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Original Research Article

Awareness and misconceptions about contraception in post-partum period in a tertiary care centre in North India: a cross-section study

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ABSTRACT

Background: Most common reason of unintended pregnancy is non-use of contraception and contraception failure. To get rid of unintended pregnancy, abortion is most common procedure done which can lead to increased maternal morbidity and mortality. The aim of this study is to explore the sociodemographic variables of reproductive women with awareness about contraception, outlook for contraception use and reason for not using contraception in all reproductive women.
Methods: A cross-sectional study was conducted including 825 postnatal women during March 2025 to August 2025 in department of obstetrics and gynaecology at AIIMS Jodhpur. The data was analysed using SPSS version 26.
Results: A total of 825 postpartum women were included, predominantly aged 25-30 years (46.7%), Hindu (84.1%), and from middle socioeconomic status (75.8%). Awareness of contraception was high (93.5%), with condoms being the most commonly known method (82.6%). However, only 68.2% had ever used contraception. Condoms (32%) and oral contraceptive pills (14.4%) were the most commonly used methods, while 31.1% used none. Fear of side effects (37%), partner/family opposition, and misconceptions regarding fertility and IUCD safety were major barriers. Contraceptive use was significantly associated with age, education, socioeconomic status, planned pregnancy, and prior LSCS.
Conclusions: Despite high awareness of contraception among postpartum women, actual use remains suboptimal due to misconceptions, fear of side effects, and partner or family opposition. Targeted, structured counselling integrated into antenatal and postnatal care is essential to bridge the knowledge–practice gap and improve postpartum contraceptive uptake.

Keywords: Awareness, Contraception, Misconception, Post partum period, Unwanted pregnancy

INTRODUCTION

Unwanted pregnancy is a worldwide problem affecting the mother, family and the society. Most common reason of unintended pregnancy is non-use of contraception and contraception failure. To get rid of unintended pregnancy, abortion is most common procedure done which can lead to increased maternal morbidity and mortality. In 1952, India launched the family planning program for national population policy to curb the rapidly growing population and reduce the poverty.[1,2] Despite this there was significant raise in population due to fear of side effects of contraceptive methods. Along with this the national family health survey indicates that approximately 47 million women wants to avoid the pregnancy but don't use methods due to misconception about side effect of contraceptive methods.[3]

Family planning is essential to promote the wellbeing of women and her family. Family planning enables the couple to make an informed choice about reproductive and sexual health. Unregulated fertility leads to unsafe

abortions, enhances the maternal morbidity and mortality along with this it compromises economic development.[4]

The couples avoids the usage of contraception due to lack of knowledge, fear of side effects and social taboos. To prevent the unwanted pregnancy and all the adverse consequences, it is important to have a knowledge about contraceptive methods, its benefits and side effects among women of reproductive age group. Immediate postpartum period is the preferable time for contraception counselling as patient is in continues contact with health care worker. Aim of study is to explore sociodemographic variables of reproductive women with awareness about contraception, outlook for contraception use and reason for not using contraception in all reproductive women attending maternity ward at AIIMS jodhpur.

METHODS

This cross-sectional questionnaire-based study was conducted in department of Obstetrics and Gynecology, All India Institute of Medical Sciences, Jodhpur, Rajasthan. This study was conducted for the period of six months (March 2025 to August 2025) after approval from institutional ethical committee (AIIMS/ IEC 2024/ 6521). During these 6 months, all the eligible postnatal women admitted in maternity ward and consenting to participate in the study were included in the study.

For all enrolled patients, demographic details was recorded with detailed history about the antenatal period, labour and delivery and post-natal period. Detailed general physical examination and gynaecological examination was done. Post-natal patient was managed as per standard protocol. For this study, a self-administered questionnaire was formed from the questions adapted from relevant study materials. The study questionnaire is divided into parts: Demographic details including name, age, address, socioeconomic status, marital status, education of couple, occupation of couple, family income. Marital and obstetrics details including age at the time of marriage, Duration of marriage, gravida parity, previous LSCS. Awareness about contraception and practice including to determine the awareness of postnatal women about Contraception like type of contraception, reason for not using or not using contraception. Outlook about contraception including to determine the knowledge of postnatal women about contraception.

RESULTS

Demographical data

A total of 825 participants were included in the study. The majority of participants belonged to the 25-30 years age group (46.67%), followed by 21-24 years (27.03%). Most participants were Hindu (84.12%), while 15.88% were Muslim. With regard to socioeconomic status, three-fourths (75.76%) belonged to the middle socioeconomic class, followed by the lower class (19.64%).

Nearly one-third of the women were uneducated (29.7%), while 36.61% had primary education and 23.27% had secondary education. Only 10.42% had attained graduate or postgraduate education. In contrast, husbands were relatively better educated, with 51.03% having graduate or postgraduate education (Table 1).

Age was significantly associated with contraceptive use (χ^2=11.82, p=0.018). Women aged 35-40 years were significantly less likely to use contraception compared to those aged 21-24 years (AOR 0.46; 95% CI: 0.26-0.82). Religion showed a significant association with contraceptive use (χ^2=5.63, p=0.017), with Hindu women having lower odds of contraceptive use compared to Muslim women (AOR 0.59; 95% CI: 0.41-0.63).

Socioeconomic status was strongly associated with contraceptive use (χ^2=22.07, p<0.001). Women from the middle socioeconomic class had significantly lower odds of contraceptive use (AOR 0.53; 95% CI: 0.44-0.61), while all women from the upper class reported contraceptive use.

Educational status of women showed a statistically significant association with contraceptive use (χ^2=41.75, p<0.001). Women with secondary education (AOR 2.23; 95% CI: 2.01-2.49) and postgraduate education (AOR 6.02; 95% CI: 5.17-7.29) had significantly higher odds of contraceptive use compared to uneducated women.

Husband's education was also significantly associated with contraceptive use (χ^2=68.33, p<0.001). Women whose husbands were graduates were more likely to use contraception (AOR 2.11; 95% CI: 1.83-2.31).

Duration of marriage showed a significant association (χ^2=27.90, p<0.001), with women married for 2 years having lower odds of contraceptive use (AOR 0.68; 95% CI: 0.55-0.81). Parity was not significantly associated with contraceptive use (p=0.62).

Previous LSCS was significantly associated with contraceptive use (χ^2=67.94, p<0.001). Women with no prior LSCS were less likely to use contraception (AOR 0.08; 95% CI=0.03-0.13). Unplanned pregnancy was strongly associated with non-use of contraception (χ^2=32.25, p<0.001), with women having unplanned pregnancies showing significantly lower odds of contraceptive use (AOR 0.37; 95% CI=0.22-0.49) (Table 2).

Awareness and practice regarding contraception

Awareness about contraception was high, with 93.45% of women reporting knowledge of at least one contraceptive method. Condoms were the most commonly known method (82.55%), followed by knowledge of multiple methods including condoms, IUCDs, and oral

contraceptive pills (11.27%). Only 6.18% reported awareness of all available methods (Table 3).

The primary source of information regarding contraception was multiple sources (61.58%), including health workers, media, and peers, while 38.42% cited family members as the sole source.

Despite high awareness, only 68.24% of women had ever used any form of contraception, while 31.76% had never used any method. The most commonly used contraceptive method was condom (32%), followed by oral contraceptive pills (14.42%) and IUCDs (13.09%). Nearly one-third of participants (31.15%) were not using any method at the time of the study.

Primary reasons for contraceptive use included not wanting pregnancy (40%) and spacing between pregnancies (27.76%). Among 257 women who were not using any contraceptive method, the most common reason cited was fear of side effects (36.96%). Other reasons included lack of any specific reason (20.62%), husband's refusal (13.23%), family denial (12.06%), willingness to conceive (12.84%), as well as the religious beliefs (4.28%).

Outlook and perceptions regarding contraception

A substantial proportion of participants held misconceptions regarding contraception. Nearly 61% believed that contraceptive methods affect future fertility, and 74.06% agreed that condom use reduces sexual pleasure. Fear of IUCD-related sexual discomfort was reported by 55.64%.

However, 71.64% agreed that contraception is used to prevent unwanted pregnancy. Misconceptions regarding serious adverse effects were less common, with 98.55% disagreeing that contraceptive pills cause stroke in every woman. Awareness about the emergency contraception was present in the 57.94% of the participants.

Belief regarding weight gain and mood changes due to contraceptive pills was reported by 71.27%, while 18.06% had no opinion on the same (Table 4).

Table 1: Socio-demographic data of study participants.

Variables	N	Percentages (%)
Age group (in years)		
21-24	223	27.03
25-30	385	46.67
31-34	162	19.64
35-40	49	5.94
>40	6	0.73
Religion		
Hindu	694	84.12
Muslim	131	15.88
SES	N	%
Lower	162	19.64
Middle	625	75.76
Upper	38	4.61
Education of patient		
Uneducated	245	29.7
Primary	302	36.61
Secondary	192	23.27
Graduate	58	7.03
Post graduate	28	3.39
Education of husband		
Uneducated	87	10.55
Primary	159	19.27
Secondary	158	19.15
Graduate	255	30.91
Post graduate	166	20.12
Uneducated	87	10.55
Duration of marriage		
1 year	130	15.76
2 years	180	21.82
3 years	211	25.58
4 years	162	19.64
≥5 year	142	17.21

Continued.

Variables	N	Percentages (%)
Parity		
One	15	1.82
Two	805	97.58
Three	5	0.61
Previous LSCS		
1	129	15.64
2	65	7.88
None	631	76.48
Pregnancy-planned/unplanned		
Yes	662	80.24
No	163	19.76

Table 2: Adjusted odds ratio and 95% confidence interval of factors associated with contraceptive use.

Variables	Did u use contraception?			Chi square value	P value	AOR (95% CI)
	Yes	No	Total			
Age group (in years)						
21-24	162 (72.65%)	61 (27.35%)	223 (100%)	11.82	0.018	1
25-30	258 (67.01%)	127 (32.99%)	385 (100%)			0.88 (0.67-1.21)
31-34	112 (69.14%)	50 (30.86%)	162 (100%)			0.15 (0.11-0.21)
35-40	25 (51.02%)	24 (48.98%)	49 (100%)			0.46 (0.26-0.82)
>40	6 (100%)	0 (0%)	6 (100%)			0.32 (0.19-0.48)
Religion						
Hindu	462 (66.57%)	232 (33.43%)	694 (100%)	5.63	0.017	0.59 (0.41-0.63)
Muslim	101 (77.1%)	30 (22.9%)	131 (100%)			1
SES						
Lower	118 (72.84%)	44 (27.16%)	162 (100%)	22.07	<0.001	1
Middle	407 (65.12%)	218 (34.88%)	625 (100%)			0.53 (0.44-0.61)
Upper	38 (100%)	0 (0%)	38 (100%)			10.28 (8.84-11.02)
Education of patient						
Uneducated	139 (56.73%)	106 (43.27%)	245 (100%)	41.75	<0.001	1
Primary	198 (65.56%)	104 (34.44%)	302 (100%)			0.82(0.77-0.99)
Secondary	158 (82.29%)	34 (17.71%)	192 (100%)			2.23(2.01-2.49)
Graduate	42 (72.41%)	16 (27.59%)	58 (100%)			1.11(0.93-1.28)
Post graduate	26 (92.86%)	2 (7.14%)	28 (100%)			6.02(5.17-7.29)
Education of husband						
Uneducated	79 (90.8%)	8 (9.2%)	87 (100%)	68.33	<0.001	1
Primary	80 (50.31%)	79 (49.69%)	159 (100%)			0.34(0.22-0.45)
Secondary	103 (65.19%)	55 (34.81%)	158 (100%)			0.84(0.68-0.93)
Graduate	204 (80%)	51 (20%)	255 (100%)			2.11(1.83-2.31)
Post graduate	97 (58.43%)	69 (41.57%)	166 (100%)			0.52(0.41-0.62)
Uneducated	79 (90.8%)	8 (9.2%)	87 (100%)			5.10(4.73-5.23)
Duration of marriage						
1 year	79 (60.77%)	51 (39.23%)	130 (100%)	27.90	<0.001	1
2 year	145 (80.56%)	35 (19.44%)	180 (100%)			0.68 (0.55-0.81)
3 year	151 (71.56%)	60 (28.44%)	211 (100%)			1.20 (0.98-1.39)
4 year	91 (56.17%)	71 (43.83%)	162 (100%)			0.52 (0.42-0.67)
≥5 year	97 (68.31%)	45 (31.69%)	142 (100%)			0.98 (0.81-1.09)
Parity						
One	10 (66.67%)	5 (33.33%)	15 (100%)	2.35	0.62	1
Two	548 (68.07%)	257 (31.93%)	805 (100%)			0.04 (0.01-0.09)
Three	5 (100%)	0 (0%)	5 (100%)			1.98 (1.63-2.12)
Previous LSCS						
1	48 (37.21%)	81 (62.79%)	129 (100%)	67.94	<0.001	1
2	48 (73.85%)	17 (26.15%)	65 (100%)			1.31 (1.09-1.52)
None	467 (74.01%)	164 (25.99%)	631 (100%)			0.08 (0.03-0.13)
Pregnancy-planned/unplanned						
Yes	482 (72.81%)	180 (27.19%)	662 (100%)	32.25	<0.001	1
No	81 (49.69%)	82 (50.31%)	163 (100%)			0.37 (0.22-0.49)

Table 3: Awareness and practice about contraception.

Know about contraception	N	Percentages (%)
Yes	771	93.45
No	54	6.55
Which contraception you know about		
Condom	681	82.55
Condom/ IUCD/OCP	93	11.27
All	51	6.18
Source of information		
Family	317	38.42
All	508	61.58
Did you use contraception		
Yes	563	68.24
No	262	31.76
Reason to use		
Spacing	229	27.76
Don't want	330	40
Don't use	266	32.24
Method used		
IUCD	108	13.09
condom	264	32
IMPA	77	9.33
OCP	119	14.42
None	257	31.15
Reason for not using		
Family denied	31	12.06
Husband denied	34	13.23
Religious issue	11	4.28
Side effects	95	36.96
Willing to have child	33	12.84
No reason	53	20.62
Total	257	100

Table 4: Outlook about contraception.

Outlook about contraception	Response			Total
	No opinion	Agree	Disagree	
Birth control pills increase the risk of uterine cancer	790 (95.76%)	28 (3.39%)	7 (0.85%)	825
Cu-T migrates in upper abdomen	360 (43.64%)	318 (38.55%)	147 (17.82%)	825
Birth control methods affects the future fertility	155 (18.79%)	503 (60.97%)	167 (20.24%)	825
Use of condom reduces the sexual pleasure	139 (16.85%)	611 (74.06%)	75 (9.09%)	825
Contraception is used to prevent unwanted pregnancy	234 (28.36%)	591 (71.64%)	0 (0%)	825
Contraceptive pills causes stroke in every women	813 (98.55%)	0 (0%)	12 (1.45%)	825
Contraceptive pills can be taken just after sexual intercourse to prevent fertilization	347 (42.06%)	478 (57.94%)	0 (0%)	825
IUCD interferes with sexual pleasure and desire	333 (40.36%)	459 (55.64%)	33 (4%)	825
Condoms can be used twice	74 (8.97%)	10 (1.21%)	741 (89.82%)	825
Birth control pills leads to the weight gain and mood swings-Yes/No/ No opinion	149 (18.06%)	588 (71.27%)	88 (10.67%)	825

DISCUSSION

According to Pal et al the Maternal mortality accounts for 303,000 maternal deaths worldwide with 99% of them in developing countries. The leading causes of maternal mortality include sepsis, haemorrhage, eclampsia/pre-eclampsia, obstructed labour, and complicated abortion. The immediate postpartum period is a good opportunity for contraception counselling as women have an extended interaction with the reproductive healthcare system during this period.[5]

Mekonnen et al conducted a study among post-partum women with the aim of assessing the knowledge and associated factors of postpartum contraceptive use among women in the extended postpartum period. He concluded that the knowledge of women regarding postpartum contraceptives was relatively low.[6]

Murry et al conducted the study aimed to assess the knowledge, attitude and utilization of family planning methods among postpartum women in India. She found the lower scores on knowledge about PPFP compared to attitudes to PPFP emphasize the need for innovative approaches to make postpartum women aware about healthy reproductive practices including adoption of FP methods of their choice.[7]

The postpartum period represents a crucial window for contraceptive counselling and initiation, offering an opportunity to address unmet needs for family planning and reduce unintended pregnancies. Despite improvements in institutional delivery rates and contacts with healthcare systems, significant gaps in awareness and persistent misconceptions about contraception continue to challenge effective postpartum family planning uptake, even in tertiary care settings.

Awareness levels and patterns of contraceptive acceptance

In this study, awareness of contraceptive methods in the postpartum period was comparable to reported facility-based findings in other tertiary centres, where moderate awareness co-exists with substantial gaps in correct knowledge. In an earlier Delhi hospital study, 56.9% of postpartum women accepted contraceptive method during their hospital stay, with IUDs being the most chosen method, suggesting that counselling at point of care can translate awareness into immediate uptake.

Meta-level evidence from nationally-representative data in India indicates that approximately 59% of women use a contraception method within the first year postpartum, with condoms and female sterilization being the most prevalent methods. However, dynamic patterns of initiation, switching, and discontinuation illustrate that static measures of uptake may mask the complexities of postpartum contraceptive behaviours.[8]

A recently published cross-sectional study at a tertiary centre in West Bengal reported that only 32.7% of women accepted postpartum IUDs (PPIUCD), and unawareness of the method was cited as the main reason for refusal. This underscores how limited awareness of specific methods-particularly long-acting reversible contraception-remains a major barrier.[9]

Misconceptions and barriers affecting contraceptive use

A persistent theme across studies is that knowledge gaps coexist with deep-seated misconceptions and sociocultural barriers that impede both awareness and acceptance: Method-specific misconceptions: Studies often report fear of side effects, such as concerns about pain, bleeding, or future fertility, particularly with long-acting methods like IUDs, contributing to low acceptance despite evidence of safety and efficacy.[9] Gender norms and cultural beliefs: In hospital-based research from North India, expectation of a male child was a common reason for rejecting postpartum contraception, reflecting persistent son-preference influencing reproductive decisions. Counselling gaps during care contacts: While contact with health professionals is an opportunity for education, the quality and consistency of counselling remain variable. Evidence suggests that focused antenatal and postpartum counselling significantly improves acceptability of contraceptive methods such as the PPIUCD, compared to routine or the minimal counselling.[10]

Role of antenatal and postpartum counselling

Multiple studies, including recent interventional research, highlight the impact of structured counselling on contraceptive acceptance. A cluster randomized trial in Puducherry demonstrated that structured contraceptive counselling during antenatal visits increased postpartum contraceptive acceptance compared to standard care, underscoring the need for systematic, targeted communication strategies. Findings from the meta-synthesis of PPIUCD studies also show that enhanced counselling using visual aids and systematic models substantially increases acceptance rates, although overall adoption remains low without addressing underlying misconceptions.

Sociodemographic and health system determinants

Education, antenatal care (ANC) attendance, and parity consistently emerge as determinants of contraceptive awareness and uptake. Women with higher levels of education and those who attended the multiple ANC visits were more likely to accept the postpartum contraception.

Although most evidence in Indian tertiary settings focuses on facility-based interactions, broader literature indicates that integration of family planning counselling into maternal health services-including ANC, delivery, and postpartum care-is positively associated with higher contraceptive use.

Comparisons with community-based data

Community-level research supports these facility-based insights. For example, national data show a wide range of postpartum contraceptive use patterns driven by sociodemographic differences, including rural/urban residence, socio-economic status, and access to health services, suggesting that findings from tertiary care centres may reflect the broader population dynamics.[8]

Public health implications and recommendations

The evidence converges on the several actionable strategies:

Enhance quality of counselling

Structured, method-specific, and culturally sensitive counselling during both antenatal and postpartum periods can improve correct knowledge and counter misconceptions.

Focus on long-acting reversible contraception

Enhancing awareness and addressing specific fears about methods like PPIUCD could increase uptake of effective spacing options.[11]

Engage partners and families

Sociocultural influences, such as male partner attitudes and family expectations, need targeted engagement to support shared decision-making.

Strengthen integration of FP with maternal services

Embedding family planning counselling and services into routine maternal health care can leverage existing contact points to bridge knowledge-practice gaps.[12]

Limitations

Comparisons across studies are limited by heterogeneity in study designs (cross-sectional vs intervention), varying definitions of "awareness," and differing contraceptive method categories. Moreover, many tertiary studies focus on immediate postpartum uptake without capturing longer-term continuation or method switching.

CONCLUSION

This study highlights that although awareness of contraception among postpartum women in a tertiary care centre in North India is high, a substantial gap persists between knowledge and actual use. Misconceptions regarding side effects, future fertility, and safety of modern contraceptive methods, along with partner and family opposition, remain major barriers to uptake. Sociodemographic factors such as age, education, socioeconomic status, planned pregnancy, and prior obstetric history significantly influence contraceptive practice. These findings underscore the need for structured, culturally sensitive antenatal and postpartum counselling, with active involvement of partners and families, to address myths and promote informed choice. Strengthening integration of family planning services into routine maternal care can improve postpartum contraceptive acceptance and contribute to better maternal and child health outcomes.

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