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Exploring Postpartum IUD Utilization in Dharwad: Awareness, Acceptance, and Rejection

Manjula G. Hadagalimath[1], Ragini K. Itagi[2]

[1]Research Investigator, [2]Field Investigator,
Population Research Centre, JSS Institute of Economic Research, Dharwad, India.

Corresponding Author: Manjula G. Hadagalimath

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ABSTRACT

Background: Postpartum contraception was recognised as an effective evidence-based method for preventing unintended pregnancy, unsafe abortion, maternal morbidity, and mortality. The World Health Organisation recommended the postpartum intrauterine contraceptive device, inserted immediately after delivery. It is an effective, long-acting, and reversible method. However, the knowledge and acceptance of this method among women remained limited. This study explored awareness, acceptance immediately following delivery, and reasons for rejection of the postpartum intrauterine contraceptive device among recently delivered women in rural and urban settings.

Methods: A cross-sectional study was conducted in Dharwad district, Karnataka. Owing to restrictions during the coronavirus pandemic, 324 women who had recently delivered were interviewed by telephone using a pre-tested schedule. Data were collected with Kobo Toolbox and analysed with SPSS (version 28).

Results: The study found that 61 percent of women were aware of the postpartum intrauterine contraceptive device, with significantly higher awareness in rural than in urban areas. Doctors and counsellors were the main sources of information in urban settings, while frontline health workers were the primary source in rural areas. Most women (88 percent) recognised the correct timing for insertion, but awareness of broader benefits was limited. Only 26 percent accepted the method after delivery. The main reasons for rejection were preference for other contraceptive methods (54 percent), fear of insertion or side effects (45 percent), and opposition from husbands or family members (29 percent).

Conclusion: The study concluded that awareness of postpartum intrauterine contraceptive devices and their benefits must be strengthened. Comprehensive counselling should begin at the first antenatal visit to ensure informed choices among eligible women.

Keywords: Postpartum Intrauterine Device (PPIUCD), Contraceptive Acceptance, Maternal Health, Awareness and Rejection, and Dharwad District

INTRODUCTION

Maternal and child health indicators are crucial for assessing any nation's health status and have been incorporated into the Sustainable Development Goals (SDG) for the 2030s (1). The antenatal, labour, and postpartum periods are critical for effective maternal care and significantly influence the pregnancy outcome. Insufficient spacing between pregnancies and an unmet need for postpartum contraception may lead to an unplanned subsequent pregnancy (2). It was

estimated that in 2008, there were 208 million pregnancies, of which 185 million occurred in developing countries and 11.3 million in South America, out of which 63 percent were unintended pregnancies (3). Worldwide, there were 86 million unplanned pregnancies, resulting in 33 million births and 41 million abortions. Of these abortions, half took place in unsafe conditions, with 98% occurring in developing countries(3,4). From 2010 to 2014, approximately 99.1 million unplanned pregnancies occurred each year, with 23% leading to unintended births and 56% resulting in abortions. In South America, the percentage of unplanned pregnancies reached 72.0% of pregnancies(4).

The USAID estimates that "Every dollar invested in family planning saves four dollars in other health and development areas, including maternal health, immunization, malaria, education, water and sanitation" (5,6). India was the first country globally to launch a Family Planning (FP) programme in 1952. Many changes were made, shifting its focus from mere population control to other crucial concerns such as saving lives, improving the health of mothers and newborns, and reducing unintentional pregnancies, maternal mortality, infant deaths, and child deaths under five (7). Ensuring healthy timing and spacing of pregnancies is now considered the most crucial intervention for reproductive, maternal, neonatal, child, and adolescent health (RMNCH+A). India launched the Postpartum Intrauterine Contraceptive Device (PPIUCD) programme in 2010. The International Federation of Gynaecology and Obstetrics (FIGO) initiated an effort in 2015 to institutionalise PPIUCD services as a core component of antenatal counselling and delivery room services in six Lower Middle-Income Countries (LMIC): Bangladesh, India, Kenya, Nepal, Sri Lanka, and Tanzania (8).

The figure illustrates trends in unmet need for family planning spacing methods in India and Karnataka, from NFHS-3 to NFHS-5. It reveals a declining trend in the unmet need for family planning in India and Karnataka over three rounds of the National Family Health Survey (NFHS-3, NFHS-4, and NFHS-5). Total unmet need constantly decreased from 13.9% in NFHS-3 to 9.4% in NFHS-5 at the national level, indicating enhanced access to and utilisation of family planning services. Correspondingly, the unmet need for spacing in India declined from 6.1% to 4% over the period. While in Karnataka, the unmet need for spacing remained stable at 6% in both NFHS-3 and NFHS-4 surveys, and in the later period, declined to 3.8% in NFHS-5. These trends signify progress in fulfilling reproductive health needs, particularly by bridging the gap between demand and access to contraceptive methods. However, sustained efforts are crucial to further reduce the unmet need, particularly in specific regions and among vulnerable populations (Figure 1).

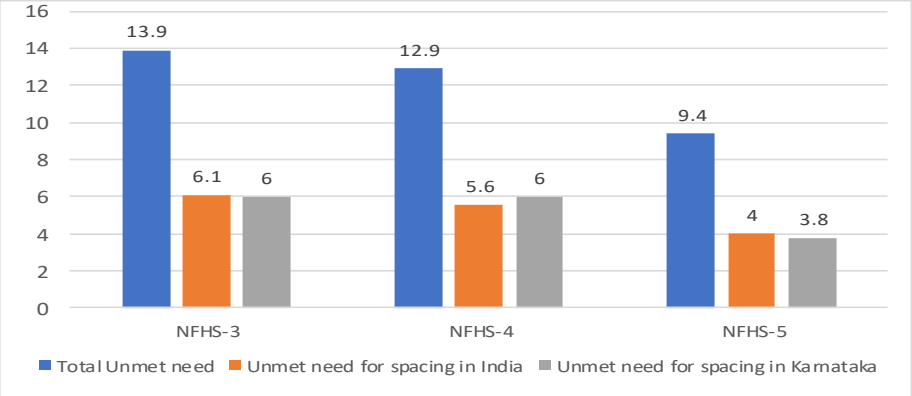

Figure 1: Trends in Unmet Need for Family Planning Spacing Methods in India and Karnataka, NFHS-3 to NFHS-5.

The FP programme provides for the enrichment of women's health by ensuring universal access to sexual and reproductive healthcare services and counselling. Additionally, FP has extensive benefits that extend beyond health, influencing all 17 SDGs (9). Postpartum family planning (PPFP) is recognised as a vital life-saving intervention for mothers and their children. It is one of the most effective family planning options that prevents unintended pregnancies and closely spaced pregnancies during the first 12 months after childbirth. The PPIUCD is highly reliable, long-lasting, cost-effective, and can be reversed immediately; it does not negatively affect hormones and lactation (10). Use of PPIUCD improves the health of women and children by preventing obstetric, financial, psychological, and other health issues that may arise from an unintended pregnancy following delivery (11). Further, it helps to reduce the number of visits to the doctor for contraceptive replenishments. Overall, literature suggests that the immediate insertion of a PPIUCD is effective, safe, and simple enough for a qualified mid-level birth attendant to perform (12).

Despite the advantages of PPIUCD, its acceptance rate remains significantly low in resource-poor countries in Africa and Asia. Various factors influence its acceptance and insertion rates, including public awareness, fears or phobias of women and their partners, taboos and myths surrounding PPIUCD, the training and motivation of healthcare workers assisting women, the involvement of a trained counsellor to address the couple's fears and misconceptions about PPIUCD, and broader factors such as pandemics, which negatively affect every aspect of global healthcare system (13). Previous studies conducted in India demonstrate that women's knowledge of PPIUCD is quite limited, and the acceptance rate is very low despite counselling regarding its benefits. Most of these studies are hospital-based and do not provide insight into the knowledge and utilization of PPIUCD based on place of residence for policy implications. Hence, this study aims to assess women's knowledge, acceptance, and reasons for rejection of PPIUCD in rural and urban settings of Dharwad district, Karnataka.

MATERIALS & METHODS

Sample Design and Sample Selection

This is a cross-sectional study, conducted in the Dharwad district of Karnataka. The district was selected randomly out of 7 districts in the Belagavi division based on the average prevalence of PPIUCD, according to the NFHS-5 figure. The Dharwad district is recognized as a specialized maternal and child health services centre. A simple random sampling method was employed for the selection of study units. All five Taluks of the Dharwad district were included in the present study. Before selecting the sample units, a list of Primary Health Centres (PHC) and Urban Public Health Centres (UPHC) within the selected Taluks was gathered. Three PHCs and two UPHCs were selected using the same sampling method to achieve the study objectives in both rural and urban areas. All Health Sub Centres (16) and wards (8) of the selected PHCs and UPHCs were included in the current study. A list of women who delivered between April 2020 and March 2021 in selected HSCs and wards was obtained from the District Health and Family Welfare Office (DH&FWO) in Dharwad, along with their phone numbers. The list contained information on 3,014 women who had delivered. The sample size for the study was determined by considering the prevalence of IUCD/PPIUCD among those aged 15-49 years in the Dharwad district (2.1), according to the NFHS-5 data. The study's estimated sample size was 444, taking into account a 25% non-response rate and a design effect of 1.5. Finally, completed 73% of interviews, including both rural and urban settings.

Inclusion criteria: Women who delivered between April 2020 and March 2021 in the selected PHCs/UPHCs and wards of

Dharwad district. Women who were able to listen and communicate well and women those given consent to participate in the study.

Exclusion criteria: Women who were not willing to participate in the study, women who have severe health issues and women who could not be contacted even after 3 attempts.

Data Collection Tool and Variables

The data was collected using a structured and pre-tested interview schedule during January and February 2022. The interview schedule was developed by reviewing various published literature on the related aspects of knowledge and utilisation regarding the objectives of this study. It focused on knowledge about the PPIUCD, sources of information, the appropriate timing for PPIUCD insertion, counselling received, advantages of PPIUCD, and other related queries. The reasons for rejecting PPIUCD were investigated, including fears about insertion, side effects, refusals by husbands or family, limited knowledge, and a lack of trained staff or facilities. Overall, 324 women were interviewed.

Data Analysis

The data was entered into Kobo Toolbox, which has been set up as a tool for field data collection in challenging environments, and the analysis was conducted using the Statistical Package for the Social Sciences (SPSS) version 28. Percentages and cross-tabulation were applied. Questions relating to knowledge were posed to all 324 women. However, questions related to the utilisation of PPIUCD and the reasons for its rejection were asked only of those to whom they were applicable.

Ethical clearance:

This study was conducted under the Annual Work Plan of the Population Research Centre (PRC), approved and funded by the Ministry of Health and Family Welfare (MoHFW), Government of India.

RESULT

Participants Characteristics

Table 1 illustrates the distribution of demographic and clinical characteristics of recently delivered women by residence. Overall, substantial proportion of women (45.4%) were aged 19–24 years, with a mean age of 25.98 years, suggesting a predominantly young maternal population; rural women were younger on average (mean age 24.73 years) than urban women (27.47 years), with 59 % of rural women aged 19–24 compared to only 29% in urban areas. Religion-wise, the majority of women belong to the Hindu religion (79%); however, religious composition differed significantly by residence. Rural residents are predominantly Hindu (89%), and urban areas have a greater representation of Muslims (30.4%). Caste distribution revealed that general category women constituted the largest group overall (42.9%), with rural areas having a higher share of general caste women (46.0%) compared to urban areas (39.2%). In comparison, urban areas had more OBC women (41.9%). Most (70.1%) of women lived in joint or extended families, with rural women more likely to reside in such settings (76.1%) than their urban counterparts (62.8%), who had a higher prevalence of nuclear families (37.2%). Educational attainment varies significantly, with 63.9% of women have completed high school or PUC. Urban women had a notably higher proportion with degree-level education or above (39.9%) than rural women (9.7%), stressing a considerable urban–rural education gap.

Table 1: Distribution of Demographic and clinical characteristics of women by place of residence, Dharwad (2022) N=324			
Characteristics	**Rural**	**Urban**	**Combined**
Age			
19-24	59.1	29.1	45.4
25-30	31.3	47.3	38.6
31 and above	9.7	23.6	16.0
Mean age of women	*24.73*	*27.47*	*25.98*
Religion			
Hindu	89.2	66.9	79.0
Muslim	8.5	30.4	18.5
Other	2.3	2.7	2.5
Caste			
Scheduled Caste/Scheduled Tribe	20.5	18.9	19.8
Other Backward Class	33.5	41.9	37.3
General	46.0	39.2	42.9
Type of family			
Nuclear Family	23.9	37.2	29.9
Joint Family/Extended Family	76.1	62.8	70.1
Women education			
Primary including illiterates	13.6	11.5	12.7
Highschool &PUC	76.7	48.6	63.9
Degree and above	9.7	39.9	23.5
Latest delivery type			
Normal	61.4	41.9	52.5
Caesarean	38.6	58.1	47.5
Place of delivery			
Medical College	24.4	10.8	18.2
District Hospital	14.2	18.9	16.4
Sub-divisional hospitals/other public hospitals	27.3	6.1	17.6
Private Hospital	34.1	64.2	47.8
Total	176	148	324

Overall, more than half (52.5%) of women had normal deliveries. According to the residence, rural women had a higher rate of normal delivery (61.4%), and caesarean deliveries were more common in urban areas (58.1%). Place of delivery further reflected these differences, with 47.8% of all women delivered in private hospitals; this was more common among urban women (64.2%) than rural women (34.1%), who more frequently used public health facilities, including sub-divisional hospitals (27.3%) and medical colleges (24.4%), indicating a residence-based disparity in institutional choice for childbirth. These demographic and clinical variations give an important framework for understanding maternal health outcomes in Dharwad.

Knowledge of PPIUCD

Table 2 shows women's awareness of PPIUCD, the timing of its insertion, and its benefits by type of residence. Overall, 61.4% of women are aware of PPIUCD, with awareness significantly higher in rural areas (71.0%) compared to urban areas (50.0%). Among those aware, the primary sources of information were ASHA/frontline workers (50.3%) and doctors or counsellors (54.3%), though the source varied by residence; rural women primarily received information from ASHA workers (67.2%), while urban women received more from doctors/counsellors (70.3%) and friends or relatives (40.5%), highlighting the more key influence of peer and health staff in urban settings. Media and IEC materials played a limited role overall (8.0%), but were slightly more utilised by urban women (14.9%) than rural women (4.0%).

Among all those interviewed, around half of the participants (51.3%) reported they received counselling for PPIUCD, with

slightly higher rates in urban (52.7%) than rural (50.4%) areas. Regarding the timing of counselling, the majority of women (90.1%) received counselling during admission for delivery or on the first day postpartum. Urban women reported this more repeatedly (94.9%) than rural women (85.7%). Overall, counselling during antenatal visits was found to be relatively uncommon (10.9%). Knowledge about the appropriate timing of PPIUCD insertion was high, with 75.9% identifying 'soon after delivery' as the right time. This knowledge was found to be constant across rural (77.6%) and urban (73.0%) women, though awareness of the within 48 hours of delivery was slightly higher in urban areas (14.9%) than rural (10.4%).

Regarding perceived knowledge about the advantages of PPIUCD, the most frequently identified benefit was prevention of unwanted pregnancy (79.4%), with urban women demonstrating higher awareness (97.3%) compared to rural women (68.8%). Nevertheless, rural women were more likely to perceive the method as safe and effective (61.6%), compared to urban women (23.0%). About other advantages, like long duration of protection (9.5%) and reduction in bleeding or cramping (2.0%), were low among both groups, and lack of awareness was more evident among rural women (12.8%) compared to nil (0) in urban areas.

Table 2: Knowledge of PPIUCD, Time of Insertion, and Its Advantages Among Women by Type of Residence, Dharwad, 2022

Knowledge about PPIUCD (N=324)	**Rural**	**Urban**	**Combined**
Yes	71.0	50.0	61.4
Source of Information			
ASHA/Frontline workers	67.2	21.6	50.3
Doctor/Counsellor	44.8	70.3	54.3
Media/IEC	4.0	14.9	8.0
Friends/ Relatives	17.6	40.5	26.1
Received Counseling (199)			
Yes	50.4	52.7	51.3
No	49.6	47.3	48.7
Time of counselling received (101)			
During ANC visit	14.3	5.1	10.9
During admission for delivery/On the first day of postpartum	85.7	94.9	90.1
Knowledge on time of PPIUCD insertion			
Soon after delivery	77.6	73.0	75.9
Within 48 hours of delivery	10.4	14.9	12.1
Don’t Know	12.0	12.2	12.1
Knowledge on Advantages of PPIUCD			
Prevents unwanted pregnancy	68.8	97.3	79.4
Safe and effective	61.6	23.0	47.2
Long life	12.0	5.4	9.5
Reduce initial bleeding and cramping	1.6	2.7	2.0
Don't Know	12.8	0.0	8.0
Other	8.8	1.4	6.0
Total	125	74	199

Acceptance of PPIUCD

Table 3 provides details of PPIUCD acceptance among study participants. Overall, acceptance of PPIUCD among the study participants was 25.6%, with a higher uptake in rural areas (30.4%) compared to urban areas (17.6%), indicating relatively greater acceptance in rural settings. Counselling had played a crucial role in the acceptance of PPIUCD. Around 82.4% had received counselling, with a high proportion in urban areas (92.3%) compared to rural area (78.9%). The type of delivery is also associated with acceptance of PPIUCD, as a whole, PPIUCD insertion was more followed by caesarean sections (56.9%) than

normal deliveries (43.1%); acceptance was more noticeable in urban areas, where 84.6% of acceptors had undergone caesarean deliveries, whereas 52.6% of rural acceptors had normal deliveries, reflecting both access to services and timing opportunities for insertion. Regarding the place of insertion, more than half (52.9%) were received in medical colleges, with a higher proportion in urban areas (61.5%) than in rural areas (50.0%). Meanwhile, more urban residents received services in private facilities (23.1%) than their rural counterparts (18.4%).

Table 3: Details of PPIUCD acceptance

Details	Rural	Urban	Combined
Accepted	30.4	17.6	25.6
Accepted by counselling received			
Yes	78.9	92.3	82.4
By type of delivery			
Normal	52.6	15.4	43.1
Cesarean	47.4	84.6	56.9
Place of PPIUCD insertion			
Medical College	50.0	61.5	52.9
District Hospital	13.2	15.4	13.7
SDH/other public health facilities	18.4	0.0	13.7
Private Hospital	18.4	23.1	19.6
PPIUCD Inserted by			
Doctor	81.6	100.0	86.3
Staff Nurse	18.4	0.0	13.7
Motivated to accept PPIUCD			
Frontline worker	31.6	0.0	23.5
Facility staff	57.9	84.6	64.7
Relatives/friends	10.5	15.4	11.8
Total	38	13	51

Most insertions were performed by the doctors (86.3%), especially in urban areas, where this reached 100%, while in rural areas, 18.4% were performed by staff nurses, indicating task-sharing at the periphery. Overall, motivation for accepting PPIUCD was primarily given by hospital staff, including doctors or counsellors (64.7%), especially among urban women (84.6%). In contrast, frontline workers played a crucial role in rural areas (31.6%), representing a more substantial influence of frontline health workers in rural uptake. Overall, Family and peers had a limited influence (11.8%).

Reasons for the rejection of PPIUCD

Reasons given by the non-acceptor of PPIUCD are presented in Table 4. The most frequently cited reason was that they are comfortable with other contraceptive methods (54.1%), with this preference being more prevalent among rural women (65.5%) compared to urban women (37.7%), suggesting higher trust in or satisfaction with alternative methods in rural settings. Fear of insertion or side effects was another prominent concern overall (44.6%), and it was more commonly reported reason in urban areas (50.8%) than rural areas (40.2%), possibly indicating knowledge of possible complications or uneasiness associated with clinical procedures in urban populations. Family or husband refusal accounted for 29.1% of rejections, a significant factor across both groups, though slightly more in rural areas (31.0%) than urban (26.2%), pointing to the continued influence of family decision-making in contraceptive choices. A desire for future fertility was cited by 14.9% of all non-acceptors, with slight variation in proportions among rural (16.1%) and urban (13.1%) areas. Lack of knowledge about PPIUCD was a barrier for 13.5% in total, again higher among rural women (16.1%)

than urban (9.8%), underscoring the persistent informational gaps in rural communities. Lastly, other unspecified reason**s,** such as religious beliefs, insufficiently trained staff at the facility where the delivery occurred, and unspecified reasons, accounted for 10.8% of responses, with slight variation between rural (10.3%) and urban (11.5%) populations.

Table 4: Reasons for rejection of PPIUCD

Reasons	Rural	Urban	Combined
Less knowledge about PPIUCD	16.1	9.8	13.5
Want another child	16.1	13.1	14.9
Refused by Husband/Family	31.0	26.2	29.1
Fear about insertion/side effects	40.2	50.8	44.6
Comfortable with other methods	65.5	37.7	54.1
Other	10.3	11.5	10.8
Total	87	61	148

DISCUSSION

The present study revealed that 61% of women are aware of the PPIUCD, which is considerably higher than the 15.3% reported in the study by MR Pradeep and DH Nayana (14). Interestingly, awareness was found to be higher among rural than their urban counterparts. These differences are because, in rural areas, ASHAs and frontline workers were identified as key sources of information, while doctors and counsellors played a more prominent role in urban areas. This disparity highlights the varying roles of health workers in different geographical contexts and suggests that community-based health education strategies are particularly effective in rural settings.

Proper counselling can significantly improve PPIUCD acceptance rates (15). The present study shows that only about 51% of women received counselling on PPIUCD, mostly during admission for delivery or immediately postpartum period. However, comprehensive counselling during ANC is essential, as it provides women with sufficient time to discuss the matter with their husbands and family members, thereby preparing for acceptance. A previous study done by Raghuwanshi et al. 2020(16) also suggests repeated counselling during the antenatal period is more effective than a single session in postpartum sessions in increasing PPIUCD acceptance.

The majority (88%) of participants knew that PPIUCD is recommended for insertion soon after delivery, 79% women understood that the PPIUCD is an effective method for preventing unwanted pregnancies, and 47% recognized it is a safe and effective method. However, awareness regarding other benefits of PPIUCD, such as its long-acting nature, non-impact on lactation, and reversibility, was relatively low. These gaps in knowledge suggest the need for more comprehensive informational campaigns to address the full range of PPIUCD benefits.

Despite high awareness, total acceptance in the current study was low (25.6%), which aligns with a study conducted by (17), who reported a 24.36% acceptance rate. Acceptance was found to be higher in rural areas (30.4%) than in urban areas (17.6%), aligning with findings from Gautam et al., 2014 (18) where the rejection rate was also high (78%). Acceptance of was more common among women who had caesarean deliveries (57%), consistent with the results of other studies (19), which highlights the convenience of inserting PPIUCD during surgical delivery. Furthermore, most of the insertions occurred in higher-level health facilities and were performed by doctors, indicating that services are concentrated at tertiary health care centres. Sharing tasks among trained SNs could increase PPIUCD accessibility, specifically in rural areas.

Around 74% women who rejected PPIUCD, highlighting that the most common reasons

were comfortable with other contraceptive methods (54%), fear of insertion or side effects (45%) and refusal by the family or husband (29%). Similar reasons were reported in a study conducted by Kanhere and others, that fear of complications and family disapproval are the main determinants for refusal (20). Particularly, women from rural areas more often cited satisfaction with other contraceptives and lack of knowledge, whereas urban women were more concerned about the side effects. This highlights the need for individual counselling and confidence-building communication strategies to address informational and psychosocial barriers to PPIUCD acceptance.

The current study shows the critical role of counselling in the uptake of PPIUCD acceptance. Antenatal counselling, involvement of family, and avoiding myths could reduce misconceptions and improve acceptance. Strengthening the role of frontline workers in urban settings and enhancing the knowledge and confidence level of Staff nurses to ensure PPIUCD services could help decentralize service provision and accessibility. Furthermore, integrating PPIUCD promotion within the agenda of the RMNCH+A strategy and aligning with the SDG target would help meet national and global health goals.

CONCLUSION

PPIUCD is a safe, effective, and convenient contraceptive option, yet despite a relatively high level of awareness, its acceptance remains low. The findings suggest that while women generally understand PPIUCD well, there is still a significant gap in knowledge about its full range of benefits. Extensive counselling, particularly during the antenatal period, and efforts to eliminate myths or misconceptions associated with PPIUCD are essential to increase its acceptance. Frontline workers, especially in urban areas, must play a greater role in improving women's understanding of this method. There is considerable potential to enhance acceptance rates through educational interventions, better access to healthcare services, and family engagement.

Limitations: The study was geographically restricted to Dharwad, which may not represent other regions in India. Further research with a more diverse sample and in-person interviews could provide stronger data.

Declaration by Authors

Ethical Approval: This study was conducted under the Annual Work Plan of the Population Research Centre (PRC), approved and funded by the Ministry of Health and Family Welfare (MoHFW), Government of India. individual informed consent was obtained from all the study participants before the interviews were conducted.

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Conflict of Interest: The authors declare no conflict of interest.

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