62%, and DMPA usage surged from 0.33% to 17.82%. Pills usage rose slightly from 13.63% to 13.21%, while barrier method usage decreased from 31.68% to 10.60%.

Implants, previously unused, were chosen by 2.97% of participants post-counselling. Reasons for choosing contraception included ease of use (56.94%), avoiding repeated administration (13.88%), reduced hospital visits (22.91%), and avoiding hormones or foreign bodies (6.25%)

Table 3: Distribution of women w.r.t. impact of counselling

Counselling session helpful (n=303)	Number of participants		Percentage
Yes	292		96.36
No	11		3.64
Able to choose contraception (n=303)			
Yes	288		95.04
No	15		4.96
Practice of contraception among women	Pre counselling (Women using any method)	Post counselling (Women opted for method)	Change (%)
Natural			
Withdrawal	37	30	-18.91
Safe period (Calendar method)	27	9	-66.6
Total	64	39	-39.06
Temporary			
Copper T	34	114	Increase
DMPA (Injections)	1	54	Increase
Pills	36	40	Increase
Barrier	96	32	Decrease
Implants	0	9	-
Reason for opting contraception (n=288)			
Easy to use	164		56.94
No repeated administration	40		13.88
No frequent hospital visit	66		22.91
No exposure to hormone or foreign body	18		6.25

Discussion

Our study revealed that 85.15% of women were aware of various contraceptive methods prior to counselling, a finding consistent with studies by Thapa S et al.[12] in which 69 % women had heard about various methods of contraception and Nath J et al.[13] in which 72% women had knowledge.

It was observed that the patients were familiar with the names of various contraceptive methods, they were unaware of their benefits, method of using, and duration of effectiveness. 21.11% of participants relied on natural methods of contraception, with 12.21% depending on withdrawal method and 8.9% on the safe period method. These findings are in line with the study by Bangal VB et al[14], in which 20% of primigravida were dependent on natural methods (LAM 12 % and safe period 8%) and 16% of multigravida were dependent on natural methods (LAM 9% and safe period 8%)

Impact of structured counselling was that, 95% of women expressed a readiness to adopt a contraceptive method, the finding which is similar to previous research by Chabrra HK et al.[15] where 91.35% women chose contraception after counselling. The proportion of women relying on natural methods decreased by 39.06% in our study. The use of Long-Acting Reversible Contraceptives (LARC), like copper T and DMPA, increased significantly, with 39.58 % women chosing copper T and 18.75% women chosing DMPA. Following structured counseling there was clarification of misconceptions about these methods. The convenience of use and their availability at government hospitals were pivotal factors in the decision-making process. Similar results were found in study by Chabbra HK et al.[15] where 23.07 % women opted for copper T and 21.36 % women opted for DMPA.

It was observed that decision for contraception choices was also influenced by the opinions of other family members. Hence including family members during contraception counselling can play a vital role is increasing acceptance for opting reliable contraception method. Despite the positive outcomes, some women reported apprehensions regarding side effects, including weakness (9.57%), menstrual irregularities (7.92%), and mood swings (6.93%). These concerns can be addressed through one-on-one counselling, as suggested by our findings.

One major challenge in reaching remote populations for contraception counselling is geographic isolation. However, telecommunication offers a promising solution. By utilizing digital platforms, the rural and far-flung population can be given structured counselling, through which experts can provide essential information. Virtual consultations, webinars, and mobile health applications can deliver real-time, personalized guidance, address misconceptions, and answer questions.

Conclusions

We concluded from our study that structured effective family planning counselling is one of the cornerstones for increasing contraceptive acceptance and use during the post-partum period. The present study highlights the need to conduct family planning counselling during the antenatal period and immediate postpartum period, particularly before the discharge of women from health care facilities so as to ensure improved contraceptive acceptance. This would curb unwanted pregnancies, unsafe abortions, improve birth spacing, reduce the high fertility rate and maternal and child morbidities and mortalities. We also concluded from our study that women are keen to adopt long-acting reversible contraceptive (LARC) methods as they are available in every institute of our state free of cost. Hence in future, Government should focus on bringing up more contraceptive methods under National Family Planning Programme like implants and progesterone only pills specially for lactating women.

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References

1. Ram, U. Contraceptive Use among Young Married Women in India. International conference on family planning: research and best practices to be jointly organized by Bill and Melinda Gates Institute for Population and Reproductive Health, John Hopkins University, School of Public Health, USA, Makerere University, School of Public Health during November 15-18, 2009 at Munyonyo, Uganda.
2. WHO. Programming strategies for Postpartum Family Planning. Department of reproductive health and research. Geneva (Switzerland).WHO:2013.
3. WHO Report of a WHO technical on birth spacing. Department of making pregnancy safer. Department of reproductive health and research. Geneva (Switzerland). WHO:2015.
4. John A. Ross, William L. Winfrey. Contraceptive use, intention to use and unmet need during extended postpartum period. International Family Planning Perspectives, 2001, 27(1):20–27.
5. John Cleland et al. Family planning : the unfinished agenda. Sexual and reproductive health. 2006; 368.
6. DaVanzo J, Hale L, Razzaque A, Rahman M. Effects of inter pregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh. BJOG 2007;114:1079–1087.
7. Shea O. Rutstein, Further evidence of the effects of preceding birth intervals on neonatal, infant and under five years mortality and nutritional status in developing countries. Demographic and Health Research Division, Macro International Inc. 11785 Beltsville Drive, Calverton, MD 20705, USA. 2008;41:72.
8. Rutstein, SO. Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in

developing countries: evidence from the demographic and health surveys. Int J Gynecol Obstet. 2005;89:S7-24.

9. International Institute for Population Sciences (IIPS). The third national family health survey (NFHS-3), India, 2005-06. Int Insti Popul Sci Mumbai. 2007;2:1-168.
10. International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), India, 2019-21: Himachal Pradesh. Mumbai: IIPS.
11. World Health Organization. Medical eligibility criteria for contraceptive use. 5th ed. Geneva: World Health Organization; 2015.
12. Thapa S, Rani A, Mishra CP. Knowledge, attitude and belief about contraception in post-partum and post abortal women in a tertiary care centre. Int J Reprod Contracept Obstet Gynecol 2014; 3:533-9.
13. Nath J, Islam F. A Study on the Knowledge, Attitude and Practice about Contraception in Postpartum Women of North India. International Journal of Science and Research (IJSR). 2014;5(6):611.
14. Bangal VB, Thitame S, Somasundaram KV. Role of peri-partum counselling in improving choice of postpartum contraception. Int J Reprod Contracept Obstet Gynecol 2020;9:3018- 24.
15. Chhabra HK, Mohanty IR, Mohanty NC, Thamke P. Impact of Structured Counseling on Choice of Contraceptive Method Among Postpartum Women. The Journal of Obstetrics and Gynecology of India. 2016;66(6):471–479.