EFFECT OF ANTENATAL AND IMMEDIATE POSTPARTUM COUNSELLING ON ACCEPTANCE OF CONTRACEPTION

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GOVT. DHARMAPURI MEDICAL COLLEGE &

HOSPITAL, DHARMAPURI

MAY- 2022

REG NO- 221916003

CERTIFICATE

This is to certify that the dissertation entitled **EFFECT OF ANTENATAL AND IMMEDIATE POSTPARTUM COUNSELLING ON ACCEPTANCE OF CONTRACEPTION** is the bonafide original work of **Dr. S. Mekala** in partial fulfilment of the requirements for **M.S. (Obstetrics and Gynaecology)** Examination of the Tamilnadu Dr. M.G.R. Medical University to be held in May 2022. The period of study was from December 2019 to July 2021.

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DECLARATION

I, Dr. S. MEKALA, solemnly declare that dissertation titled, EFFECT OF ANTENATAL AND IMMEDIATE POSTPARTUM COUNSELLING ON ACCEPTANCE OF CONTRACEPTION is a bonafide work done by me at Govt. Dharmapuri Medical College & Hospital, during 2019-2021 under the guidance and supervision of my Chief Prof. Dr.R.PADMAPRIYA, M.D. OG

The dissertation is submitted to Tamilnadu, Dr. M.G.R. Medical University, towards partial fulfilment of requirement for the award of **M.S in Obstetrics and Gynecology.**

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ABBREVIATIONS

WHO – World Health Organisation

NFHS – National Family Health Survey

KAP- Knowledge, Attitude, Practices

LN – Labor Natural(Normal vaginal delivery)

LSCS- Lower Segment Cesarean Section

ST – Female permanent sterilization (Tubectomy)

PPIUCD – Post partum Intra Uterine Device

OCP – Oral Contraceoptive Pills

ANTARA- Depot Medroxy Progesterone Acetate (Injectable Harmone Contraceptives)

P – Parity

G – Gravida

L – No of live children

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INTRODUCTION

INTRODUCTION

India is the second most populous country in the world. Baseline population is 1100 million at present and the natural increase of 1.7% in India is a matter of serious concern. If the current trend continues, India will overtake China in 2045. National population policy 2000, stated that stabilizing the population is an essential requirement for promoting sustainable development with more equitable distribution.

India is the first country in the world to formulate demographic goal and take up a government sponsored **Family Planning Programme** in conjunction with first five year plan as early as in 1951(1951-1956) with the objective of reducing the birth rate to the extent necessary to stabilize the population at a level consistent with reputement of natural economy.

Family planning is a pillar of safe motherhood and is now seen as a human right. It is a cost effective method reducing maternal morbidity and mortality. Contraceptive methods have a considerable positive impact on maternal and infant health and population growth.

KAP survey is a survey to analyse the gap between the knowledge , attitude and practices. KAP survey were started in 1950 to measure the spread of Family planning thought out of the world by showing that there were many women who would like to space or limit their birth but who don’t know about or have access to family planning services (KAP gap)they provided the first estimate of the need for Family Planning Repeated pregnancy causes major health problems to mother. Reduced birth spacing increases maternal morbidity. Contraception counselling is an important part of family planning services. It offers proper advise for contraceptive choices to meet family planning needs and optimizing pregnancy spacing.

India is the first country in the world to have launched a National Programme for Family planning in 1952.with its historic initiation, family planning programme has undergone transformation in terms of policy and actual programme implementation.

Over the years the programme has been expanded to reach every nook and corner of the country and has penetrated the Primary \health Centres and sub Centers in rural areas, Urban Family Welfare Centers and Post-partum Centers in the urban areas. Technological advances, improved quality and coverage for health care have resulted in a rapid fall in Crude birth Rate (CBR), Total Fertility Rate (TFR) and growth rate.

Millions of women die every year due to complications of pregnancy and child birth in developing countries across the world. Hence proper antenatal and immediate postpartum counselling in the hospital would ensure a good decision making in the couple regarding family planning.

Family planning has undergone a paradigm shift and emerged as one of the interventions to reduce maternal and infant mortalities and morbidities.It is well-established that the states with high contraceptive prevalence rate have lower maternal and infant mortalities.

Greater investments in family planning can thus help to mitigate the impact of high population growthby helping women to achieve the desired family sizeand avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent induced abortion and eliminate most of these deaths. Studies show that if the current unmetneed for family planning could be fulfilled over the next 5 years, we can avert 35,000 maternal deaths, 1.2 million infant deaths, save more than Rs. 4450 crores and save Rs. 6500 crores, if safe abortion services are coupled with increased family planning services. This strategic direction is the guiding principle in implementation of family planning programme in future.

OBJECTIVES

OBJECTIVES OF THE STUDY

- To know the prevalence of awareness and hindrance regarding usage of various family planning services
- To avoid unwanted birth as well as pregnancy & regulate the interval between consecutive pregnancies

REVIEW OF LITERATURE

CONCEPT OF UNMET NEEDS AND ITS STANDARD FORMULATION

The concept of unmet needs can be applied to all sexually active men and women of reproductive age, who respond that they want to postpone or avoid child bearing and also report that they are not using any contraception are defined as unmet needs.[1]

In that those who want to have no more children are considered to have an unmet need for limiting births, while those who want more children but not for atleast two more years are considered to have an unmet need for spacing births.[2]

PREVALANCE OF UNMET NEEDS

Contraceptive use is uneven both among and within countries. It varies according to wealth, education, ethnicity, rural or urban residence and the strength of national family planning programme. In most women aged younger than 30years had greater needfor contraception for birth spacing. Unmet needs to decline with increased level of education among women in countries other than sub Saharan Asian ones. [3]

UNMET NEED IN RURAL INDIA

In most developing countries, rural, uneducated and poor married women are more likely to be at risk for unplanned pregnancy than are urban, educated & married despite improvements in access and use in some regions in recent decades, largenumbers of women continue to have an unmet need for contraception.

It is estimated that if all unwanted birth could be eliminated, total fertility would drop to the replacement level. Moreover, several studies report that the desire to limit family size and to space the next birth are the main reasons mentioned by majority of abortion seekers, clearly highlighting that there is substantial unmet need of

contraception in India. According to NFHS5, unmet need in India is 9.4%, indicating more than 30 million married women has unmet need of contraception. Unmet need for spacing is 4% and for limiting 5.4%. In Tamilnadu it is 4.8% for spacing and 5.3% for limiting. Anju puri et al, in Delhi, surveyed 243 women,65.4% of them were not using any form of contraception. Thus a total of 49.8% women were identified to have unmet need of contraception in the study group.[5]

GAP IN CHILD BEARING INTENTIONS

For more than 30 years, surveys in less developed countries have asked women about their child bearing intentions and use of family planning. These surveys have long shown an inconsistency in women's responses: A significant number of women say that they do not want another child but not using any method of contraception. This gap between women's preferences and actions inspired many government to initiate or expand family planning programs in order to reduce unintended pregnancies and lower their country's fertility rate .The term "unmet need" has served to gauge family planning need in less developed countries.[6,7,8]

VARIATIONS OF UNMET NEED WITH AGE

According to NFHS -3 unmet need decreases with age of the patient, 27% in 15-19yrs to 2% in45-49 yrs. Younger women had greater unmet need for spacing than limiting, and for older women the reverse pattern is evident. Rural women have higher unmet need than urban. According to NFHS-3, unmet need for spacing in the age group 15-19yrs is 25.1%,20-24yrs is 14.9 %, 25-29yrs is 6%, 30-34yrs 2.1%, 35-39yrs is 0.1%, 45-49yrs is 0.1%.

Unmet need for limiting is highest in the age group 25-29yrs is 9.9% and is least in the age group 45-49 yrs. 10 According to Bhattacharya, study done in Calcutta In the

unmetneed group of 15-19 years, the proportions of limiters and spacers are equal (50%), but in the later age groups 20-24 years, 25-29 years and 30-34 years, the proportions of limiters are 48%, 86%, 100% respectively, increasing significantly with advancement of age with proportionate decrease of spacers. Studies show that clear relationship emerges between women's age and level of unmet need when unmet need is divided into its spacing and limiting components.[9]

UNMET NEED AND EDUCATIONAL STATUS:

According to NFHS -3 unmet need for spacing is 5.5% for women with no education and for limiting it is 8.1%. And for those who have completed < 5^{th} standard completeunmet need for spacing and limiting is the same 5.2%. For those who have completed 5^{th} -7^{th} standard unmet need for spacing is 7.3% and that for limiting is 5.2%, for those who have completed 8^{th} -9^{th} standard completed unmet need for spacing is 7.7% and for limiting it is 5.7%,for those who have completed 10^{th} -11^{th} standard for spacing it is 7.0% and for limiting it is 5.2%,and >12^{th} standard completed it is 6% for spacing and 4.7% for limiting.

In a study in Delhi, Prevalence of unmet need is high among illiterate women (46.1 %) and primary literacy group (52.1%), compared to that in the higher educational groups. Contraceptive use rate increases significantly as educational status gets improved, the use rate being 36.5% in illiterate, 43.4% in the primary group, more than 50 % in middle & secondary group and 100% in the Higher Secondary & above. With higher educational level, proportion of spacer in the unmet group is significantly increasing from 33% in the illiterate group to 100% in the highest educational status group with reciprocal decrease in the proportion of limiter. [10]

Studies in Turkey have shown that better educated women have somewhat less

unmet need than women with little or no education. Unmet need for family planning varies by woman's education, but only within a narrow range of 14 to 17 percent. [11]

UNMET NEED AND NUMBER OF LIVING CHILDREN IN THE FAMILY

Unmet need for limiting births is low (18.30%) in women having one child and is gradually increases with each additional child. That in case of 12 women having one child, the unmet need for spacing is seen to be highest (26.5%) and gradually decreases with each additional child. Ram et al study, 92% of the mothers with unmet need had 2 or more children.[12]

PRESENCE OF MALE CHILD IN FAMILY Male child Syndrome"

It is still a widely prevalent concept. Ram et al, found the fact that acceptance of family planning methods after delivery of at least one male child was significantly higher (53.25%) than those with no male child (6.18%). These findings are comparable with a study conducted in rural area of South Delhi which revealed that contraceptive prevalence increased from 37.5% in those who were having no male child to 63% with three or more male children. [12]

REASONS FOR UNMET NEED OF CONTRACEPTION

Although the Indian government has recently shifted away from its long-standingpolicy of promoting female sterilization as the primary form of family planning, the reality is that government health service providers still offer women very little information about and access to temporary methods of contraception. Many women also face family opposition to the use of temporary contraceptives. Without the option of using temporary contraception, many women resort to abortion. Of these, the vast majority either do not realize that abortion is legal.[13]

REASONS FOR NEVER USE OF CONTRACEPTION

Most women with unmet need who cite a health concern about a particular method have never used that method themselves. Sometimes they have heard about medical problems that others experienced with use of contraception. Sometimes people'sfears are based on rumors. In Kenya 3% women said pills accumulating into life- threatening masses in the stomach and other bizarre effects thought to accompany contraceptive use.[14] In Nepal 5% women said that they would not consider sterilization because it was said to cause weakness and so require additional nutritious foods that theycould not afford60. Thus several reasons can combine to contribute to unmet need-poor quality services or methods lead to real health problems that, in turn, become the basis for exaggerated rumors, which are spread and believed by many people who have little direct knowledge of contraception [15]

REASONS FOR DISCONTINUATION OF CONTRACEPTION:

The tendency to discontinue contraceptive use seems to be more common in rural areas than in urban areas. Many women have discontinued contraceptive use, not because they wanted to become pregnant, but because they experienced side effects and health problems attributed to contraceptives. As contraceptive use increases and becomes a more established behavior, prevalence is no longer a sufficient marker of programme success. Contraceptive continuation may become more important than acceptance in increasing contraceptive prevalence.62 Information on method-specific discontinuation rates, not unexpectedly, higher discontinuation rates for pills and condoms than intra- uterine devices (IUDs).[16]

In Nepal found that 15% of women in the unmet need group had discontinued use, slightly more than 50% of them because of side effects or health concerns. Another

study in Nepal, where contraceptive prevalence was just 23%, found that about 25% of the unmet need group had discontinued contraceptive use because of side effects.(15) In Kenya 46% women who discontinued using contraception did so because they experienced side effects and could not find a different method65. In Jordan 43% women in focus-group discussions spoke of modern contraception mainly in terms of their side effects and health risks. In Ghana health concerns and side effects 36% were by far the most common reasons given for discontinuation among women who had used oral contraceptives but had stopped coming to family planning clinics. Discontinuation often leads to unwanted pregnancies. Nearly 50% of the women who had discontinued use became pregnant within 32 months, and more than 60% of these pregnancies were unintended. Some 39% of these unintended pregnancies were aborted.[17]

HEALTH CONCERNS AND SIDE EFFECTS

In many countries concerns about health and contraceptive side effects cause much unmet need. These concerns come from a variety of sources, including women's own experiences with using contraception, experiences of friends, and the rumors that often result as these experiences are told and retold throughout communities.[19]

Elizabeth et al, In a longitudinal study, followed 259 for 18 months, to study the patterns of menstrual bleeding following the use of contraception, ammenorrhoea, infrequent bleeding and frequent bleeding were reported by 41%, 23%and 17.5% respectively. Non menstrual side-effects comprised breast tenderness in 18.75%, acne in 10%, headache and dizziness in 3.75%. Depressive mood disorders, pelvic pain and loss of libido were mentioned each by two of the women 2.5%.[20,21]

In NFHS-3 10% is attributed to health reasons/fear of side-effects for non-use of contraception.

LIMITED KNOWLEDGE

Inadequate knowledge of contraceptive methods, and incomplete or erroneous information in 56% about where to obtain methods and how to use them are the main reasons for not accepting family planning [22,233]. Khan, in a KAP study found that, compared to acceptance of 90%, only 54% actually practiced contraception,[24]

In a study done by Srivastava, awareness rate was found to be 82.2%.[25] Awareness of specific reversible methods that are suitable for young women was even more limited among young women compared to other women. For example, only three fifths of married adolescents were aware of condoms, compared to nearly three fourths of women between 20-34 years.[26,27]

As might be expected, lack of awareness of *any* contraceptive method is most likely to explain unmet need in countries with little contraceptive use, as in sub-Saharan Africa. This is because, if a woman does not know about contraception itself, she cannot cite other reasons for not using it, such as lack of availability or side effects.[28]

The researchers created a "knowledge index" consisting of three items:

Mentioning a modern contraceptive method without being prompted; (2) being aware of its source; (3) and having an opinion about its side effects. In general, the level of unmet need is lower in countries where this knowledge index is higher. In five of the six sub-Saharan countries studied and in Peru, less than 50% of women with an unmet need could mention even one method, identify its source, and discuss its side effects.[29]

OPPOSITION FROM HUSBANDS

Many women do not use contraception because their husbands are opposed .In seven sub-Saharan countries contraceptive use among women whose husbands disapprove of family planning averages only 40%[9]. In a study in Delhi, 19.8% of women

said opposition from husband as the main reason for not using a contraception[30].

In Kenya, among women who had stopped using contraception for reasons other than having another child, 12% had stopped because their *husbands* wanted another child or had forced them to discontinue for another reason[50].

As Moni Nag has noted, a woman may have unmet need for family planning because of the high "social cost of challenging the opposition from her spouse or anyone else in her social influence group [311]. For instance, in Trishal, Bangladesh, women with unmet need were more likely than contraceptive users to oppose family planning themselves, but they also were more likely to say that their husbands opposed it and that the community opposed it. Husbands' attitudes may affect not only whether or not wives use contraception but also the choice of a method and how long it is used[32].

In Botswana only 47% of women with an unmet need think that their husbands approve of family planning compared with 82% of contraceptive users. In Pakistan the difference is even more striking - 32% compared with 83%.[33].

Also, women with unmet need are much less likely than contraceptive users to have talked with their husbands about family planning. For example, in Ghana only 44% of women with unmet need had discussed family planning with their husbands in the preceding year compared with 72% of contraceptive users[34]. In India the level of unmet need for limiting births was significantly lower among couples who had discussed family planning than among those who had not, but discussion made little difference to unmet need for spacing- possibly because temporary methods were not readily available.

OPPOSITION FROM FAMILIES AND COMMUNITIES

Although less important than husband's opposition, lack of support by extended families and community leaders also prevents some women from using contraception. In Philippines, only 50% of women with unmet need consider contraception socially acceptable[35]. Bhattarcharya et al, found 32% of unmet need attributed to opposition from husband and families. Ram et al noted in Kolkata that 12% of women had suggested the reasons for unmet need to be opposition from family members.

CONTRACEPTIVE SERVICES UNDER THE NATIONAL FAMILY WELFARE PROGRAMME

The methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. There is another method (emergency contraceptive pill) to be used in cases of emergency.

SPACING METHODS

These are the reversible methods of contraception tobe used by couples who wish to havechildren in future. These include:

A. Oral Contraceptive Pills (OCPs)

- These are hormonal pills which have to be taken by a woman, preferably at a fixed time, daily. The strip also contains additional placebo/iron pills to be consumed during the hormonal pill free days. The method may be used by majority of women after screening by a trained provider.
- At present, there is a scheme for delivery of OCPs at the doorstep of beneficiaries by ASHA with a minimal charge. The brand “MALA-N” is available free of cost at all public healthcare facilities.

B. Condoms

- These are the barrier methods of contraception which offer the dual protectionof preventing unwanted pregnancies as well as transmission of Reproductive Transmitted Infection/Sexually TransmittedInfection (RTI/STI) including HIV. The brand "Nirodh" is available free of cost at government health facilities and suppliedat the doorstep by the ASHAs for minimal cost.

C. Intra-Uterine Contraceptive Devices(IUCD)

- Copper containing IUCDs are a highly effective method for long term birth spacing.
- Should not be used by women with uterine anomalies or women with active PID or those who are at increased risk of STI/RTI (women with multiple partners).
- The acceptor needs to return for follow up visit after 1, 3 and 6 months of IUCD insertion as the expulsion rate is highest in this duration.
- Two types:
    - Cu IUCD 380A (10 yrs)
    - Cu IUCD 375 (5 yrs)
- New approach of method delivery- post-partum IUCD insertion by specially trained providers to tap the opportunities offered byinstitutional deliveries.

PERMANENT METHODS:- These methods may be adopted by any member of the couple and are generally considered irreversible.

A. Female Sterilisation

- Two techniques:
  - **Minilap:** Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked. Can be performed by a trained MBBS doctor.
  - **Laparoscopic:** Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopiantubes in the abdomen. Can be done only by trained and certified MBBS doctor or specialist.

B. Male Sterilisation

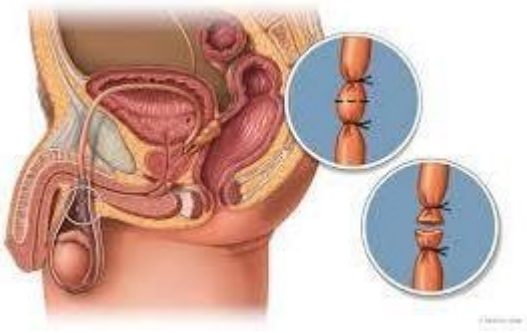
- Through a puncture or small incision in the scrotum, the provider locates each ofthe 2 tubes that carries sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery). The procedure is performed by MBBS doctors trained in these. However, the couple needs to use an alternative method of contraception for firstthree months after sterilization till no spermsare detected in semen.
- Two techniques being used in India:o Conventional
  - Non- Scalpel Vasectomy – no incision, only puncture and hence no stitches

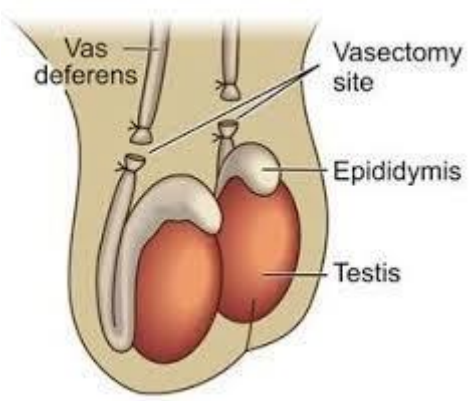
Emergency Contraceptive Pill (ECP)

- To be consumed in cases of emergency arising out of unplanned/unprotected intercourse and

The pill should be consumed within 72 hours of the sexual act and should neverbe considered a replacement for a regular contraceptive.

Male sterilization



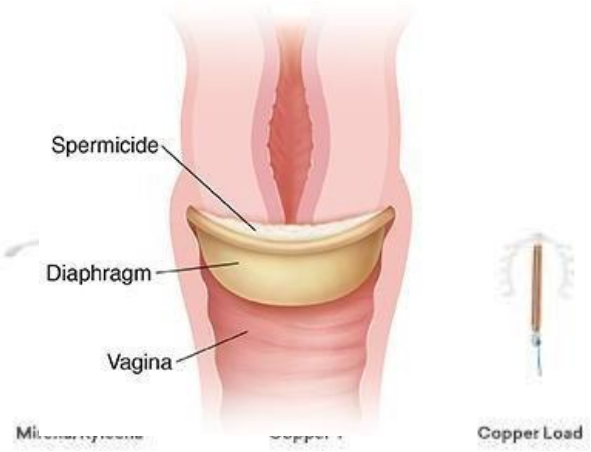


1. Female Sterilization

Condoms

Diaphragm:

The Diaphragm is a vaginal barrier, also known as “Dutch Cap” the diaphragm is a shallow cup made of synthetic rubber or plastic material. It ranges in diameter from 5-10cm (2-4 inches). It has to remain in place for at least 6hrs. Failure rate with spermicidal very from 6-12/ 100WY.



- Copper 7

SYMPTOTHERMIC METHOD

This method combines the temperature, cervical mucus and calendar techniques for identifying fertile period.

BREAST FEEDING

Lactation prolongs postpartum amenorrhea and provides some of protection against pregnancy .No more than 5-10% of women conceive during lactational amenorrhea.

TERMINAL METHODS MALE STERILIZATION

In vasectomy it is customary to remove a piece of vas at least 1cm after clamping the ends are ligated and then folded back on themselves and sutured into position, so that the cut ends face away from each others.

NO SCALPEL VASECTOMY

This is a new technique that is safe, convenient and acceptable to makesthis is funded by UNFPA.

FEMALE STERILIZATION

This can be done as a interval procedure, postpartum, or at the time ofabortion. Two procedures are common;

Laparoscopy

The abdomen is approached though laparoscope and once the tubes are accessible the falope rings or clips are applied to occlude the tubes.

Minilaparotomy

This is a modification of abdominal tubectomy, a smaller abdominal incision of only 2.5-3cm, conducted under local anesthesia. This is suitable for postpartum sterilization.

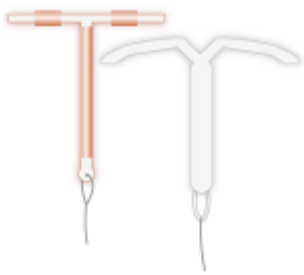
CONTRACEPTION: PROS AND CONS OF DIFFERENT CONTRACEPTIVE METHODS

Hormonal Implants

Hormonal implants are a type of birth control in the shape of a tiny tube that is placed under the skin of a woman's upper arm. The implant prevents pregnancy and is effective for 3 years. The implant is about the size of a toothpick and made of a flexible plastic that contains a type of progestin hormone medicine called etonogestrel.

Success Rate with Typical Use: 99%	
Pros	**Cons**
Long-term method of birth control (protects against pregnancy for 3 years after insertion–it can be removed by a health care provider when you want to or you can wait for 3 years when it's time for a change of implant) Very effective against pregnancy May cause light or no menstrual periods	Doesn't protect against STIs Requires minor surgery and insertion of the tiny rod(s) underneath the skin Requires minor surgery to remove device Can cause side effects such as irregular menstrual periods, depression, nervousness, hair loss, and weight gain Could get infection at area where rod is implanted

Intra-Uterine Devices (IUDs)



An intra-uterine device is a type of birth control that is inserted through the vagina and cervix into the uterus to prevent pregnancy. There is more than one kind of IUD. Some IUDs (Mirena®, Skyla®, Kyleena®, and Liletta™), contain the hormone levonorgestrel (a type of progesterone). When one of these IUDs is in place, levonorgestrel is continuously released into the uterus. Another type of IUD, the ParaGard®, is hormone-free. The ParaGard® (also called the Copper IUD) has copper wire coiled around the stem and arms of the IUD. All IUDs are T-shaped and have strings attached to the end. The strings make it easier for you to do placement checks (if you're comfortable) and for your health care provider to remove the IUD when it is time to take it out.

Success Rate with Typical Use: 99%	
Pros	**Cons**
Very effective against pregnancy Provide protection against pregnancy as long as in place in your uterus- protects as soon as inserted (so don't need to remember to use contraception if you have sexual intercourse) Doesn't need daily attention- just need to check to make sure in place at least once a month at time of menstrual period Comfortable- you and your partner cannot feel the IUD, although you partner may feel the string The levonorgestrel IUD (Mirena®, Skyla®, Lilleta®, Kyleena™) lessens menstrual flow and can be used to treat heavy periods	Both types do not protect against STIs. Other methods should be considered if high risk for STIs.Needs to be inserted by a health care provider. Slightly higher risk of infection in the first 20 days after insertion Can fall out or can rarely puncture the uterus Slightly higher risk for infection in the first 20 days after insertion The **Copper IUD** can have side effects such as menstrual cramping, longer and/or heavier menstrual periods, and spotting between menstrual periods.

Depo-Provera® Hormonal Injections

Depo-Provera® is a female hormonal method of birth control. It's very effective in preventing pregnancy. Depo-Provera® contains a synthetic (man-made) form of the hormone progesterone, called depo medroxyprogesterone acetate (DMPA). The Depo-Provera® injection gives 3 months' protection against pregnancy. You should get one injection every 3 months (13 weeks) to get the best protection against pregnancy. It's safe to get your injection up to 3 weeks earlier if you can't get your next injection in exactly 13 weeks.

Success Rate with Typical Use: 96%	
Pros	**Cons**
Each injection provides 3 months of protection against pregnancy Very effective against pregnancy if used correctly Many women stop getting their menstrual period while getting injections. (This is not a medical problem and menstrual periods usually return 6-18 months after you stop taking injections) Helps protect against uterine cancer Doesn't interrupt sexual activity	Doesn't protect against STIs Need to see your health care provider every 3 months for an injection Depending on your insurance, your birth control may be free or there may be a co-pay May have side effects such as weight gain, tiredness, and possibly a decrease in bone density Many women have very irregular menstrual bleeding or spotting for the first 3 to 6 months and sometimes longer

Birth Control Pills: General Information

Birth control pills (also called oral contraceptive pills and the “Pill”) are a type of female hormonal birth control method and are very effective at preventing pregnancy. The Pills are small tablets that you swallow each day. Most pills contain two types of synthetic (man-made) female hormones: estrogen and progestin. These are similar to the estrogen and progesterone normally made by the ovaries. These pills are called “combination oral contraceptives,” and there are many different kinds.

The hormones in the pills prevent pregnancy by suppressing the pituitary gland, which stops the development and release of the egg in the ovary (ovulation) (see female reproductive anatomy image below). The progestin also helps to prevent the sperm from reaching the egg and changes the lining of the uterus.

Another type of pill contains only one hormone (progestin) and is called either the “progestin-only pill,” or the “mini-Pill.” It works by stopping ovulation and by helping to prevent the male’s sperm from reaching the egg.

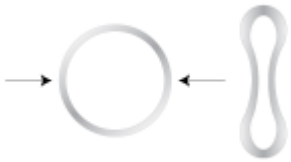
Success Rate with Typical Use: 93%	
Pros	**Cons**
Very effective against pregnancy if used correctly Makes menstrual periods more regular and lighter Decreases menstrual cramps and acne Makes you less likely to get ovarian and uterine cancer, pelvic inflammatory disease, ovarian cysts, and anemia	Doesn't protect against STIs Depending on your insurance, your birth control may be free or there may be a co-pay. Need to remember to take every day at the same time Can't be used by women with certain medical problems or by women taking certain medications Can occasionally cause side effects such as nausea, increased appetite, headaches, and, very rarely, blood clots Need a prescription

Hormone Patch (Ortho-Evra/Xulane)

The patch looks like a square Band-Aid (less than 2″ x 2″) and is worn on the skin. It contains hormone medicine similar to birth control pills, but the dose absorbed through the skin is 60% higher than the birth control pills with 35ug of estrogen. In some studies, but not in others, there is a higher risk of blood clots. Make sure not to smoke if using the patch. When used correctly, the patch is as effective as birth control pills in preventing pregnancy. Just like birth control pills, your health care provider may also prescribe the patch for irregular periods, menstrual cramps, or endometriosis.

Success Rate with Typical Use: 91%	
Pros	**Cons**
Very effective against pregnancy if used correctly Makes menstrual periods more regular and lighter Decreases menstrual cramps and acne Makes you less likely to get ovarian and uterine cancer, pelvic inflammatory disease, ovarian cysts, and anemia Doesn't interrupt sexual activity	Doesn't protect against STIs Still need condoms to lower the risk of STIs Can't be used by women with certain medical problems or by women taking certain medications Can occasionally cause side effects such as nausea, increased appetite, headaches, and irregular bleeding in the first few cycles Increased risk of blood clots Need a prescription

Vaginal Hormonal Ring (NuvaRing®, Annovera™)



What is the vaginal hormonal "ring"?

The vaginal hormonal ring is a method of birth control that contains estrogen and progestin, the same hormones that are in combination birth control pills. It It is inserted into the vagina similar to a tampon.

How does the ring work?

There are two different hormones called estrogen and progestin in the vaginal ring. When the ring is inserted in a woman's vagina, the medicine is released into the vagina and absorbed through the vaginal wall. The medicine then enters the bloodstream to stop the ovaries from releasing eggs. This medicine also makes the cervical mucus thicker, which helps to prevent sperm from traveling upwards towards the uterus and fallopian tubes.

93% (NuvaRing),-97% (Annovera™)	
Pros	**Cons**
Very effective against pregnancy if used correctly Makes menstrual periods more regular and lighter Decreases menstrual cramps and acne Makes you less likely to get ovarian and uterine cancer, pelvic inflammatory disease, ovarian cysts, and anemia Doesn't interrupt sexual activity	Doesn't protect against STIs Still need condoms to lower the risk of STIs Can't be used by women with certain medical problems or by women taking certain medications Can occasionally cause side effects such as nausea, increased appetite, headaches Increased risk of blood clots

Diaphragm

What is a (contraceptive) diaphragm and how does it work?

A contraceptive diaphragm is a nonhormonal birth control method that is used to prevent pregnancy. It has a soft latex-free dome with a flexible rim made from silicone. Latex diaphragms are no longer being made; however, they may be available in certain regions outside of the U.S. A diaphragm works by forming a barrier to stop sperm from reaching the cervix to prevent pregnancy. The diaphragm should always be used with spermicidal cream or gel. The spermicide comes with instructions and tells you how much to apply *inside* the dome *before* inserting it. The spermicide is used with the diaphragm to kill any sperm that might leak in around the edges of the dome.

Success Rate with Typical Use: 83%	
Pros	**Cons**
Can be put in place right before intercourse or 2-3 hours before intercourse Don't need to take out between acts of sexual intercourse (protects against pregnancy for about 6 hours, but need to reapply spermicide)	Doesn't protect against STIs Need to get fitted by a health care provider and need a prescription May be difficult to find Can't take out until 6 hours after intercourse Cost $25-$45, plus the cost of spermicidal gel May get moved out of place during sexual intercourse Some women may be allergic to the diaphragm or to the spermicide Need to be re-fitted after a 10 pound weight gain or loss and after pregnancy Can be messy Need to reapply spermicide with each act of sexual intercourse Can cause an increase in urinary tract infections

Cervical Cap

What is the cervical cap and how does it work?

The cervical cap is a soft dome-shaped cup made of silicone, with a firm rounded rim. The rim fits tightly around the base of your cervix. The cap forms a physical barrier to stop sperm from reaching your uterus but it does not perfectly stop sperm. Spermicide must always be used with the cervical cap to kill or prevent the sperm from moving. When used correctly, the cervical cap and spermicide work to prevent pregnancy. The FemCap is the only brand of cervical cap that is currently available in Europe, Canada, and the United States.

Success Rate with Typical Use: 83%	
Pros	**Cons**
Can insert several hours before sexual intercourse Can leave in place 24-48 hours, will give protected sex for up to 48 hours Use less spermicide with the cap than with the diaphragm, no need to apply more spermicide with each act of intercourse	Doesn't protect against STIs Cost $30-$50, plus the cost of spermicidal gel Need to be fitted by a health care provider and need a prescription Limited sizes available Can't take out until 6-8 hours after intercourse May get moved out of place Some women may be allergic to material of cap or to spermicide Can't be used by women with a history of abnormal Pap tests Can cause increased urinary tract infections

Condoms: Male Condoms

The male condom is a sheath (covering) worn over the penis during sexual activity. It prevents pregnancy by acting as a barrier, preventing semen from entering the vagina so the sperm can't reach a female's "egg". Condoms also decrease the chances of getting a sexually transmitted infection (STI) by acting as a barrier, preventing infections (bacteria and viruses) from passing from one partner to another. Using condoms also allows guys to be active in preventing pregnancy.

Success Rate with Typical Use: 87%	
Pros	**Cons**
Lowers risk of STIs Contraception that provides the most protection against sexually transmitted infections (latex condoms are best) Don't cost much (50 cents each), can buy at almost any drug store (don't need a prescription) Men feel they can "last longer" when using a condom Allow men to have an active part in preventing pregnancy	Have to use a new one every time you have sexual intercourse (can only be used once) May disrupt/interrupt sexual activity as it needs to be put on just before penetration Can break Women may be allergic to latex

Condoms: Female Condom or Internal Condoms

The female condom, also known as an "internal condom," is a lubricated sheath worn by the female inside of her vagina during sex. The FC2 is made of nitrile (a type of synthetic rubber). The FC2 is latex-free, so this is a good option if you or your partner has a latex allergy. The FC2 is pre-lubricated and is the only female condom that has been approved for vaginal sex by the United States Federal Food and Drug Administration (FDA). These condoms have been used by women and men, for vaginal sex and anal sex. There are other condoms sold outside of the United States that are made of natural rubber latex (Cupid®, l'Amour® and Jeitosa®).

The female condom acts as a barrier to sperm and many sexually transmitted infections by completely lining the vagina. The female condom has a ring at each end. The inner ring, at the closed end of the sheath, lies inside the vagina. The outer ring, at the open end of the sheath, lies outside the vagina after the female condom has been inserted. The female condom provides protection against pregnancy and some protection against STIs.

Success Rate with Typical Use: 79%	
Pros	**Cons**
Provide protection against STIs (new product, so not clear how much protection given) and pregnancy Can be inserted well before intercourse so less interruption of sexual activity Male does not need to withdraw right after ejaculation, as he does with a male condom	May move or be uncomfortable Can only use for one act of sexual intercourse Cost about $2.50 each

Contraceptive Sponge

The contraceptive sponge is a small, donut-shaped foam sponge that contains a spermicide called Nonoxynol-9. The contraceptive sponge is a *vaginal barrier method* that prevents pregnancy by keeping sperm from fertilizing an egg that your ovaries make each month. The sponge does not protect you from STIs. To lessen the risk of getting an STI, a condom should always be used. Women who are allergic to nonoxynol-9 should not use any *vaginal barrier method* that contains this spermicide.

Success Rate with Typical Use: 76-83%	
Pros	**Cons**
Can insert right before or several hours before sexual intercourse and will provide protection against pregnancy for a total of 24 hours Don't need a prescription	Doesn't protect against STIs and may increase the risk of HIV infection in women who have sex multiple times daily because of irritation from the spermicide Can't take out until 6 hours after sexual intercourse Can't be used by women who are allergic to nonoxynol-9 (in the spermicides) Increases urinary tract infections

METHODOLOGY

METHODOLOGY

STUDY DESIGN

Community based cross sectional study

STUDY AREA

Government Dharmapuri Medical College Hospital

STUDY POPULATION

Delivered mothers in PN and POSTOP wards in GDMCH

INCLUSION CRITERIA

All antenatal women who admitted for delivery in AN ward and Labor ward between age group 19-45 years both primi gravida and multi gravida with gestational age >=36weeks and who delivered in GDMCH

EXCLUSION CRITERIA

1. Unmarried women who delivered in GDMCH
2. Women who delivered in other subcentres
3. Age less than 18years and more than 45years

SAMPLE SIZE – 400

SAMPLING PROCEDURE

Simple random technique

STUDY PERIOD

December 2019 to July 2021

DATA COLLECTION

After obtaining informed consent orally, relevant information was obtained from the antenatal mothers admitted for delivery using structured questionnaire which includes 4 parts comprising the background characteristics of the respondents, marital status and knowledge & attitude towards contraception. These patients are followed up in postnatal

ward and the reason for adopting and not adopting the contraception were obtained. Questions were asked in local language and questionnaire filled on the spot. At the end any misconceptions and queries were clarified.

DATA ANALYSIS

Data was coded and analyzed as percentage and chi square using statistical software SPSS16.

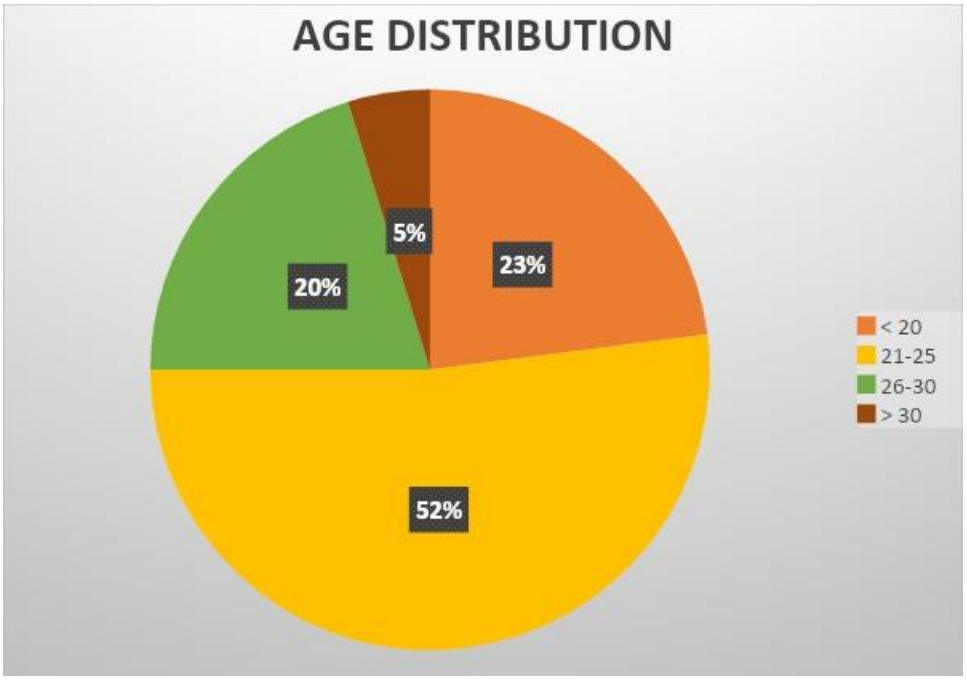
RESULT

RESULTS

AGE DISTRIBUTION(TABLE-1)

Most of the study population (52%) were between age group 21-25years and very few (5%)of the study population were more than 30years of age

AGE IN YEARS	NO OF PATIENTS	PERCENTAGE
< 20 X	92	23%
21-25	208	52%
26-30	81	20%
> 30	19	5%



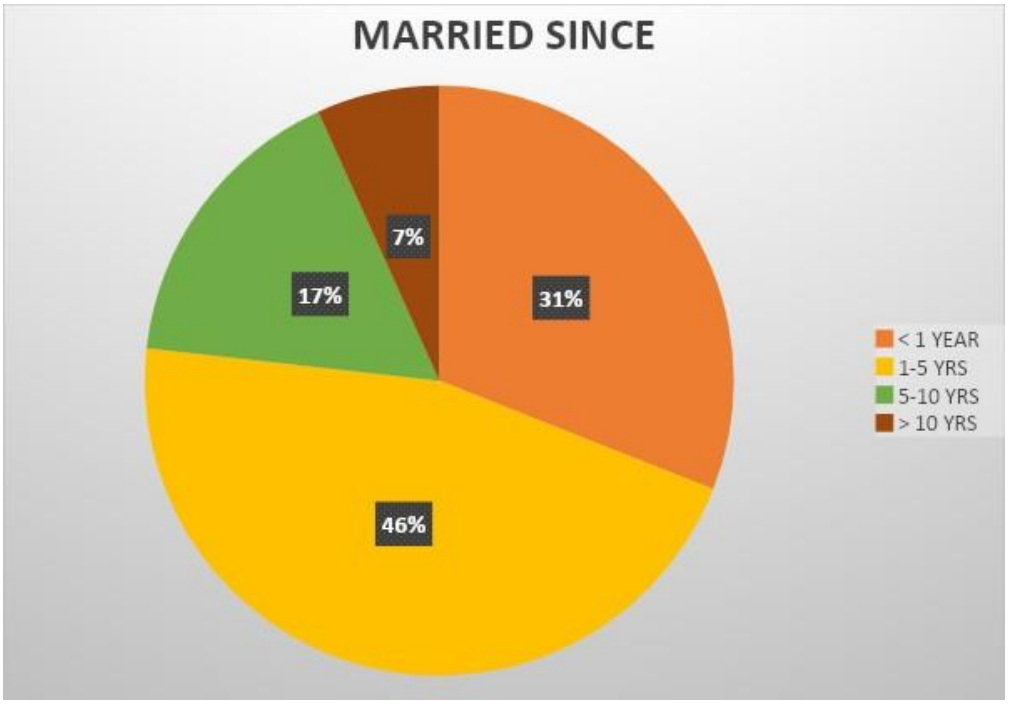
MARRIED SINCE(TABLE-2)

Most of the study population (77%) was married within 5years while very few (7%) were married more than 10years of age

MARRIED SINCE	NO OF PATIENTS	PERCENTAGE
< 1 YEAR	124	31%
1-5 YRS	183	46%
5-10 YRS	66	16%
> 10 YRS	27	7%

MARRIED SINCE (TABLE-2.1)

MARRIED SINCE	ADOPTED	NOT ADOPTED
>Or = 10 YRS	27(82%)	6
< or = 2 YRS	116(63%)	68
3-9YRS	125(68%)	58



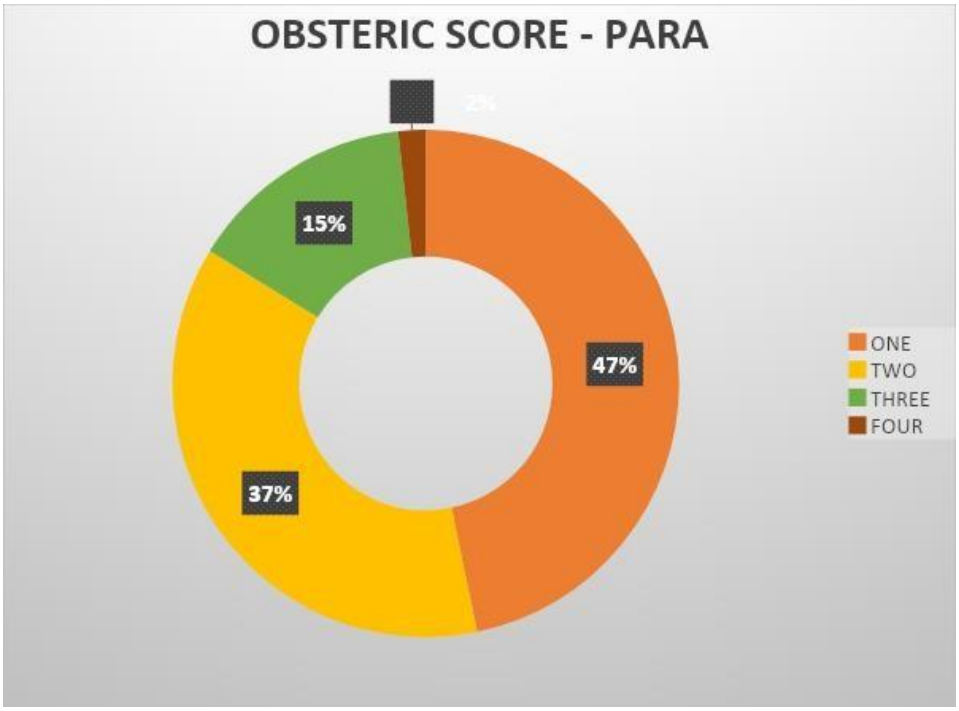
OBSTETRIC SCORE – PARA(TABLE-3)

Among all antenatal women majority of them were PRIMI (47%) and the number decreased as parity increased. higher order birth (>=P3) constitute 16% of respondents

OBSTETRIC SCORE	NO OF PATIENTS	PERCENTAGE
ONE	187	47%
TWO	148	37%
THREE	58	14%
FOUR	7	2%

OBSTETRIC SCORE(TABLE -3.1)

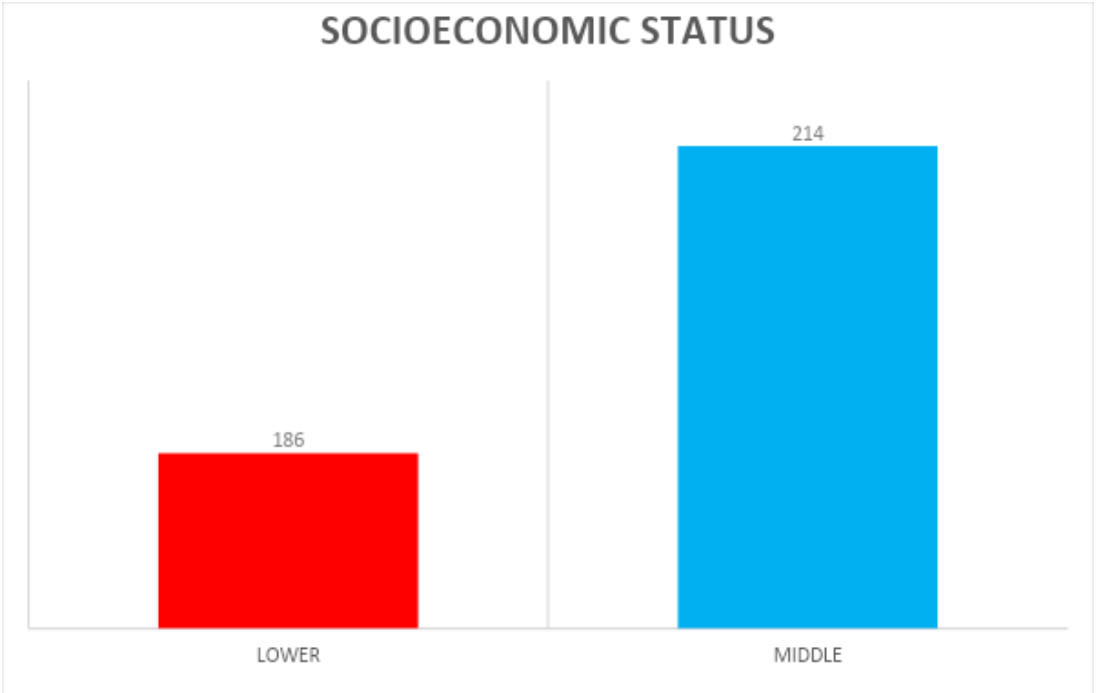
PARITY	TOTAL MEMBERS	ADOPTED	NOT ADOPTED
P1	187	115(61.5%)	72
P3	148	100(67.5%)	48
>Or = P3	65	57(87.5%)	8



SOCIOECONOMIC STATUS(TABLE-4)

In my study respondents belong to either middle socio economic status (54%) or lower socio economic status(46%)

SOCIOECONOMIC STATUS	NO OF PATIENTS	PERCENTAGE
LOWER	186	46%
MIDDLE	214	54%



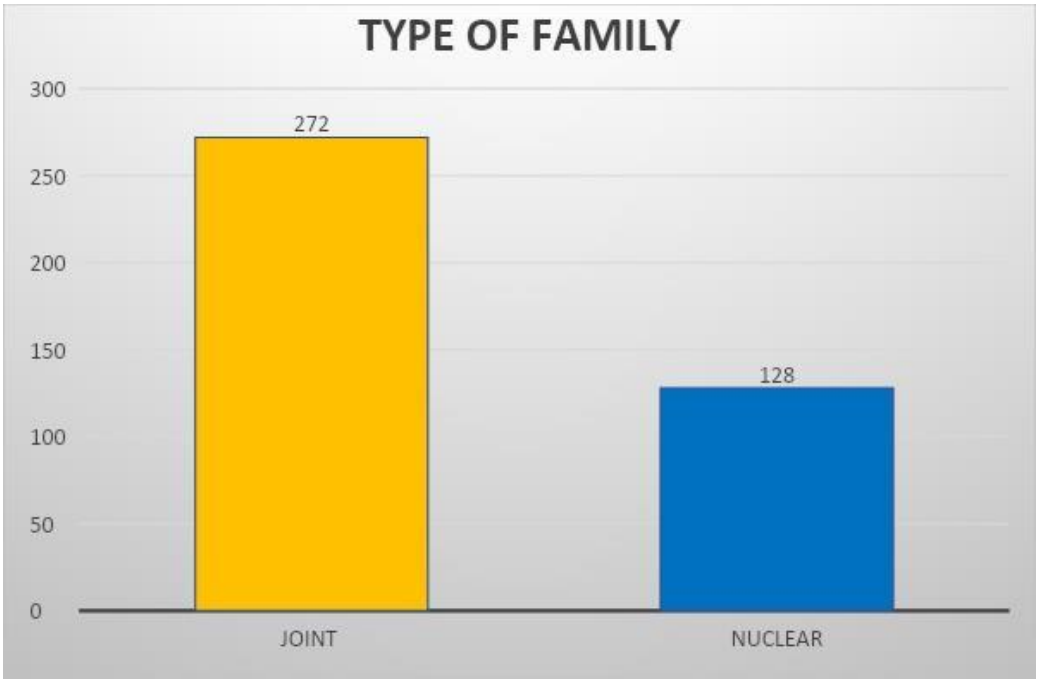
TYPE OF FAMILY (TABLE-5)

Since our respondents belong to rural area, most of them living together with elders as joint family(68%)

TYPE OF FAMILY	NO OF PATIENTS	PERCENTAGE
JOINT	272	68%
NUCLEAR	128	32%

TYPE OF FAMILY(TABLE-5.1)

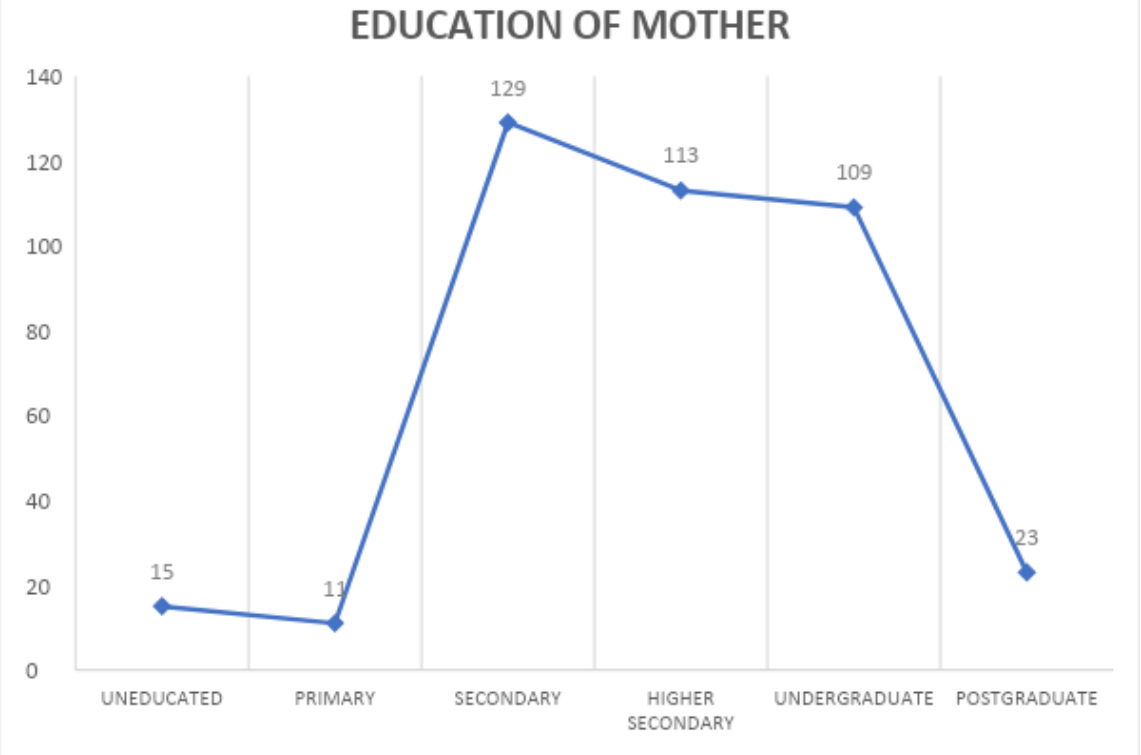
TYPE OF FAMILY	TOTAL MEMBERS	ADOPTED	NOT ADOPTED
JOINT	272	180(66%)	92
NUCLEAR	128	86(67%)	42



EDUCATION STATUS OF MOTHER(TABLE-6)

Most of the respondents were educated, 33% of them completed graduation while 60% have completed atleast secondary school. Only 4% of respondents were uneducated.

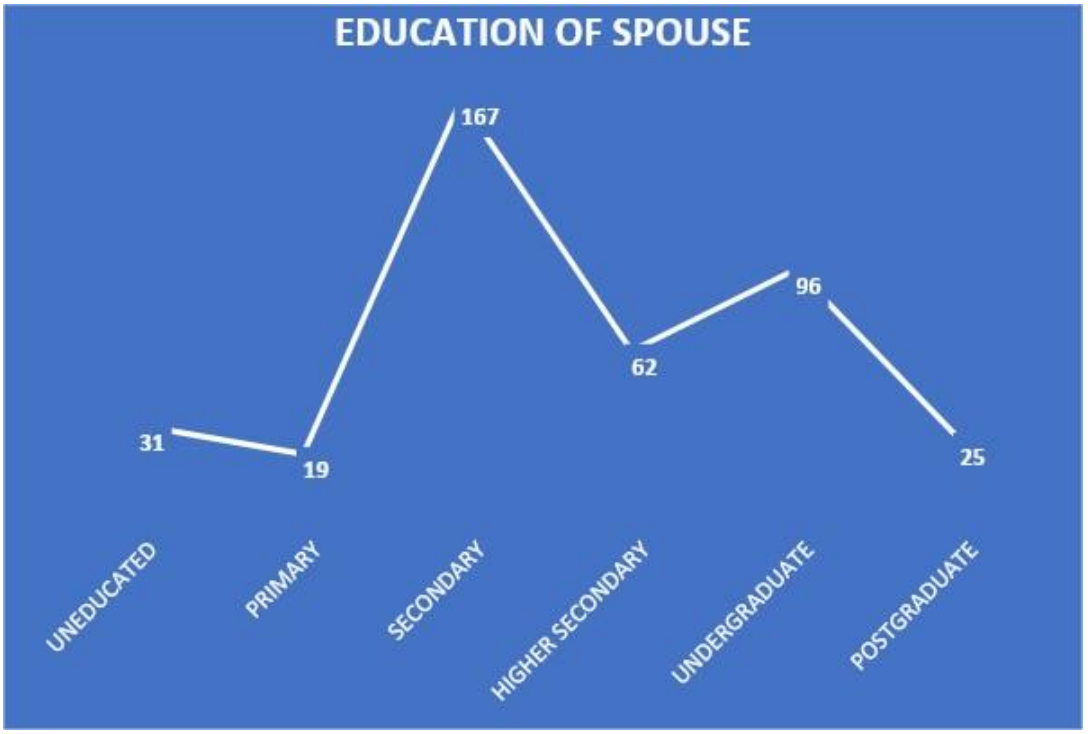
EDUCATION OF MOTHER	NO OF PATIENTS	PERCENTAGE
UNEDUCATED	15	4%
PRIMARY	11	3%
SECONDARY	129	32%
HIGHER SECONDARY	113	28%
UNDERGRADUATE	109	27%
POSTGRADUATE	23	6%



EDUCATION STATUS OF SPOUSE(TABLE-6.1)

Most of the respondents spouse were educated. 30% of them have completed graduation. 57% have completed atleast secondary school. Only 8% of them were illiterate

EDUCATION OF SPOUSE	NO OF PATIENTS	PERCENTAGE
UNEDUCATED	31	8%
PRIMARY	19	5%
SECONDARY	167	42%
HIGHER SECONDARY	62	15%
UNDERGRADUATE	96	24%
POSTGRADUATE	25	6%



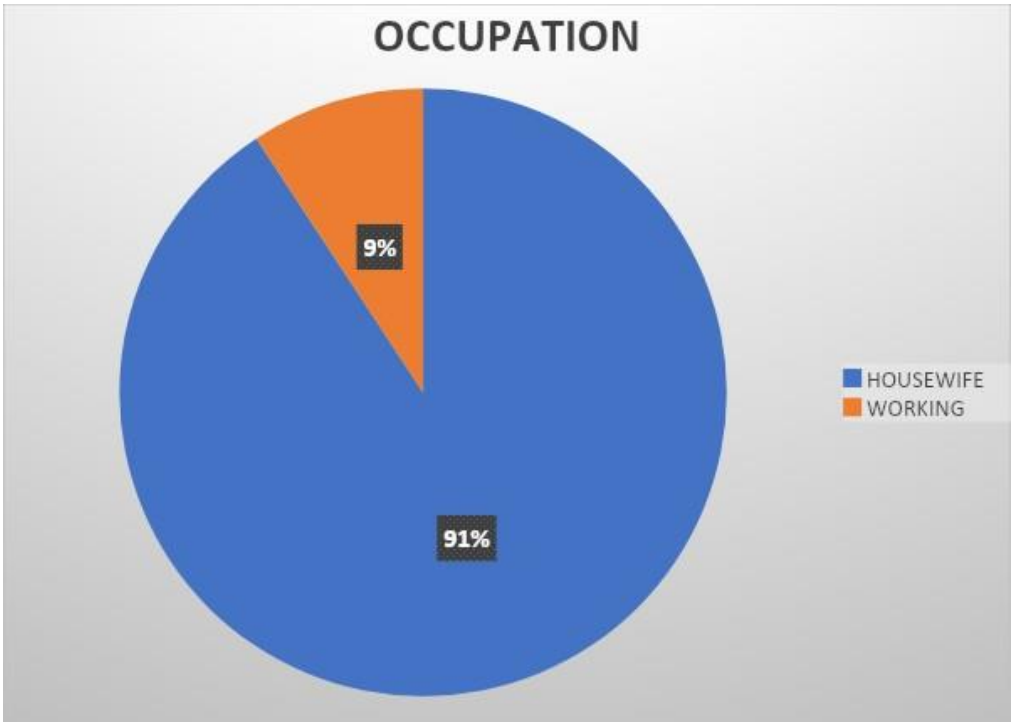
OCCUPATION OF THE PATIENT (TABLE-7)

Though most of the respondents were educated, only 9% were working while remaining 91% were housewife.

OCCUPATION	NO OF PATIENTS	PERCENTAGE
HOUSEWIFE	363	91%
WORKING	37	9%

OCCUPATION(TABLE-7.1)

OCCUPATION	TOTAL MEMBERS	ADOPTED	NOT ADOPTED
HOUSE WIVES	363	254(70%)	109
WORKING WOMEN	37	24(65%)	13



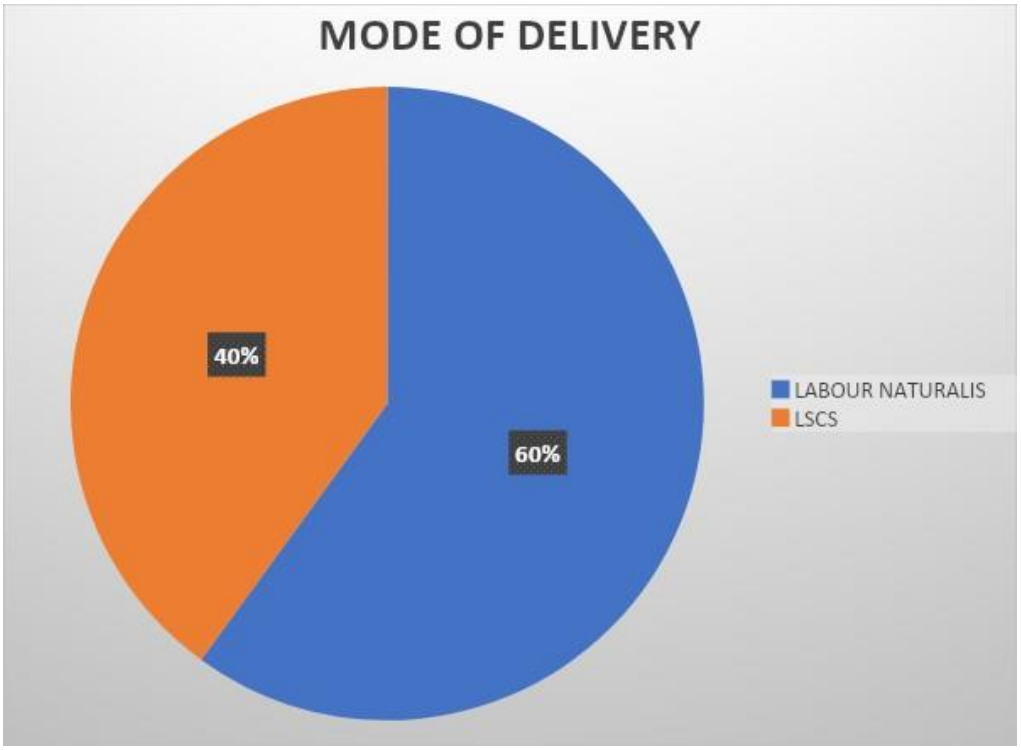
MODE OF DELIVERY(TABLE-8)

60% of respondents delivered by normal vaginal delivery while 40% of them delivered by lower segment cesarean section.

MODE OF DELIVERY	NO OF PATIENTS	PERCENTAGE
LABOUR NATURALIS	240	60%
LSCS	160	40%

MODE OF DELIVERY(TABLE-8.1)

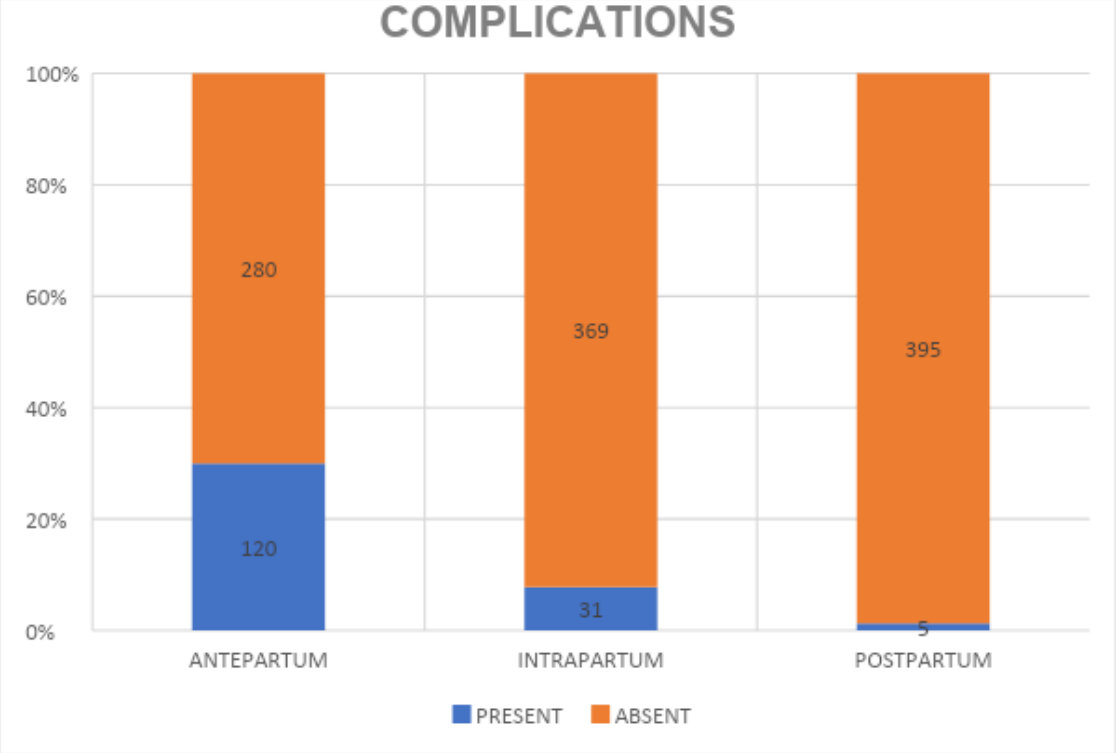
MODE OF DELIVERY	TOTAL MEMBERS	ADOPTED	NOT ADOPTED
LN	240	158(66%)	82
LSCS	160	118(74%)	42



COMPLICATION DURING PREGNANCY(TABLE-9)

40% of the respondents had either antepartum , intrapartum or post-partum complications during this pregnancy

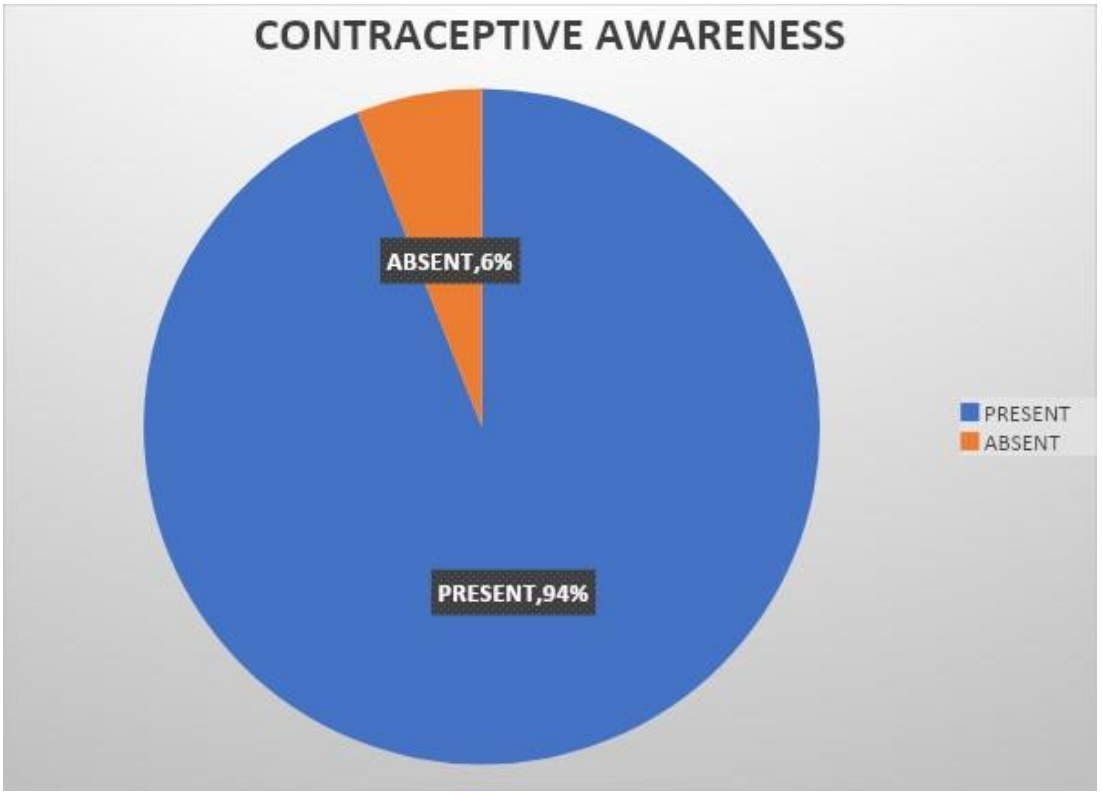
COMPLICATION	PRESENT	ABSENT
ANTEPARTUM	120	280
INTRAPARTUM	31	369
POSTPARTUM	5	395



CONTRACEPTIVE AWARENESS(TABLE-10)

94% of the respondents were aware of any one of the contraceptive services available.

CONTRACEPTIVE AWARENSS	NO OF PATIENTS	PERCENTAGE
PRESENT	376	94%
ABSENT	24	6%

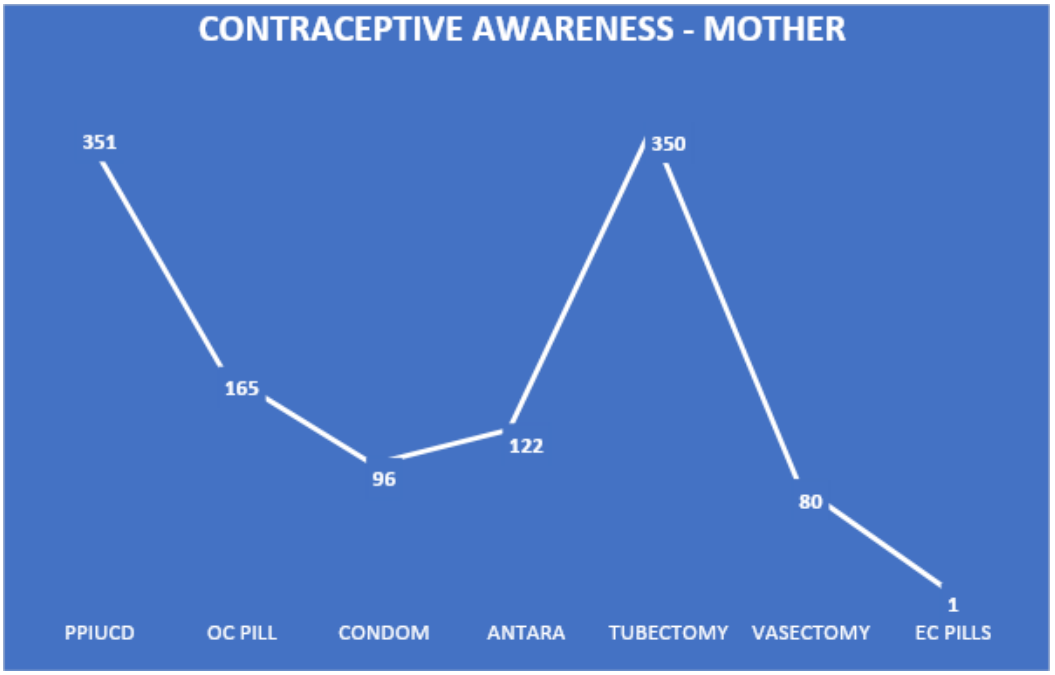


AWARENESS ABOUT TYPE OF CONTRACEPTION IN MOTHER

(TABLE-10.1)

Out of that 94% - 88% of them were aware about PPIUCD, 87% of them were aware about tubectomy. Awareness about emergency contraception were least accounting for only 1%.

TYPE OF CONTRACEPTIVE	NO OF PATIENTS	PERCENTAGE
PPIUCD	351	88%
OC PILL	165	41%
CONDOM	96	24%
ANTARA	122	30%
TUBECTOMY	350	87%
VASECTOMY	80	20%
EC PILLS	1	1%

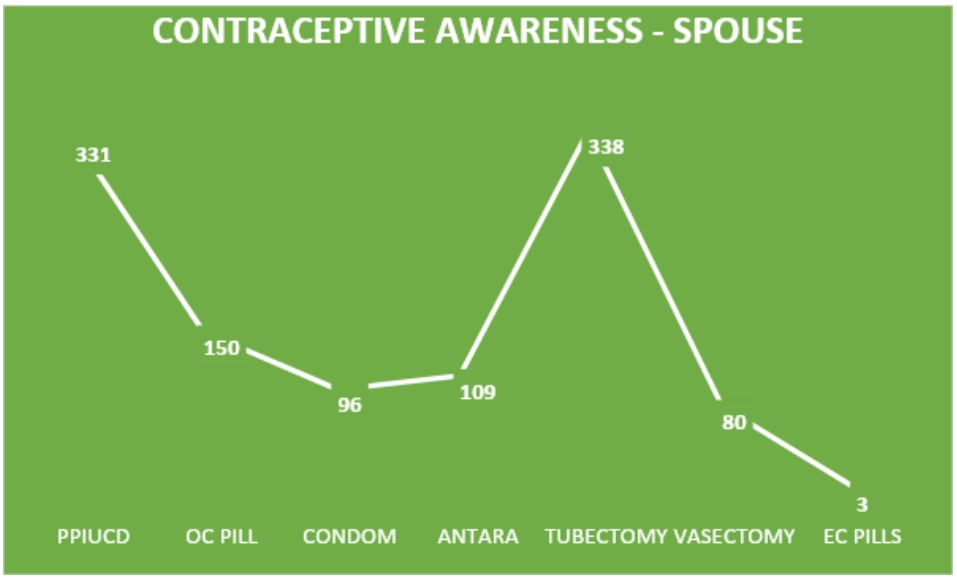


AWARENESS ABOUT TYPE OF CONTRACEPTION IN SPOUSE

(TABLE-10.2)

Out of 90% respondents spouse- 84% of them were aware about PPIUCD, 82% were aware about tubectomy. Only 1% of them were aware about emergency contraception.

TYPE OF CONTRACEPTIVE	NO OF PATIENTS	PERCENTAGE
PPIUCD	331	82%
OC PILL	150	37%
CONDOM	96	24%
ANTARA	109	27%
TUBECTOMY	338	84%
VASECTOMY	80	20%
EC PILLS	3	1%

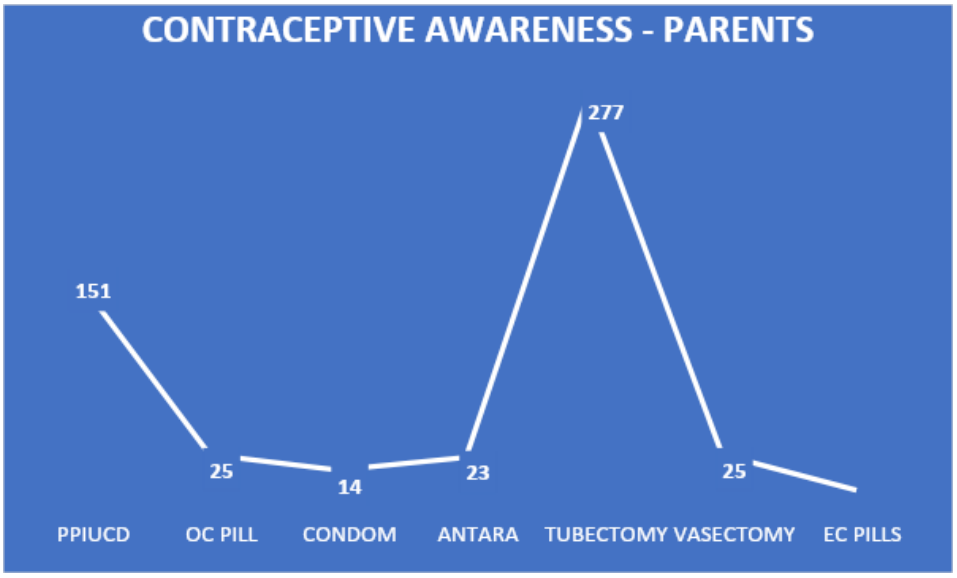


AWARENESS ABOUT TYPE OF CONTRACEPTION IN PARENTS

(TABLE-10.3)

Only 70% of the parents or attenders of respondents were aware of any one of the contraceptive methods. 69% were aware of tubectomy while 38% were aware about PPIUCD. no one were aware about emergency contraception

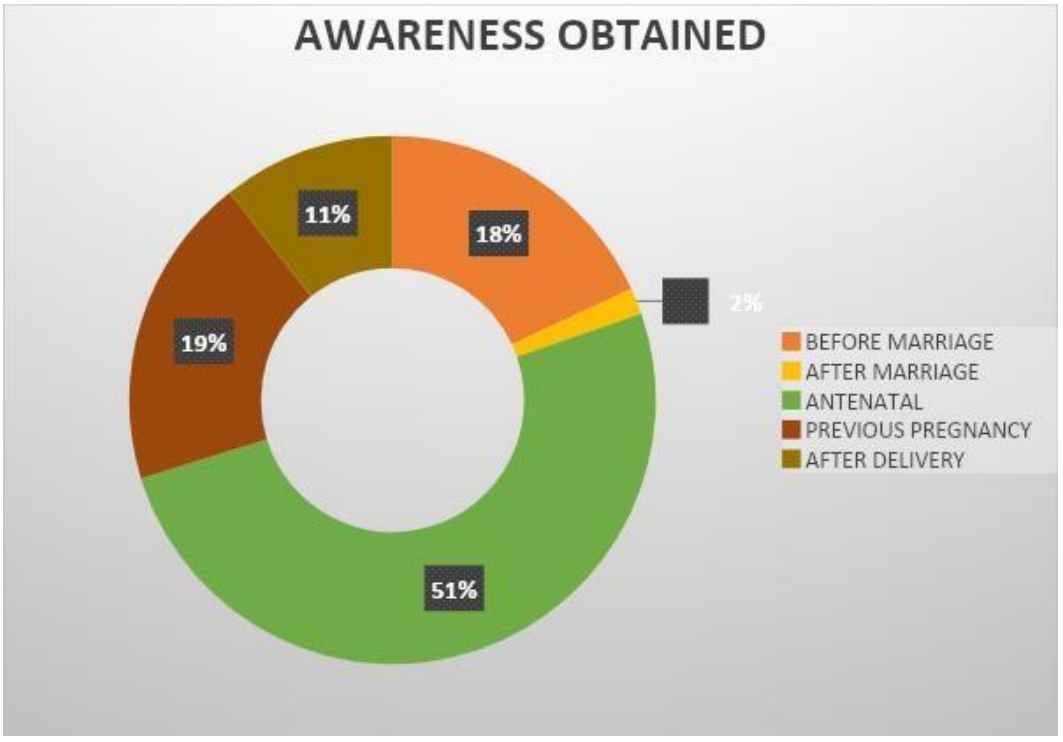
TYPE OF CONTRACEPTIVE	NO OF PATIENTS	PERCENTAGE
PPIUCD	151	38%
OC PILL	25	6%
CONDOM	14	3%
ANTARA	23	6%
TUBECTOMY	277	69%
VASECTOMY	25	6%
EC PILLS	0	0%



WHEN WAS AWARENESS ABOUT CONTRACEPTIVE OBTAINED

(TABLE-11)

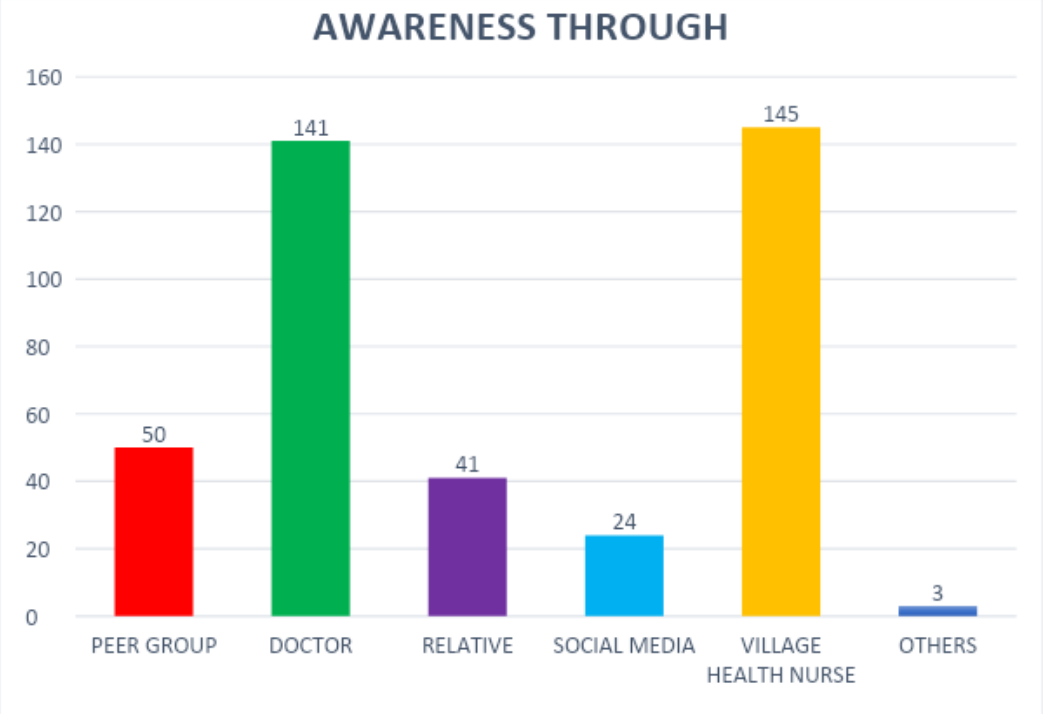
AWARE OF CONTRACEPTIVE	NO OF PATIENTS	PERCENTAGE
BEFORE MARRIAGE	68	18%
AFTER MARRIAGE	6	2%
ANTENATAL	190	50%
PREVIOUS PREGNANCY	72	19%
AFTER DELIVERY	40	11%



SOURCE OF KNOWLEDGE ABOUT CONTRACEPTION (TABLE-12)

Mostly the patients get awareness during the antenatal period through village health nurse (36%), Doctors(35%) and 22% through peer groups or relatives.

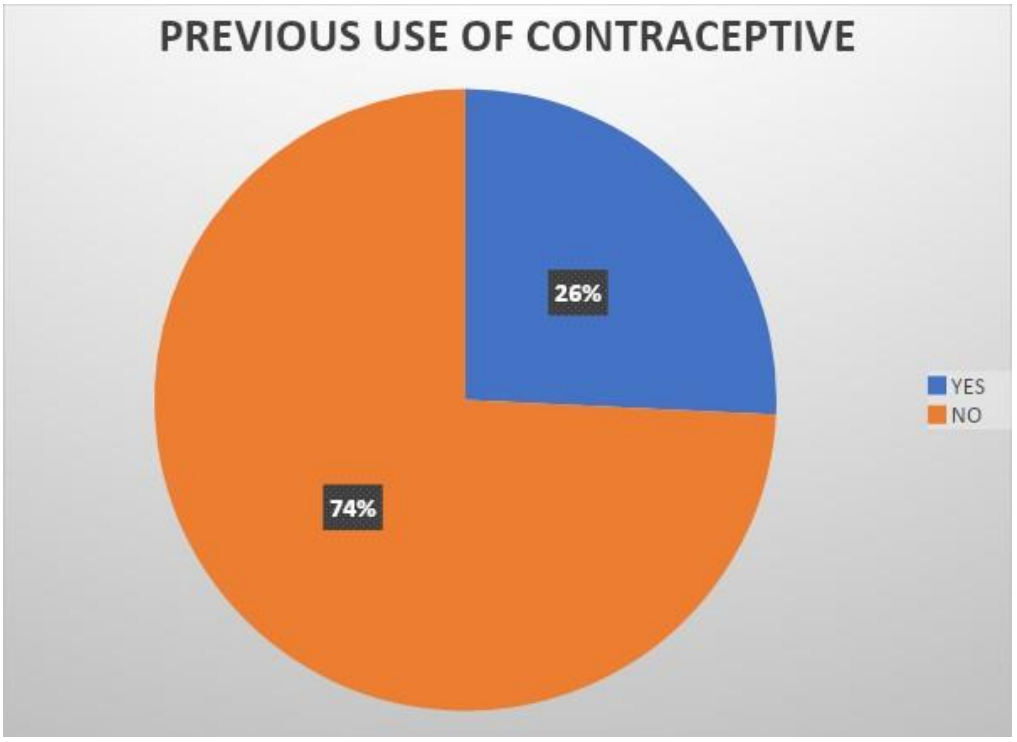
SOURCE OF KNOWLEDGE	NO OF PATIENTS	PERCENTAGE
PEER GROUP	50	12%
DOCTOR	141	35%
RELATIVE	41	10%
SOCIAL MEDIA	24	6%
VILLAGE HEALTH NURSE	145	36%
OTHERS	3	1%



PRIOR PRACTICE OF CONTRACEPTION(TABLE-13)

Though most of the respondents were aware of contraceptive methods available, 74% of them had never used any of the methods previously.

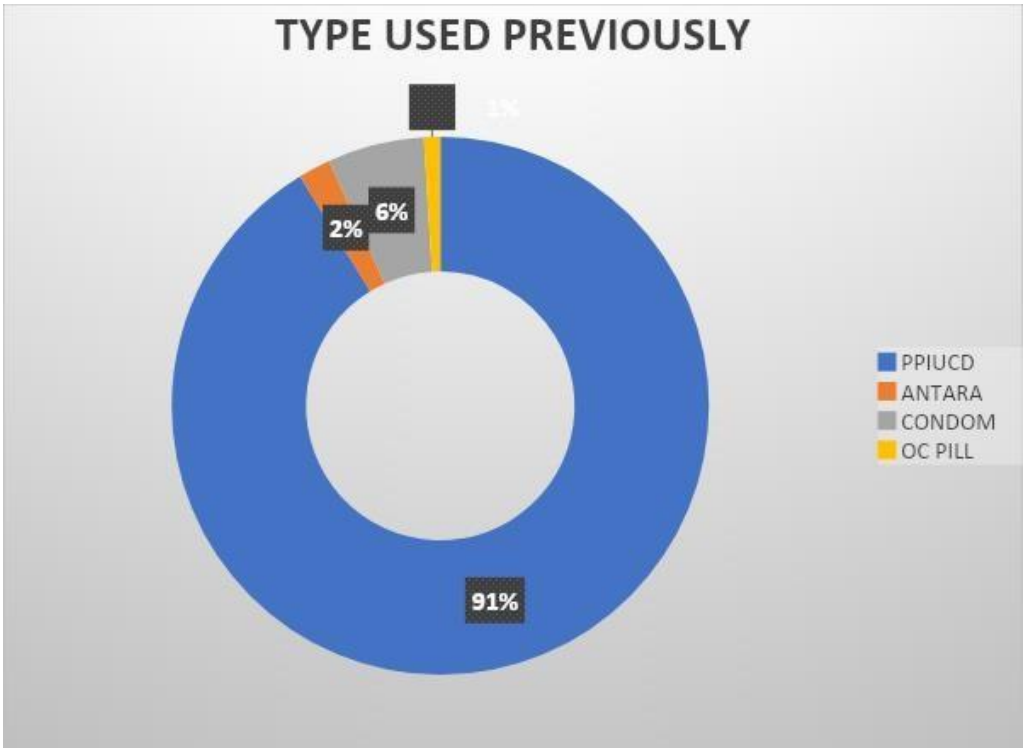
PREVIOUS USE	NO OF PATIENTS	PERCENTAGE
YES	103	26%
NO	297	74%



METHOD OF CONTRACEPTION PREVIOUSLY USED(TABLE-14)

Only 26% of the total repondents have used any one of the contraceptive methods prior. Among the methods used most commonly used method was PPIUCD (91%).6% of them have used condoms.

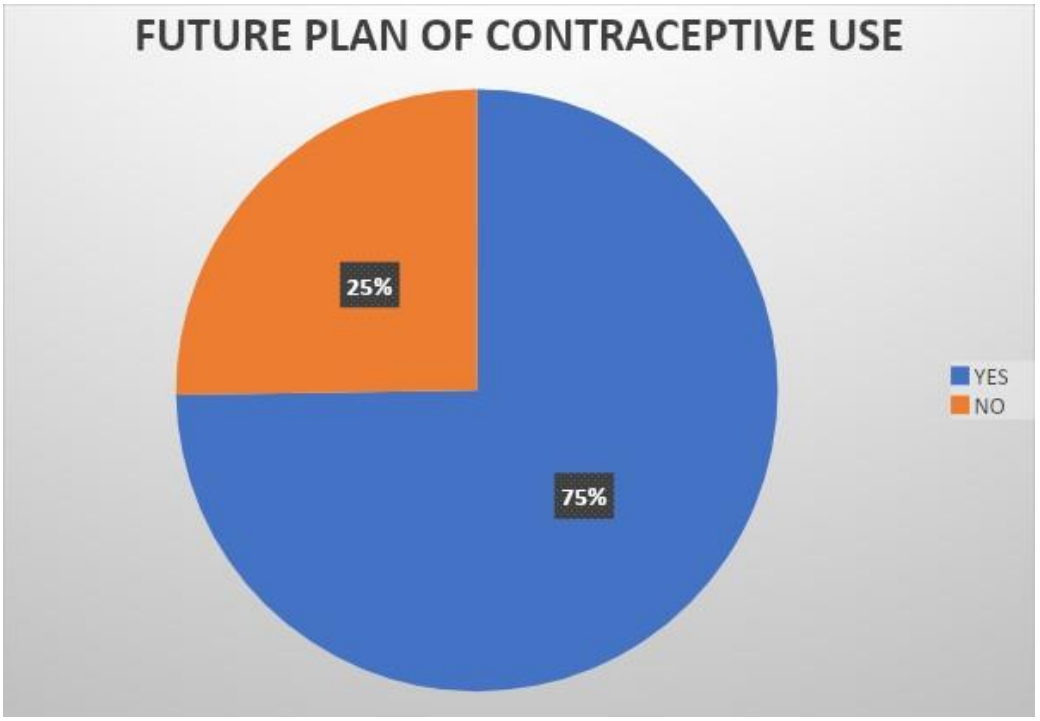
METHOD	NO OF PATIENTS	PERCENTAGE
PPIUCD	94	91%
ANTARA	2	2%
CONDOM	6	6%
OC PILL	1	1%



FUTURE PLAN OF CONTRACEPTIVE USE(TABLE-15)

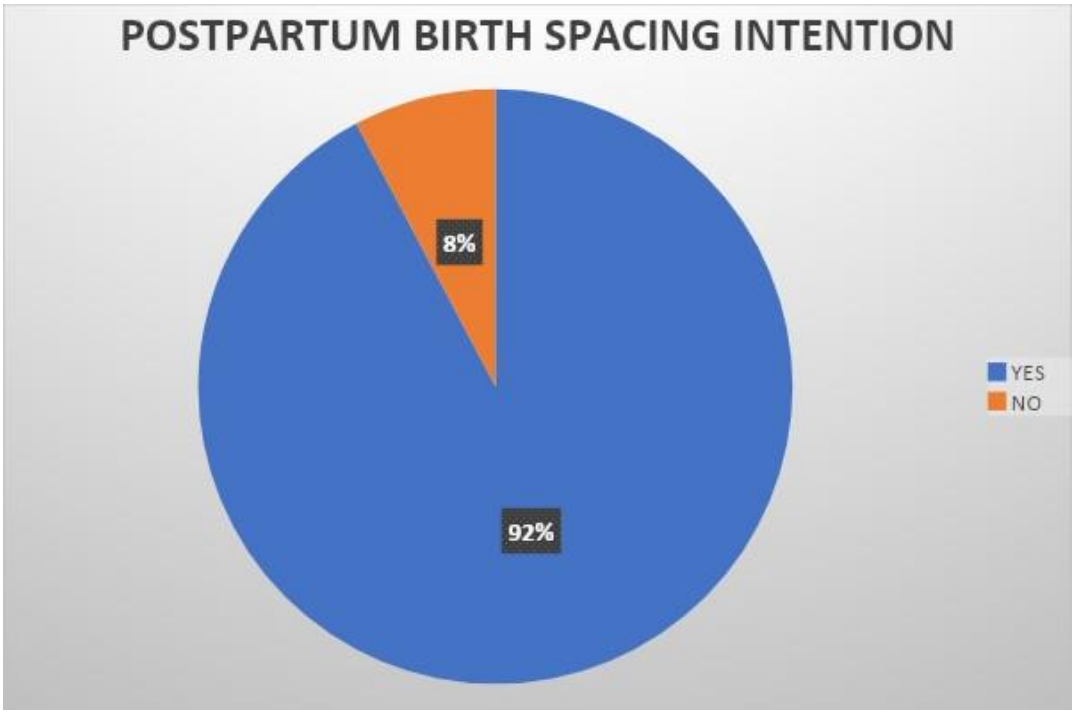
75% of the respondents have plan for future use of any of the contraceptive services available.

FUTURE PLAN	NO OF PATIENTS	PERCENTAGE
YES	299	75%
NO	101	25%



POSTPARTUM BIRTH SPACING INTENTION(TABLE-16)

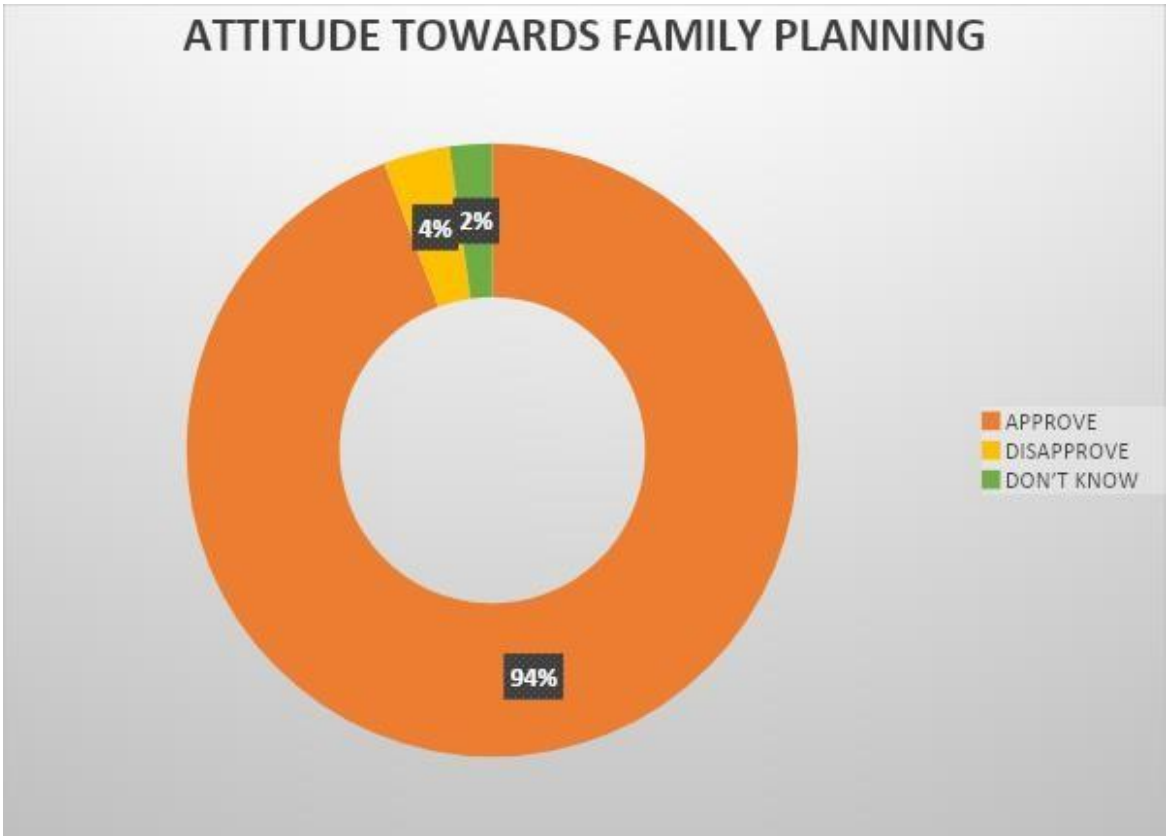
BIRTH SPACING	NO OF PATIENTS	PERCENTAGE
YES	369	92%
NO	31	8%



ATTITUDE TOWARDS FAMILY PLANNING(TABLE-17)

Among the respondents 94% of them approve contraceptive usage, 4% disapprove its use and 6% of them were still have no idea about its usage.

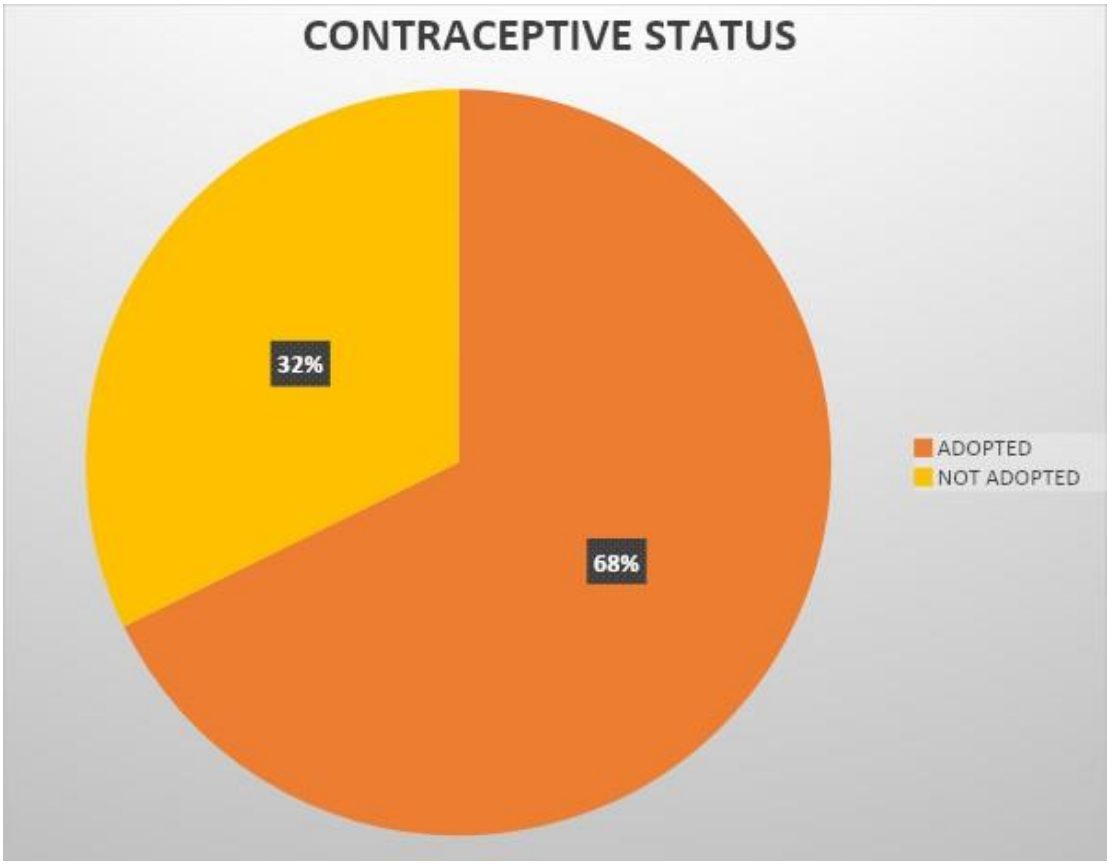
ATTITUDE	NO OF PATIENTS	PERCENTAGE
ACCEPT	377	94%
DON'T ACCEPT	14	4%
DON'T HAVE ANY IDEA	9	2%



CONTRACEPTIVE ADOPTED AFTER COUNSELLING(TABLE-18)

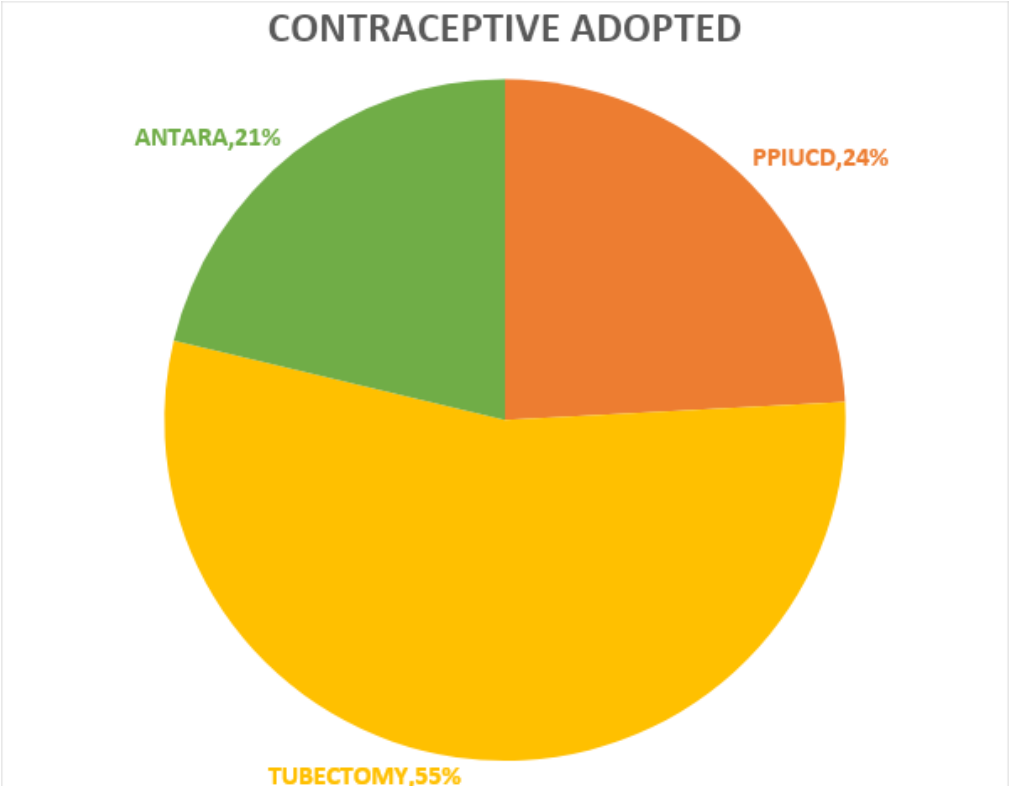
68% of the respondents have adopted any of the contraceptive services after counseling them about its advantages and disadvantages. While 32% were still not adopting any of the services in spite of counseling.

CONTRACEPTIVE STATUS	NO OF PATIENTS	PERCENTAGE
ADOPTED	271	68%
NOT ADOPTED	129	32%



TYPE OF CONTRACEPTIVE ADOPTED(TABLE-19)

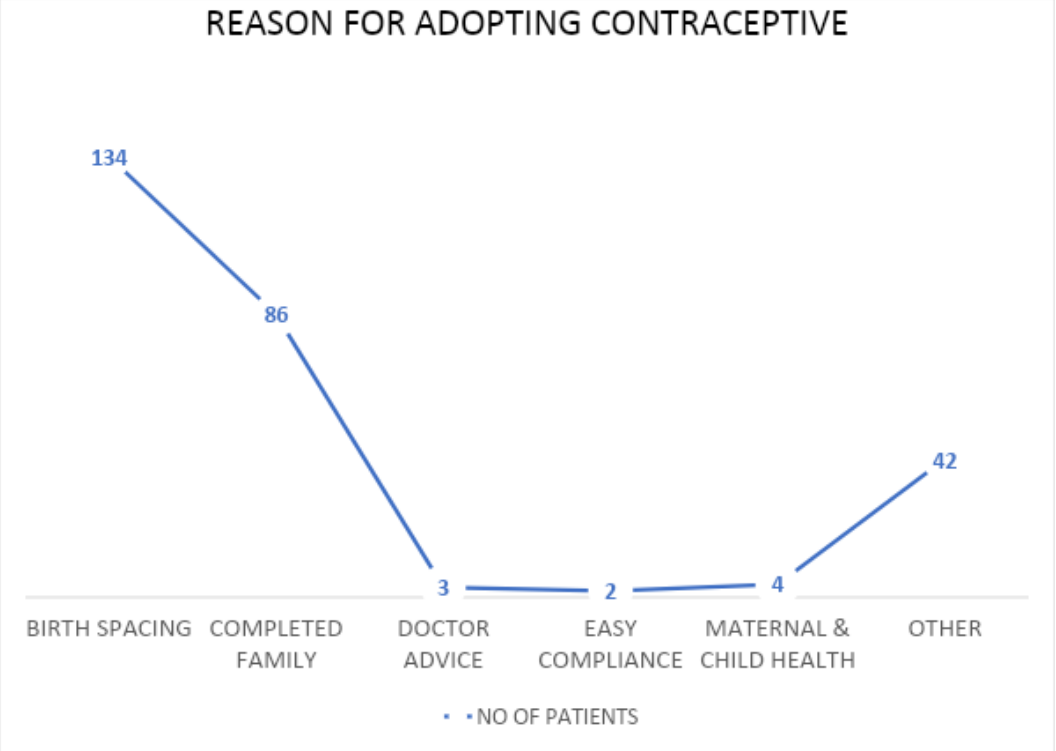
CONTRACEPTIVE ADOPTED	NO OF PATIENTS	PERCENTAGE
PPIUCD	92	24%
TUBECTOMY	208	55%
ANTARA	81	21%



REASON FOR ADOPTING CONTRACEPTIVES(TABLE-20)

Among the reasons for adopting contraceptive services, most common were birth spacing (49%) followed by completed family(32%).

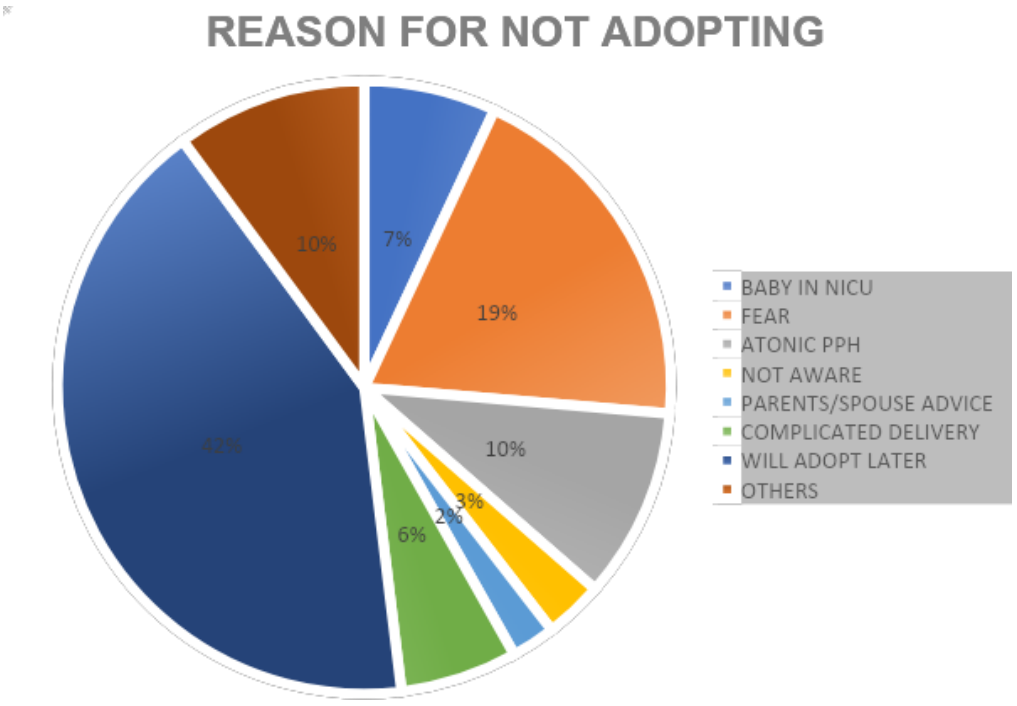
REASON	NO OF PATIENTS	PERCENTAGE
BIRTH SPACING	134	49%
COMPLETED FAMILY	86	32%
DOCTOR ADVICE	3	1%
EASY COMPLIANCE	2	1%
MATERNAL & CHILD HEALTH	4	2%
OTHER	42	16%



REASON FOR NOT ADOPTING CONTRACEPTIVE METHODS(TABLE-21)

Among the reasons for not adopting the contraceptive services, most common was fear of side effects(20%)

REASON FOR NOT ADOPTING	NO OF PATIENTS	PERCENTAGE
BABY IN NICU	9	7%
FEAR	25	20%
ATONIC PPH	13	10%
NOT AWARE	4	3%
PARENTS/SPOUSE ADVICE	3	2%
COMPLICATED DELIVERY	8	6%
WILL ADOPT LATER	54	42%
OTHERS	13	10%

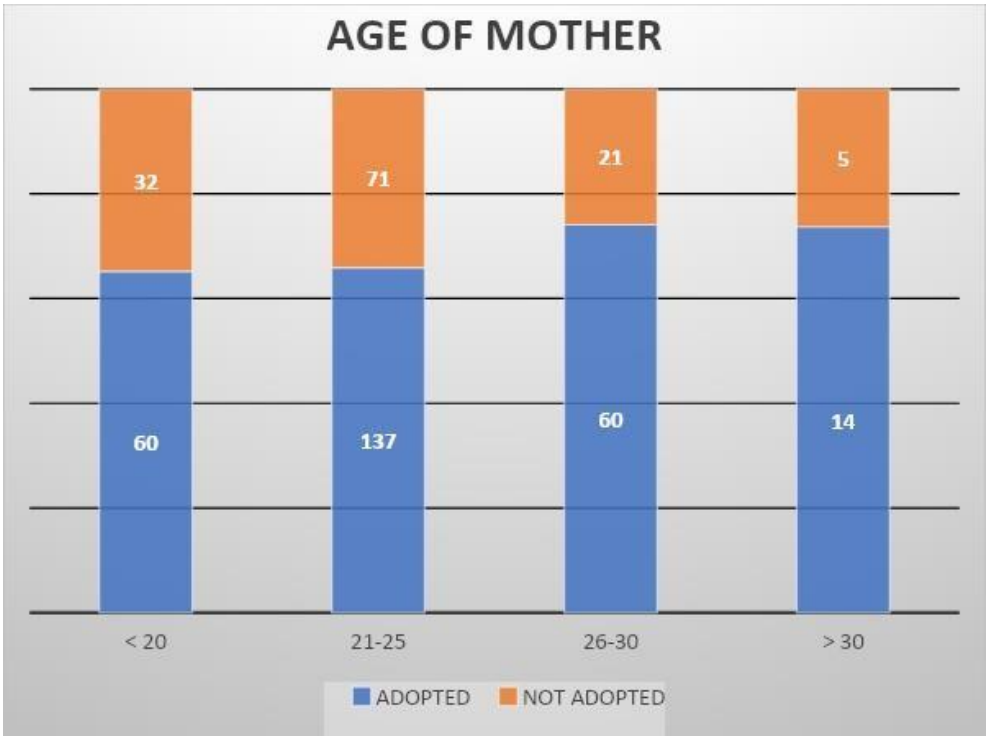


FACTORS RELATED TO CONTRACEPTIVE ADOPTION

AGE OF MOTHER(TABLE-1.1)

In my study, Age of the patients have no significant influence over the percentage of patients adopting the contraceptive services.

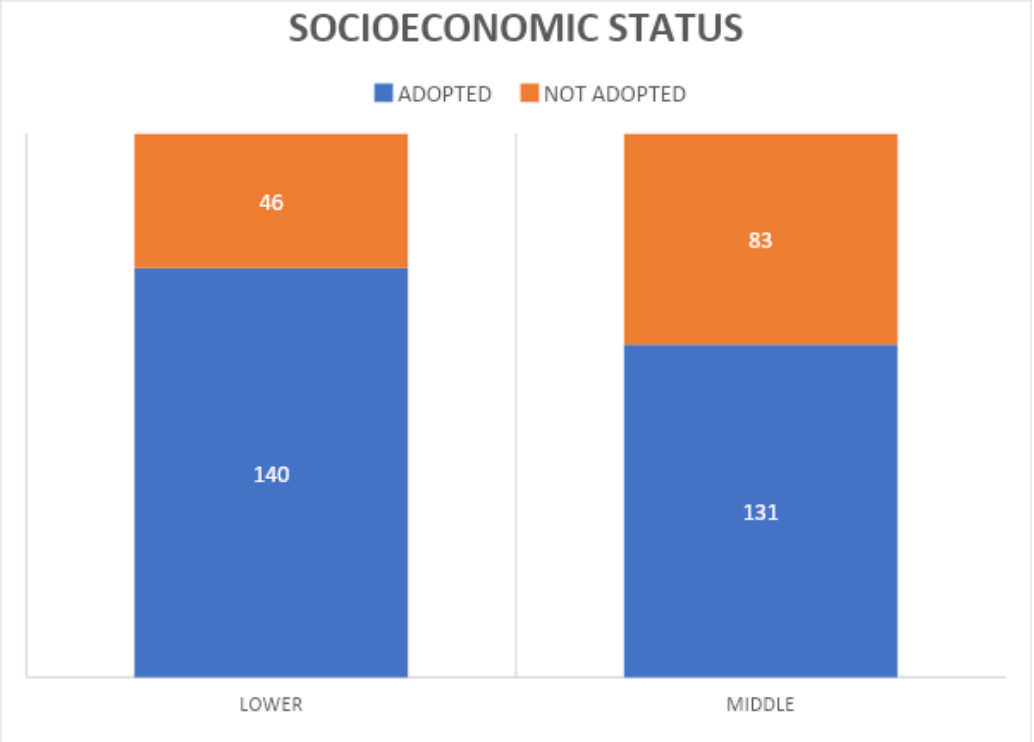
AGE OF MOTHER	ADOPTED	NOT ADOPTED
< 20	60	32
21-25	137	71
26-30	60	21
> 30	14	5
KRUSKAL WALLIS TEST		
P VALUE - 0.494		
NON SIGNIFICANT		



SIGNIFICANCE OF SOCIOECONOMIC STATUS(TABLE-4.1)

Adoption of contraception by patients of low socioeconomic status is high when compared to middle socioeconomic status in my study.

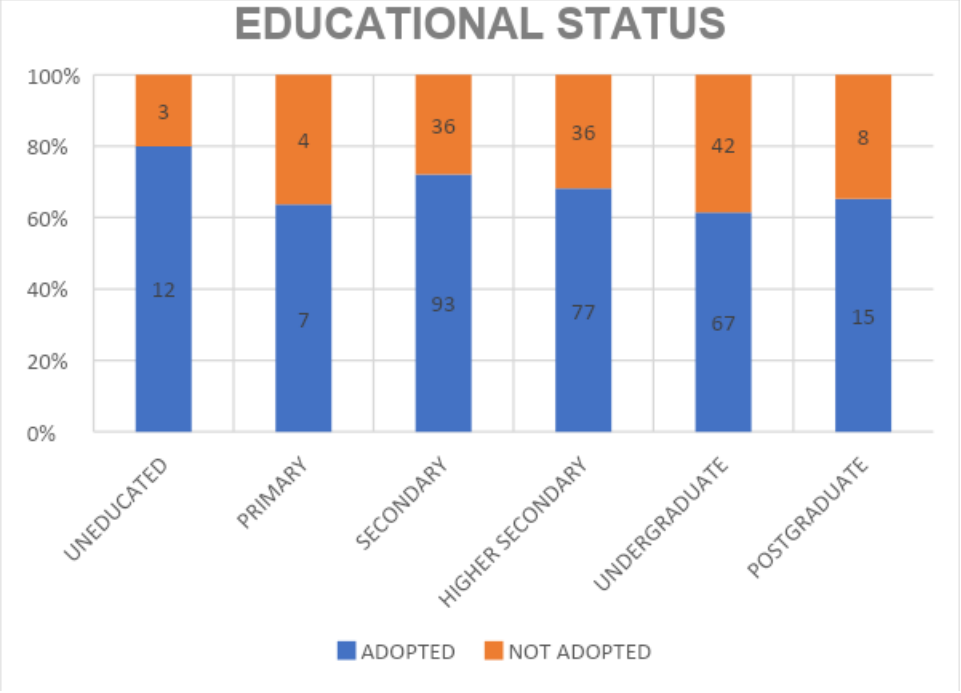
SOCIOECONOMIC STATUS	ADOPTED	NOT ADOPTED
LOW	140	46
MIDDLE	131	83
CHI SQUARE TEST		
P VALUE - 0.002		
SIGNIFICANT		



SIGNIFICANCE OF EDUCATIONAL STATUS OF PATIENT(TABLE-6.2)

In my study, Education status of the patients did not have any significant influence over the adoption of contraceptive services.

EDUCATION STATUS	ADOPTED	NOT ADOPTED
UNEDUCATED	12	3
PRIMARY	7	4
SECONDARY	93	36
HIGHER SECONDARY	77	36
UNDERGRADUATE	67	42
POSTGRADUATE	15	8
KRUSKAL WALLIS TEST		
P VALUE - 0.510		
NON SIGNIFICANT		

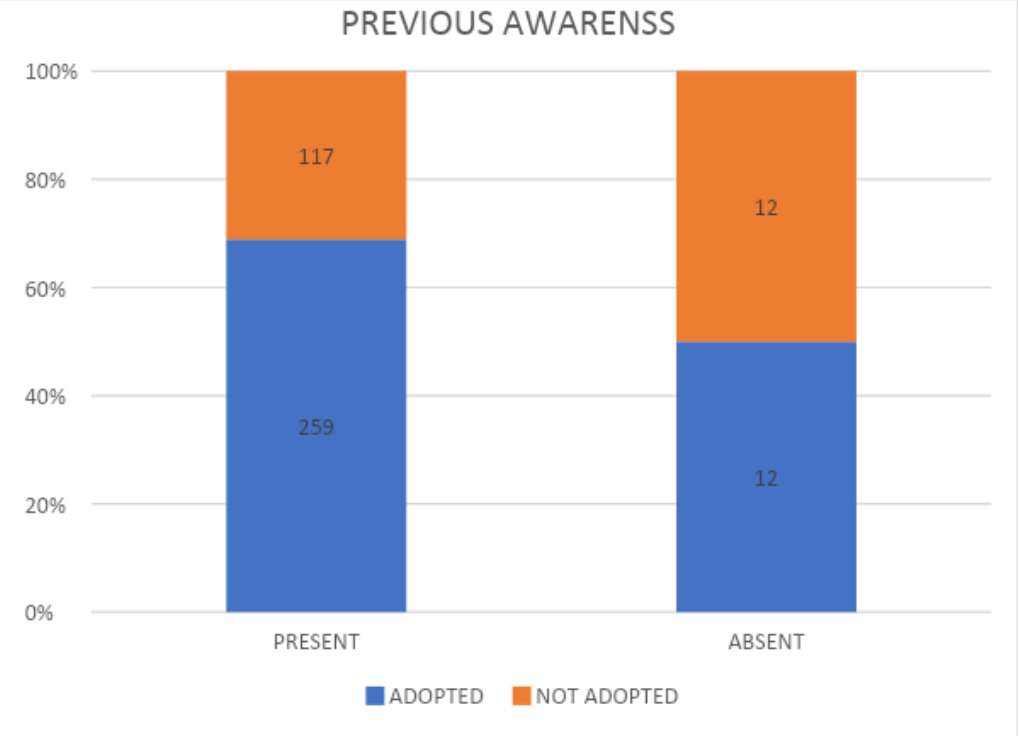


PREVIOUS AWARNESS ABOUT CONTRACEPTIVES

(TALE-10.4)

In my study, Previous awareness about the contraceptive services had significant influence over the percentage of patients adopting any of the contraceptive services at present.

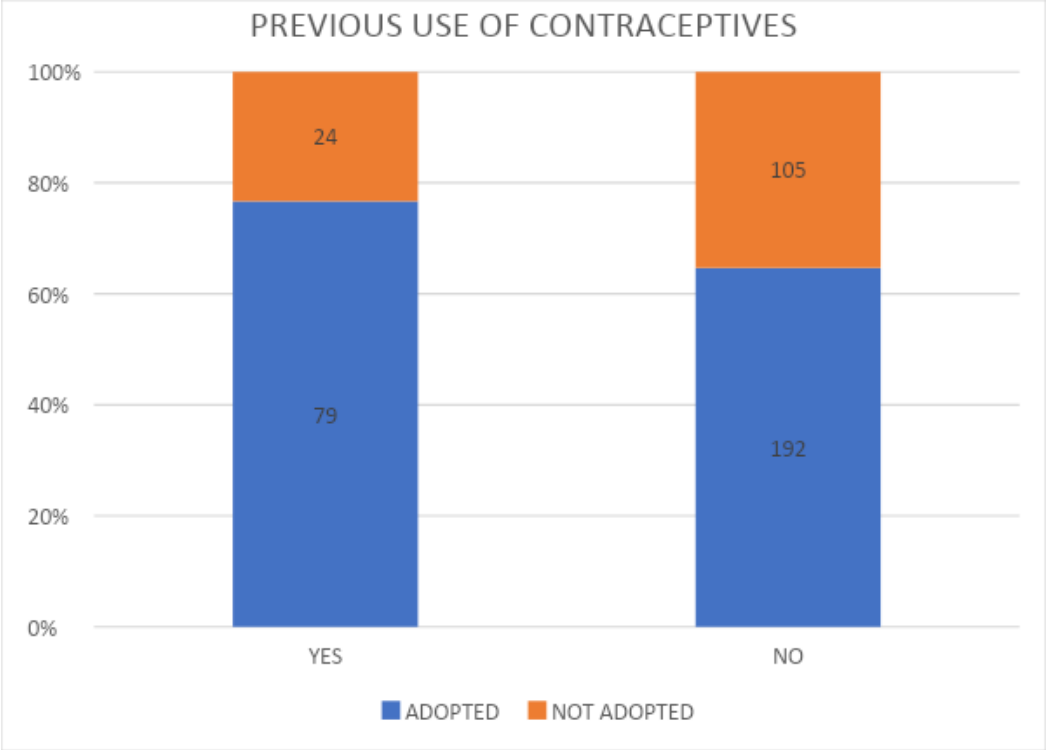
PREVIOUS AWARENESS	ADOPTED	NOT ADOPTED
PRESENT	259	117
ABSENT	12	12
CHI SQUARE TEST		
P VALUE - 0.05		
SIGNIFICANT		



HISTORY OF PREVIOUS USE OF CONTRACEPTIVES(TABLE-13.1)

In my study,Previous use of any of the contraception has significant influence over percentage of patients adopting contraceptive services now.

PREVIOUS USE	ADOPTED	NOT ADOPTED
YES	79	24
NO	192	105
CHI SQUARE TEST		
P VALUE - 0.024		
SIGNIFICANT		



DISCUSSION

DISCUSSION :

1. SOCIO DEMOGRAPHIC CHARACTERISTICS

- Socio demographic characteristics of the patients have been studied. Among all the women majority of them (52%) were between the age group 21-25years, 23% were less than 20yrs and only 5% were more than 30years of age [Table1]. There is no significant difference in acceptance of contraception with age of the patient [Table1.1].
- In my study as the duration since marriage increases acceptance of contraception also increases [Table2.1]. Most the patients in my study (77%) were married within 5years while very few respondents were married more than 10 years ago.[Table2].
- Among the study population, majority of them were Primi gravida (47%) and the acceptance of contraception was only 61%. Higher order of birth (P3, P4, P5) constitutes 16% of respondents and their acceptance of contraception is 87%[Table3] [Table3.1]. This shows that as the parity increases acceptance of contraception also high.
- In my study respondents belong either to middle socio economic status (54%) or lower socio economic status [Table4]. Acceptance of contraception is significantly high in lower socio economic status [Table4.1].
- Since our respondents mostly belong to rural area, most of them were living with elders as joint family (68%) [Table5]. There is no significant difference in acceptance of contraception between patients influenced by parents & peer groups.[Table 5.1].
- In our study 60% of respondents had done high school. 34% of them had done graduation. Only <7% had studied less than primary school [Table6]. There is no

significant difference in acceptance of contraception between educated and uneducated patients [Table6.1].which goes against the study by Ingle et al.

- Though most of the respondents were educated only 9% of them were working while remaining 91% of them were house wife [Table7]. There is no significant difference in acceptance of contraception between working and non working patients.[Table7.1].
- In my study 60% of respondents delivered by normal vaginal delivery and 40% of them by cesarean section [Table8]. There is significantly high acceptance among patients delivered by cesarean section [Table8.1].

2. AWARENESS ABOUT CONTRACEPTION

- The knowledge about contraception among respondents were studied. 94% of them were of any one of the contraceptive methods. The most popular method was female sterilization(88%), followed by PPIUCD(87%) then comes the OCpills(30%).Only 1% of the respondents were aware of emergency contraception[Table10].
- Overall awareness of any contraceptive is 94% among the respondents[table 9].There is significant difference in acceptance of contraception with knowledge about contraception among the patient. [table 10.4]. K.Bhastin et al , found an awareness of 94.4% in east delhi and significant difference in acceptance based on knowledge about contraception.
- The most important source of knowledge is from village health nurse (36%) , doctors (35%) followed by relatives and peer groups (22%).[table 12] and the knowledge about contraception was obtained mostly during present antenatal period followed by previous pregnancy.[table 11. It implies only 71% of knowledge is obtained through medical and paramedical officials.

- Previous use of any contraceptive method by the patients were studied, though 94% of them were aware of contraceptive methods, only 26% of them had previously adopted any one of them. The most commonly adopted contraceptive method is PPIUCD (91%) followed by condom (6%)[table 14]. 74% of them had never used any mode of contraception [table 13]. There is significantly high acceptance of contraception in previously used patients [table 13.1].
- 92% of the patients had birth spacing intention while 8% had no idea about birth spacing [table 16]

3. ACCEPTANCE AND ADOPTION OF CONTRACEPTIVE SERVICES

- The analysis of attitude towards acceptance of family planning practices showed that 98% of women were AWARE of contraception among them 94% accept its usage while 4% of them did not accept its usage. 2% of them did not have any idea about family planning.[table 17]
- In my study, the current use of any of the contraceptives among respondents is 68% [table 18]. In Tamilnadu 68.6% of currently married women were using some method of contraception as per NFHS-5 which is almost equal to that of my study. Among the contraceptive uses it is found that majority (52%) of them have undergone tubectomy and the least used method is OC pills (0.1%) [table 19]. This matches with the highest used method as per NFHS-5.
- In this study 32% of the patients did not adopt any kind of contraception which is greater than that of any state data 2019 – 2021 according to NFHS-5 i.e, 10.1%.[table 18]. The most common reason for not adopting contraception were Misconception that immediate acceptance may lead to weakness (42%), followed by fear of pain (20%), very few due to intrapartum and postpartum complications and some were influenced by spouse and relatives [table 21].

CONCLUSION

CONCLUSION

- Acceptance of contraception among patients delivered by cesarean section (75%) is significantly high when compared with normal vaginal delivery (65%). Since during LSCS sterilization or IUCD insertion is done concurrently under anesthesia. In labor natural patients are afraid of pain during insertion of PPIUCD and there is a need for increased duration of stay in hospital away from home in case of puerperal sterilization. Fear of pain can be overcome with Reassurance , Tender loving care and family counseling. Sterilisation services can be improved by conducting camps at rural areas and promoting puerperal sterilization at PHC level.
- Previous awareness about contraception increases the acceptance of contraception following delivery. Therefore counselling the patients on full range of available contraceptive methods and especially about advantages and side effects with its management from the day of diagnosis of pregnancy till delivery during each visit by medical professionals at all levels (PHC,CHC,TERTIARY CARE CENTER) not only to patients but also to all accompanying persons is to be made mandatory.
- 32.5% of the patients had never used any of contraception, the reason for not adopting were were Misconception that immediate acceptance may lead to weakness, followed by fear of pain , opposition by family members. And the counselling should be given not only to the patients but also to the spouse and their parents regarding different contraceptive services provided and any misconceptions or queries needs to be clarified. Uncovered patients need to be followed up by VHN regarding acceptance in near future.

- Among the patients who adopted the contraceptive services , the most common reason for adoption of service were birth spacing(49%) followed by completed family(32%)and interval sterilization(16%). Women need to be counselled on the full range of available methods so that they can choose the method that best matches their individual circumstances and the intentions and can change the methods when they need to.
- There is significant difference in adoption of family planning services between patients who had previously used and not used [table 13.1]. This indicates there is problem with initiation of contraceptive services. We need to pinpoint the obstacles in the society and weakness in the services that needs to be overcome.

LIMITATIONS

The study has been conducted only in one tertiary care center where all contraceptive facilities are available.

REFERENCE

REFERENCES

1. Charles Westoff “Unmet Need for Contraception in the 21st Century”.
2. Westoff ,”unmet need for family planning.
3. Casterline, John B. and Steven W. Sinding. Unmet Need for Family Planning in Developing Countries and Implications for Population Policy. Population and Development Review 26(4): 691- 723 December 2007.
4. Stover, John. Revising the Proximate Determinants of Fertility Framework: WhatHave We Learned in the Past 20 Years? Studies in Family Planning Vol. 29, No.3, September 2004.
5. Anju Puri, Suneela Garg, Malti Mehra Assessment of Unmet Need for Contraception in an Urban Slum of Delhi vol. 29, No. 3 (2004-07- 2004- 9).
6. Farina G Abrejo, Babar T Shaikh, Sarah Saleem Reproductive Health 2008, 5:4 (10 September 2008).
7. Gillespie, Duff G. What Happened to Family Planning and, for That Matter, Reproductive Health? International Family Planning Perspectives Vol. 30, No. 1,March 2004.
8. Judith R. Seltzer ,Evolution of Family Planning Programs in Developing Countries,. January 15, 2005.
9. K. Bhattacharya1, R. Ram1, D. N. Goswami1, U. D. Gupta I,
10. K. Bhattacharyya1 S. Ray 2 Study of Unmet Need for Family Planning among Women of Reproductive Age Group Attending Immunization Clinic in a MedicalCollege of Kolkata Indian Journal of Community Medicine Vol. 31, No. 2, April- June, 2006.

11. Sharma AK, Grover V, Agrawal OP, Dubey KK, Sharma S. Pattern of Contraceptive Use By Residents of a Village in South Delhi. India Journal of Public Health 1999; 41 (3): 75-78.
12. Sahin HA, Sahin HG, Reasons for not using family planning methods in Turkey; European journal of reproductive health care, 2003; 8: 11-16.
13. Ram R, Ghosh M N, Bhattacharya S, Haider A, Chatterjee C, Naskar N. Study of unmet need for family planning among married women of reproductive age attending Immunisation clinic in a Medical College of Calcutta. Indian J. of Community Medicine, 2000; 25: 22-25.
14. Rajaretnam, T. and R. V. Deshpande. Factors Inhibiting the use of Reversible Contraceptive Methods in Rural South India. Studies in Family Planning Vol. 25, No. 2, 111-121, March-April 1994.
15. Julie, Billings, Reasons for unmet need of contraception in Kenya, 2003.
16. Stash, Sharon. Explanations of Unmet Need for Contraception in Chitwan, Nepal. Studies in Family Planning Vol. 30, No. 4, December 1999.
17. Zhang F, Determinants of contraceptive discontinuation in Northern India: a multilevel anlysis, Indian journal of community medicine, Vol 14, 2004, 36-38.
18. Prachi R, Das GS, Ankur B, Shipra J. A study of knowledge, attitude and practice of family planning among women of reproductive group in Sikkim; journal of obs & gynec India 2008; 58; 63-7.
19. Raab M, Discontinuation of contraceptive practices among married women of Ghana, International Family planning perspectives, June 2004
20. David LH, Bhas M, knowledge and side-effects of contraceptive methods among rural married women; Indian journal of family welfare; 2002.

21. Elizabeth Tolley, Sarah Loza, Impact of menstrual side-effects on contraceptive discontinuation: findings from a longitudinal study in Cairo; Egypt 2002.
22. JE Edwards et al, Women's knowledge and attitudes to, contraceptive effectiveness and adverse health effects. British journal of family planning 2000:73-80.
23. Murty J, Efficacy and side-effects of oral contraceptives; Journal of family planning and reproductive health care; vol 29, Jan 2003; 41-42.
24. Viswanathan, H., S. Godfrey and N. Yinger. 1998. *Reaching Women: A Study of Unmet Need in Uttar Pradesh, India*. Washington, D.C.: International Centre for Research on Women.
25. Khan,ID. KAP study on contraceptives among married women, Indian journal for practicing doctors vol 5,no 2, (2008-06).
26. Srivastava R, Srivastava DK, Sharma N,Contraceptive knowledge, attitude and practices (KAP) survey .journal of obs & gynec India 2005: 55;546-50.
27. Santhya, K.G. and S.J. Jejeebhoy. 2003. Sexual and reproductive health needs of married adolescent girls. *Economic and Political Weekly*, 38(41): 4370-74.
28. Kumar, R., A.K.Aggarwal et al, Adolescent behaviour regarding reproductive health. Indian journal of peadriatrics, 67(12);877-881.
29. Phillips, James F., Wendy L. Greene, and Elizabeth F. Jackson. Lessons from Community-based Distribution of Family Planning in Africa. 1999.
30. Prachi R, Ankur B, Shipra J. A study of knowledge, attitude and practice of family planning among women of reproductive group in Subsaharan Africa 2008;58;63-7.

31. Dutta K' "Reasons for unmet need of contraception among rural women of Delhi" , Indian journal of community medicine , 2004 , P 17-19
32. Collette,Julie , Social factors influencing contraceptive practices in Kenya , 2005 , P 20-23
33. Nag M. Some cultural factors affecting cost of fertility regulation. Population bulletin of the united nation 2000.
34. Domiciliary Distribution to Site-Based Family Planning Services in Bangladesh. International Family Planning Perspectives Vol. 27, No. 2, June 2001.
35. Rozina Mustafa, Uzma Afreen , contraceptive knowledge, attitude and practices among rural women of pakistan, 2005.
36. Casterline JB, Social challenges of unmet need of contraception in Philipines, International family planning perspectives, Vol 22, 2004.

PROFORMA

GOVERNMENT DHARMAPURI MEDICAL COLLEGE HOSPITAL

PROFORMA

NAME ADDRESS D.O.A

AGE PHONE.No. D.O.D

IPNO OBSTETRIC SCORE

MARITAL STATUS

OBSTETRICHISTORY

SOCIO ECONOMIC STATUS

TYPE OF FAMILY - NUCLEAR / JOINT FAMILY

EDUCATION OF PATIENT SPOUSE

OCCUPATION OF PATIENT SPOUSE

MENSTRUAL HISTORY LMP EDD

CONCEPTION HISTORY

REASON FOR ADMISSION

MEDICAL HISTORY

SURGICAL HISTORY

ANTENATAL COMPLICATIONS IF ANY

VITALS Temperature PR BP

MODE OF DELIVERY

LABOR NATURAL --> (SPONTANEOUS / INDUCED)

LSCS --> (ELECTIVE / EMERGENCY)

INTRAPARTUM COMPLICATIONS IF ANY POSTPARTUM CONTRACEPTION - Adopted

- Not adopted

FOLLOW UP

KNOWLEDGE, ATTITUDE AND PRACTISE OF CONTRACEPTION

QUESTIONNAIRE

1. WHAT ARE THE CONTRACEPTION PATIENT AWARE OF ?

PPIUCD OC PILLS

CONDOM TUBECTOMY

ANTARA VASECTOMY

EMERGENCY CONTRACEPTION

2. CONTRACEPTION AWARENESS OF SPOUSE ?

3. CONTRACEPTION AWARENESS OF PARENT / IN LAWS ?

4. WHEN DO PATIENT KNOW ABOUT VARIOUSCONTRACEPTION METHODS ?

5. HOW DID PATIENT COME TO KNOW ABOUTCONTRACEPTIVE METHODS ?

PEER GROUPS DOCTORS

RELATIVES SOCIAL MEDIA

VILLAGE HEALTH NURSE OTHERS

6. CONTRACEPTION METHODS PREVIOUSLY USED?

7. CHOICE OF CONTRACEPTIVE METHOD FOR FUTURE USE ?

8. POSTPARTUM BIRTH SPACING INTENTION - YES/NO ?

9. ATTITUDE TOWARDS FAMILY PLANNING ?

APPROVE DISAPPROVE DONT KNOW

10. REASON FOR ADOPTING ANY CONTRACEPTION ?

11. REASON FOR NOT ADOPTING ANY CONTRACEPTION ?

INFORMED CONSENT

Institutional Human Ethics Committee

Government Dharmapuri Medical College, Dharmapuri

INFORMED CONSENT FORMAT FOR RESEARCH PROJECTS

(Strike off items that are not applicable)

I am S.MEKALA, FINAL YEAR M.S. (OBG), carrying out a study on the topic: EFFECT OF ANTENATAL AND IMMEDIATE POSTPARTUM COUNSELLING ON ACCEPTANCE OF CONTRACEPTION.

As part of my research project being carried out under the aegis of the Department of: OBSTETRICS & GYNECOLOGY

My research guide is: DR.R.PADMAPRIYA M.D. (OBG)

The justification for this study is: MOTIVATION AND SPREAD OF KNOWLEDGE ABOUT FAMILY PLANNING MEASURES IS IMPORTANT TO IMPROVE THE ATTITUDE AND PRACTICES OF CONTRACEPTION

The objectives of this study are:

Primary objective: To Know the prevalence of awareness and hindrance regarding usage of various family planning services

Secondary Objective: To avoid unwanted birth as well as pregnancy and regulate the interval between subsequent pregnancies

Sample size: 400

Study volunteers / participants are: 19YRS -45YRS.

Location: GOVERNMENT DHARMAPURI MEDICAL COLLEGE.

We request you to kindly cooperate with us in this study. We propose collect background information and other relevant details related to this study. We will be carrying out:

Initial interview: 15 minutes.

Data collected will be stored for a period of 18 MONTHS. We will not use the data as part of another study.

Health education sessions: Number of sessions: 3.

Approximate **duration** of each session: 30 minutes.

Clinical examination:

ANAEMIA, PEDAL EDEMA, PER ABDOMEN, PER VAGINUM

Final interview (specify approximate duration): 15 min if **photograph** is taken, purpose: n

Benefits from this study: TO REDUCE MATERNAL MORBIDITY AND MORTALITY

Risks involved by participating in this study: NIL

Reimbursement or compensation for the inconvenience: No

If yes describe the plan

Emergency Medical Treatment: If applicable, add here along with available medical treatment in case of complications.

Compensation for protocol Related Injury: No

If yes describe the details of compensation or insurance for protocol related injury to the study participant. Explain who will bear the cost in case of trial related injury?

How the **results** will be used:

If you are uncomfortable in answering any of our questions during the course of the interview / biological sample collection, **you have the right to withdraw from the interview / study at anytime.** You have the freedom to withdraw from the study at any

point of time. Kindly be assured that your refusal to participate or withdrawal at any stage, if you so decide, will not result in any form of compromise or discrimination in the services offered nor would it attract any penalty. You will continue to have access to the regular services offered to a patient. You will **NOT** be paid any remuneration for the time you spend with us for this interview / study. The information provided by you will be kept in strict confidence. Under no circumstances shall we reveal the identity of the respondent or their families to anyone. The information that we collect shall be used for approved research purposes only. You will be informed about any significant new findings - including adverse events, if any, – whether directly related to you or to other participants of this study, developed during the course of this research which may relate to your willingness to continue participation.

Consent: The above information regarding the study, has been read by me/ read to me, and has been explained to me by the investigator/s. Having understood the same, I hereby give my consent to them to interview me. I am affixing my signature / left thumb impression to indicate my consent and willingness to participate in this study (i.e., willingly abide by the project requirements).

Signature / Left thumb impression of the Study Volunteer / Legal Representative:

Signature of the Interviewer with date:

Witness:

Contact number of PI: 709231099

அரசு மருத்துவக்கல்லூரி மருத்துவமனை, தருமபுரி.

ஒப்புதல் படிவம்

தேதி :

மரு.மேகலா.ச ஆகிய நான் அரசு மருத்துவக்கல்லூரி மருத்துவமனை தருமபுரி மகப்பேறியல் மற்றும் பெண்ணோயியல் துறையின் கீழ் "பிறப்புக்கு முந்தைய மற்றும் உடனடி மகப்பேற்று ஆலோசனையின் விளைவு கருத்தடை ஏற்றுக்கொள்ளுதல்" பற்றிய ஆய்வு மேற்கொள்கிறேன்.

என் ஆய்வு வழிகாட்டி பத்மபிரியா.ர துணை பேராசிரியர் ஆய்வு மேற்கொள்வதன் கருத்தடை :

கருத்தடை அணுகுமுறை மற்றும் நடைமுறையை மேம்படுத்த குடும்பக் கட்டுப்பாடு நடவடிக்கைகள் பற்றிய அறிவை உந்துதல் மற்றும் பரப்புதலின் முக்கியத்துவம்.

ஆய்வின் நோக்கம் :

பல்வேறு குடும்பக் கட்டுபாடு சேவைகளின் பயன்பாடு தொடர்பான விழிப்புணர்வு மற்றும் இடையூறுகளின் பரவலை அறிய

தேவையற்ற பிறப்பைத் தவிர்க்கவும் மற்றும் கருவுற்றிருக்கும் கால இடைவெளியைக் கட்டுப்படுத்தவும்.

ஆய்வு மேற்கொள்ளும் இடம் :

மகப்பேறு பிரிவு அரசு மருத்துவக்கல்லூரி மருத்துவமனை தருமபுரி.

ஆய்வு செய்யப்படும் முறை:

கேள்வி பதிலாக ஆய்வில் பங்கு பெறுபவரில் தகவல் மருத்துவ ஆய்வு அறிக்கை உள் நோயாளி பதிவேட்டில் இருந்து பெறப்படும் ஆராய்ச்சியின் மாதிரி அளவு: 400

பரிசோதனை :

இந்த ஆய்வில் கிடைக்கும் தகவல்கள் பட்ட மேற்படிப்பு ஆய்வு பல்கலைக்கழத்தின் சமர்ப்பித்தலுக்கு மற்றும் பயன்படுத்தப்படும் இந்த தகவல்கள் வேறு எந்த ஆய்விற்கும் பயன்படுத்தமாட்டாது.

இந்த ஆய்வின் கேள்விகளுக்கு பதில் அளிப்பதிலோ தகவல்களை அளிப்பதிலோ உங்களுக்கு ஏதேனும் ஆசௌகரியம் இருந்தால் எந்த நேரத்தில் வேண்டுமானாலும் ஆய்வில் இருந்து விலகிக்கொள்ளும் உரிமை உங்களுக்கு உண்டு. ஆய்வில் விலகிக்கொள்வதால் உங்களுக்கு அளிக்கப்படும் சிகிச்சை முறையில் எந்த வித பாதிப்பும் இருக்காது என்று உங்களுக்கு உறுதி அளிக்கிறோம். மருத்தவமனையில் நோயாளிகளுக்கு அளிக்கப்படும் சேவைகளை நீங்கள் தொடர்ந்து பெறலாம். இந்த ஆய்வில் பங்கேற்க ஒப்புக்கொள்வதால் வேறு எந்த விதமான கூடுதலான பலனும் உங்களுக்கு கிடைக்காது. நீங்கள் அளிக்கும் தகவல்கள் ரகசியமாக வைக்கப்படும். ஆய்வில் பங்கேற்பவர்கள் பற்றியும் அவர்கள் குடும்பத்தை பற்றியும் எந்த தகவலும் எக்காரணம் கொண்டும் வெளியிடப்படாது என்று உறுதியளிக்கிறோம். நீங்கள் அளிக்கும் தகவல்கள் அங்கீகரிக்கப்பட்ட ஆய்விற்கு மட்டுமே பயன்படுத்தப்படும். இந்த ஆய்வில் தொடர்ந்து பங்குபெறுவது பற்றிய நிலைபாட்டை நீங்கள் தெரிவிக்கலாம்.

ஆய்வுக்குட்படுபவரின் ஒப்புதல்: இந்த ஆய்வைப்பற்றிய மேற்கூறிய தகவல்களை நான் படித்து அறிந்து கொண்டேன். ஆய்வாளர் படிக்க கேட்டு

தெரிந்து கொண்டேன். ஆய்வினை பற்றி நன்றாக புரிந்து கொண்டு இந்த ஆய்வில் பற்கு பெற ஒப்புக்கொள்கிறேன். இந்த ஆய்வில் பங்கேற்பதற்கான எனது ஒப்புதலை கீழே கையொப்பமிட்டு கை ரேகை பதிந்து நான் தெரிவித்துக் கொள்கிறேன்.

பங்கேற்பாளரின் பெயர் மற்றும் முகவரி :

பங்கேற்பாளரின் கையொப்பம் / கை ரேகை சட்டபூர்வ பிரதிநிதியின்

கையொப்பம்

தேதி :

ஆய்வாளரின் கையொப்பம்

தேதி :

KEY WORDS

1. OBSTETRIC SCORE → `P – PARA / L – LIVE CHILD / A – ABORTION
2. SOCIO ECONOMIC STATUS → L – LOW CLASS/ M – MIDDLE CLASS
3. EDUCATION →
    - P – PRIMARY SCHOOL
    - S – SECONDARY SCHOOL
    - HS – HIGHER SECONDARY SCHOOL
    - UG – UNDER GRADUATION
    - PG – POST GRADUATION
4. OCCUPATION → H – HOME MAKER
5. COMPLICATION / CONTRACEPTION AWARENESS → Y – YES / N – NO
6. PATIENT / PARENT CONTRACEPTION AWARENESS
    - 1 – PPIUCD
    - 2 – OC PILLS
    - 3 – CONDOM
    - 4 – ANTARA
    - 5 – TUBECTOMY
    - 6 – VASECTOMY
    - 7 – EMERGENCY CONTRACEPTION
7. WHEN PATIENT AWARE →
    - B M – BEFORE MARRIAGE
    - A N – DURING ANTENATAL CHECKUP

8. CONTRACEPTION ADOPTED → ST – PERMANENT TUBAL STERILISATION

9. ATTITUDE TOWARDS CONTRACEPTION →
    - A – APPROVE
    - D – DISAPPROVE
    - DON'T KNOW – NO IDEA

10. MODE OF DELIVERY →
    - LN – LABOR NATURAL
        - LSCS – LOWER SEGMENT CESAREAN SECTION

MASTER CHART