PRACTICE OF IMPLANTING COPPER – T WITHOUT CONSENT AND ITS IMPLICATIONS ON THE HEALTH OF THE WOMEN IN SHAHDARA DISTRICT, DELHI

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of Master of Business Administration (MBA)

in

Hospital and Health Management

by

Dr. Sushmita Biswas

Under the Supervision and Guidance of

Dr. Susmit Jain

2022

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled **Practice of implanting Copper – T without consent and its implications on the health of the women in Delhi** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Name of Student: Dr. Sushmita Biswas

Date: 2/7/2022

CERTIFICATE

This is to certify that (Name of Student) in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management)/MBA (Pharmaceutical Management)/MBA (Rural Management) from the IIHMR University, Jaipur has successfully completed her/his internship at (name of the organization) during March 22, 2022 to June 19, 2022.

Place: New Delhi	Preceptor/ Head of the Organization
Date: 19th June, 2022	Name of the Organization: SEHER, Unit of CHSJ, New Delhi

CERTIFICATE

This is to certify that dissertation titled **"PRACTICE OF IMPLANTING COPPER – T WITHOUT CONSENT AND ITS IMPLICATIONS ON THE HEALTH OF THE WOMEN INSHAHDARA DISTRICT, DELHI"** is a record of the research work undertaken by Dr. Sushmita Biswas in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide IIHMR University, jaipur	School Dean IIHMR University, Jaipur
Date: 2/7/ 2022	Date: 2/7/2022

ABSTRACT

Due to its 380 mm^2 Copper T - 380A, copper surface area is the IUD that is used the most frequently worldwide. The Copper T-380A comprises the device's vertical stem and horizontal arms are encircled by a plastic T-shaped core and copper. Because a silver core is included within the copper sheath to avoid copper fragmentation, the Copper T-380A has a longer lifespan than early copper IUDs. Most essential, before proceeding with the implantation, the patient's written consent must be obtained in India. However, there have been numerous instances where these IUDs have been implanted without the patient's knowledge or without the essential information being provided.

The question being addressed in this study is the current scenario in the Shahdara district of Delhi w.r.t. Copper – T insertion in women without their consent and post insertions complications that they have endured. The main objective is to study the current family planning techniques in India; to analyze the contraceptive methods used by women in Janata Majdoor Colony, Shahdara and to identify the cases behind forced or non-informed IUD insertion in Government hospitals. In this study we will use the primary data to address research questions involving the analysis of the primary data collected using different techniques and methods. Quantitative and qualitative data to be analyzed using MS-EXCEL. Codes will be prepared appropriately, and data entered accordingly. The majority of women who have had three or more children had an IUD implanted. 87 percent of the women were not asked for consent before having the Cu-T inserted, and barely more than one-tenth of them had given it. A little less than three-fifths of the woman reported that the hospital staff was harsh and violent throughout the procedure, making them uncomfortable. Ninety percent of the women who completed the poll reported that neither they nor their husbands had ever gotten any counselling on the Cu-T treatment. And the 10% of people who knew obtained it from their relatives or close family members rather than from ASHA staff or doctors as they are supposed to.

ASHA workers need to be trained and talked about their responsibilities towards the women especially during their pregnancy and after the delivery of their baby. The mistreatment of the ladies during delivery or when they visit the hospitals to get their Cu-T removed should be highlighted and they need to speak up against such behaviour towards them.

Acknowledgements

I am extremely grateful to my organization mentor, Ms. Shreeti, who is a part of SEHER, a Unit of Centre for Health and Social Justice, New Delhi for her support, supervision and tutelage throughout the two months period of my internship. I would also like to thank Sandhya Gautam ma'am and Areeba Khalid ma'am for their invaluable advice during my internship.

This report would not have been complete without the guidance and expertise of my mentor, Dr. Susmit Jain.

Last but not least, I want to express my gratitude to my parents, brother, peers, and friends for supporting me during my lows and inspiring me to keep working hard even in these challenging times.

TABLE OF CONTENT

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
COC	Combined Oral Contraceptive
Cu-T	Copper - T
DMPA	Depot Medroxyprogesterone Acetate
ECP	Emergency Contraceptive Pill
FP	Family Planning
IEC	Information Education Communication
IUCD	Intrauterine contraceptive device
IUD	Intrauterine Device
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MBBS	Bachelor of Medicine, Bachelor of Surgery
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
PPIUCD	Post Partum Intrauterine contraceptive device
SBA	Skilled Birth Attendant
SN	Staff Nurse
TFR	Total Fertility Rate

Chapter 1: Introduction

The first mention of placing in uterus the contraceptive devices with intent to prevent conception appeared in the scientific literature around the beginning of the 20th century. The first intrauterine device (IUD) was a contraceptive ring made of various materials such as steel and silk moth intestines.

Inert, plastic IUDs with a variety of sizes and shapes, including as the Lippes Loop, Margulies Spiral, and Saf-T-Coil, were largely used in the 1960s to redesign the IUD. In the 1970s, copper was added to the plastic contraceptive device to increase its effectiveness. This allowed for a smaller, more easily inserted contraceptive that also had less negative side effects. When one particular IUD, the Dalkon Shield, associated with septic miscarriage and pelvic inflammatory disease in the middle of the 1970s and 1980s, the usage of IUDs decreased.

Today, two types of IUDs that contain progestin or copper have reemerged as reliable, acceptable methods of birth control. The majority of these contraceptives, known as copper IUDs, More than 150 million women have used it worldwide, it is the most widely used reversible contraceptive method after sterilization in women.

The uterine fundus is where T-shaped or frameless copper IUDs are secured to the myometrium. Due to its 380 mm2 copper surface area, the Copper T-380A is the IUD that is used the most frequently worldwide. Copper T-380A consists of a T-shaped plastic core, with copper wrapped around the device's vertical stem and horizontal arm. The copper T-380A lasts longer than previous copper coils because the silver core is integrated into the copper sheath to prevent copper fragmentation.

Many Indian women reject the IUD, preferring to rely on less reliable techniques or none at all. According to experts, many women would rather have abortions than have an IUD put. Insufficient access to health-care practitioners, prevalent myths, and a lack of information about contraception methods, according to family planning organisations. The copper T, which is free for low-income patients at government health institutions, is usually the only form of IUD available to Indian women who rely on government hospitals for their health care. The copper T has been around since the 1970s and operates on a simple mechanism.

Reviewing the benefits and risks of using the Copper IUD and reviewing the patient's medical history, the health care recommends the option of IUD implantation. Most importantly, the patient's written consent before moving on with the implantation is mandatory in India. But there have been many cases where the insertion of these IUDs has taken place without consent or without providing necessary information before signing the consent form of the patient.

Examples of the few women who have gone through it and what were the implication that they have to went through?

The woman is not even said to have been transplanted with an intrauterine device at a local public hospital in West Bengal. Kalpani is a tranquil tiny hamlet located in North Bengal's Cooch Behar district. This town of fewer than 7,000 people is encircled by the verdant streams of the swift-flowing Torsa. The horrific exploitation of women's reproductive rights is demonstrated by the stunning paddy fields that are cut off from the rest of the world.

"No, I was not willing to have a copper-T inserted," claims a few women who were forced to have intrauterine contraceptive implants after giving birth in a government-run hospital.

A 30-year-old woman gave birth to her second kid in the first few days of January. The knowledge that an intrauterine contraceptive device (IUCD) with a copper base had already been implanted into her body against her will tempered her joy, though.

The woman's story is backed up by numerous other people who assert that the IUCD, also known as Copper-T, was surgically inserted into their bodies without their consent at a community health centre in the tribal-dominated Dindori district of Madhya Pradesh.

An IUD device to prevent conception, according to a claim made by a woman from Madurai who gave birth at the Government Rajaji Hospital (GRH) on November 12 without her permission. The mother reported feeling abdominal ache three days following the delivery of her second kid. "The physicians attempted to dismiss it as typical discomfort. Later, I questioned the doctors about whether an IUD may have been implanted. Then they revealed to me the placement of a "Copper T" gadget. That astonished me because they performed the treatment without asking for my permission. If I hadn't asked, I never would have known, she said.

Every lady who gives birth in a government-run hospital is required to be counselled about family planning alternatives and provided with the one she desires. Counsellors are present in every hospital, although some have been found guilty of skipping sessions.

The question being addressed in this study is the current scenario in the Shahdara district of Delhi w.r.t. Copper – T insertion in women without their consent and post insertions complications that they have endured.

According to the NFHS-IV, India's TFR is 2.2 and 53.5 % of married women (aged 15 to 49 years) use contraceptives, with 47.8% using a modern method.
Various strategies are in place under family planning programme in the country:

- **Policy Level:**
  - Target free approach
  - Voluntary adoption of Family Planning Methods
  - Based on felt need of the community
  - Children by choice and not chance
- **Service Level:**
  - More emphasis on spacing methods
  - Assuring Quality of services
  - Expanding Contraceptive choice

The Medical eligibility criteria for PPIUCD services are grouped as –

CATEGORY 1:

- Post placental, postpartum <48 hours or during cesarean section
- >Six weeks postpartum

CATEGORY 2: No conditions

CATEGORY 3:

- Between 48 hours and 6 weeks postpartum
- Chorioamnionitis
- Prolonged rupture of membrane (ROM) >18 hours

CATEGORY 4:

- Puerperal sepsis
- Unresolved postpartum hemorrhage

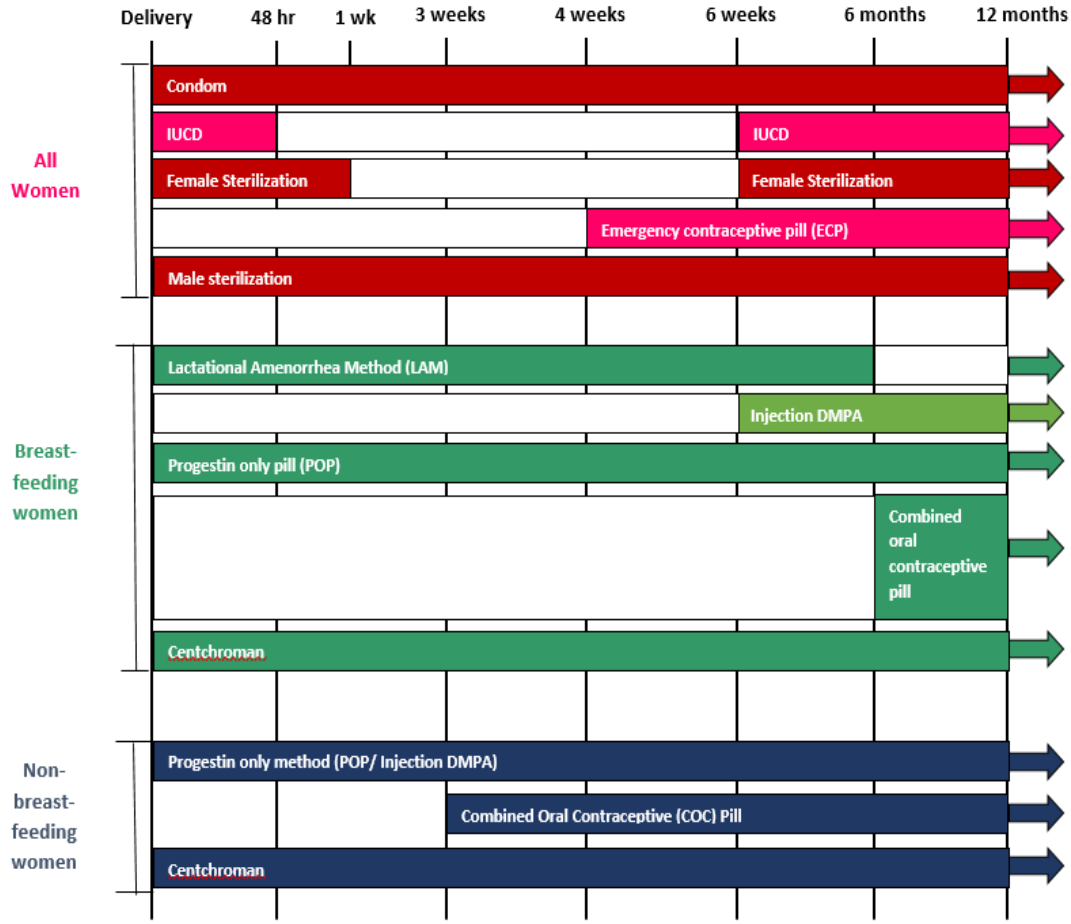

Fig 1.1: Time of Initiation of Postpartum Family Planning Method

Modern Techniques: There are many different methods of birth control available, including injectables, intrauterine devices (IUDs/PPIUDs), contraceptive tablets, implants, male and female condoms, diaphragm, foam/jelly, the traditional days technique, the lactational amenorrhea method, and emergency contraception.

For women who are currently married and are between the ages of 15 and 49, the usage of contraception increased from 54% in 2015–16 to 67% in 2019–21. The percentage of sexually active, unmarried women in the 15-49 age range who use condoms or Nirodhs increased from 12 to 27 percent between 2015–16 and 2019–21.

	NFHS-3 (2005-06)	NFHS-4 (2015-16)			NFHS-5 (2019-21)		
		Urban	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Any method	**66.9**	54.8	56.6	**54.9**	76.5	71.3	**76.4**
Any modern method	**56.5**	48.5	51.0	**48.6**	57.6	59.7	**57.7**
Female sterilization	**23.0**	19.8	22.3	**19.8**	18.0	18.6	**18.0**
Male sterilization	**0.8**	0.2	2.5	**0.2**	0.2	0.5	**0.2**
IUD/ PPIUD	**5.0**	5.4	6.8	**5.4**	6.6	11.0	**6.7**
Pill	**4.5**	2.9	5.4	**2.9**	2.7	3.4	**2.7**
Condom	**22.9**	20.1	13.9	**20.0**	28.4	23.2	**28.3**
Injectables	-	-	-	-	0.3	1.8	**0.4**

Table No. 1.2: Comparison of contraception in NFHS 3, 4 and 5

The public health system provides current method contraceptive procedures to nearly seven in ten (68%) individuals. The remaining modern method users obtained their technique from various sources (7%) like stores, their husband, friends, and family (25%) as well as the commercial health sector . Urban users received their method from the public health sector at a lesser rate (55%) than rural users (74%) did. Female and male sterilisation, IUDs/PPIUDs, and injectables are primarily provided by the public health sector, whilst pills, injectables, and condoms/Nirodhs are primarily provided by the commercial health sector.

Over the last ~5 years, we can see that the use of family planning methods has increased remarkably, and use modern method has increased in both urban and rural settings. The most important points to note here is that the male sterilization has remained the same but the use of IUD/ PPIUD had increased twice that during NFHS – 4 in the rural areas.

The total unmet needs haves reduced over the years. Overall demand for family planning among married Indian women between the ages of 15 and 49 rose from 66 percent in 2015–16 to 76 percent in 2019–21. From 13% in NFHS-4 to 9% in NFHS-5, the percentage of people without access to family planning choices has decreased.

Over three-quarters of currently married women between the ages of 15 and 49 want to utilise family planning; 14% want to space births, and 63% want to reduce the number of children they have. As evidence that their need has been met, 67% of currently married women utilise a form of birth spacing or birth control. However, 9% of women who are currently married have unmet family planning needs, of which 4% have unmet needs for spacing births and 5% have unmet needs for restricting births.

The following list serves as a foundation for advice and includes some of the performance standards for each key area. These criteria can be adapted by program managers for monitoring service implementation.

S.No.	Key areas	Performance Standards
1	Human and Physical Resources	The clinic features a large, spotless area where services can be rendered. Medical supplies, prescription medications, and contraceptives all benefit from following good storage practises. The clinic has the tools and resources necessary to offer IUCD services. It has materials for storing records and supplies for infection control so that it may offer family planning services.
2	IEC materials for family planning that are client-focused	Posters/ Panels with facts on the clinic's family planning services and office hours are available at the clinic. There is information about the rights of clients in relation to family planning. The clinic offers family planning method samples, IEC materials, and flip charts for counselling.
3	Management Systems	For the delivery of family planning services, there are written procedural protocols/instructions. A simple FP client record system is in place at the clinic. The records are examined and analyzed on a regular basis.

4	Infection Prevention practices	In the clinic, clean running water is available. Hand hygiene facilities are freely available. Available and utilised in accordance with industrial standards are antiseptics treating skin and/or mucous membranes. Instruments and other items are decontaminated according to the standards (immediately after use and before cleaning). The garbage disposal system adheres to standards.
5	Services for Family Planning/New Clients - General Counseling	The doctor employs suitable interpersonal communication techniques during the visit. The medical expert informs the patient about the range of contraceptive options available at the clinic and encourages her decision. Pregnancy is ruled out by the doctor.
6	IUCD Provided to a Prospective Client	The provider determines if the woman is qualified to utilise the IUCD. With the IUCD, the provider describes the warning indicators. The clinician inserts the IUCD as directed and completes the pre-insertion duties. The healthcare professional provides directions for the follow-up appointments and/or return visits.
7	Monitoring and treatment of IUCD adverse effects and issues	The provider of the service confirms that the woman is happy with the IUCD. The provider determines and takes care of any adverse effects or issues with the IUCD.
8	IUCD Removal	Following the recommendations for standard practise, the physician gets ready for the procedure and removes the IUCD. Additionally, they provide post-removal tasks and counselling on alternative family planning strategies.

Table No. 1.3: Performance standards for key areas in IUD

OBJECTIVES

- To study the current family planning techniques in India
- To analyze the contraceptive methods used by women in Janata Majdoor Colony, Shahdara
- To identify the cases behind forced or non-informed IUD insertion in Government hospitals

Chapter 2: Review of Literature

What is the implication of this illegal practice?

Most of the women in real-life case studies later refused the contraception after learning that a device or pill had been abused given to them against their will. According to experts, these cases demonstrate how inadequate family-planning strategies were proving to be ineffective and discouraging women from using contraception entirely.

Every woman who gives birth at a government-run hospital is required by law to receive counselling about her options for family planning and how to have the family she wants. There are counsellors in every hospital, but some have been caught skipping sessions.

Over the past ten years, there has been a sharp reduction in the use of male contraception in India, with condom usage plummeting by 52%. However, the government still promotes women-focused contraception through programmes.

Under the Janani Suraksha Yojana (JSY), the government is encouraging and providing financial incentives to women who give birth at government clinics and hospitals in an effort to reduce maternal fatalities. However, it is evident that both doctors and government officials give little weight to women as individuals and their opinions.

How is forcing impoverished women to have contraceptive implants placed in their bodies, which can prevent pregnancy for up to ten years, anything other than a targeted eugenics campaign? Think about the uproar if middle-class metropolitan women faced a similar situation.

In reality, women who are solely eligible for public healthcare are only data that the government and its representatives can use to indicate higher rates of institutional deliveries or contraception use. Under the condition of anonymity, a local frontline healthcare provider acknowledged that during her career, she had personally observed more than 40 similar cases.

“If the nurses and doctors would only take the time to explain this contraceptive method to the women, they would not be so scared,” one of the victims of this illegal practice says. Fearing that intrauterine devices might be forcibly inserted, most pregnant ladies in the neighbourhood these days avoid going to the hospital. How little control women

actually have over their own bodies and lives in this "shining" India of the twenty-first century is shown by the fact that doctors can continue to practise in blatant violation of all medical ethics.

S. No.	Author	Year	Title	Study Description	Conclusions
1.	NN Ambadekar, KZ Rathod, and SP Zodpey	2011	Study of Cu T Utilization Status and Some of the Factors Associated with Discontinuation of Cu T in Rural Part of Yavatmal District	The government has started a sizable training programme for medical and paramedical staff to supply trained personnel for IUD insertion. We think that putting more emphasis on IUD training would affect how often people use the devices. In order to evaluate the Cu T utilisation status and investigate the factors contributing to their discontinuance, the current study was conducted in rural areas of the Yavatmal district in Maharashtra.	In comparison to tribal area 12 (3.7%)8, the percentage of removal was higher in non-tribal area 54 (50.9%). Maximum removals were 23 (43.9%) within 3 months of insertion out of 66 removals. Medical issues 20 (30.3%), pregnancy planning 19 (28.8%), and automatic removal 19 (28.8%) were the main causes of discontinuation (28.8 percent). Higher numbers of living children and health concerns at the time of insertion were substantially correlated with Cu T removal.

2	Avinash Kumar, Anam A Alwani, B Unnikrishnan, Rekha Thapar, Prasanna Mithra, Nithin Kumar, Vaman Kulkarni, Ramesh Holla	2018	Determinants of Intrauterine Device Acceptance among Married Women in Coastal Karnataka, India	A community health centre (CHC), a government maternity hospital, and a private tertiary care hospital all connected to Kasturba Medical College (KMC) in Mangalore, Karnataka, India, were the sites of the current cross-divisional study. A questionnaire was used to evaluate demographic information, information source, factors encouraging IUD usage, justifications, and adverse consequences.	82% of families and over 91% of husbands supported the use of contraceptives. The primary source of information on IUDs for 89% of the participants was their healthcare provider. 29.1% of participants used IUDs to prevent pregnancy, while 68.2% used them to space out their children. 36% of the women who used IUDs reported side effects, with vaginal bleeding accounting for 61.5% of them.
3	Neha Taneja, Sujata Gupta, Karuna N. Kaur	2020	A retrospective study of post-partum intrauterine contraceptive	All women who gave birth vaginally, were advised to insert a PPIUCD during prenatal period, early	54.6% of acceptance rate with respect to PPIUCD. Most cases (46.4%) were between the ages of 21 and 25, and the majority were primipara (39.8%). 34.8%, 14%, and 6.1% of

			devices in a government maternity home of Delhi	labour, or within 48 hours of giving birth, and were willing to take part in the study. After getting a PPIUCD, participants were questioned prior to discharge as well as at six, ten, fourteen, and six months or earlier as needed.	patients visited the OPD for standard follow-up at 6 weeks, 6 months, and 1 year.
4	Kirti Iyengar and Sharad D. Iyengar	2016	The Copper-T 380A IUD: A Ten-Year Alternative to Female Sterilisation in India	In a rural part of the Indian state of Rajasthan, a clinic connected to an outreach programme introduced the Copper-T 380A, a contraceptive with a ten-year effective life cycle, as a female sterilisation alternative. The Copper-T 380A was preferred by	The intervention dealt with women's concerns, ensured service standards, and protected women's ability to request removal of the Copper-T at any time. The Copper-T 380A gives women the freedom to change their thoughts about having children in the future up until menopause because it is a long-term yet reversible choice. Including this choice in family planning services can lessen reliance on medical professionals and costly equipment while addressing a portion of the unmet need for contraception among women who are unwilling to choose sterilise.

				older women and women who had attained the desired family size, notably among tribal women, according to data on 216 insertions during a 34-month period. Over 25% of the 30 removals at that time were due to non-medical factors such family resistance, child loss, or remarriage.	
5.	Somesh Kumar, Reena Sethi, Sudharsanam Balasubramaniam, Elaine Charurat, Kamlesh Lalchandani,	2014	Women's experience with postpartum intrauterine contraceptive device use in India	2,733 married women between the ages of 15 and 49 who underwent PPIUCD at sixteen healthcare facilities dispersed throughout eight states and the national capital region of India were	At the time of insertion, nearly all women (99.6%) expressed satisfaction with IUCD, and 92 percent of them did the same at the six-week check-up. By six weeks of follow-up, the IUCD expulsion rate was 3.6 percent. The study's implementation by the various institutions resulted in significant variances in the rates of issues and complications.

	Richard Semba, Bulbul Sood			examined at the time of IUCD insertion and six weeks afterwards.	

Chapter 3: Methodology

The data was collected for a group of 30 women were interviewed from Janata Majdoor Colony, Shahdara district of Delhi. For the study undertaken, I have only used the data pertaining to the Copper – T insertions in women and the consent and complications that they have faced.

We are conducting this study to analyse the Copper – T insertion in women and their complications. In this study we will use the primary data to address research questions involving the analysis of the primary data collected using different techniques and methods.

Study design: Descriptive cross-sectional study

Setting: Janata Majdoor Colony, Shahdara, New Delhi

Study Population:

- **Inclusion criteria:** Women who have received Copper T insertion without consent
- **Exclusion criteria:** Women who opted for Copper T/ other sterilization method
- **Study tools:** A semi structured questionnaire

Duration of Study: March 21, 2022 – June 18, 2022

Sample size: The total sample size is 30

Sampling Technique: Purposive sampling

Data Collection Procedure: A semi-structured questionnaire will be created, pretested, and updated as necessary. The data will then be evaluated using MS-Excel before any conclusions are drawn. Secondary information from the NFHS-4 and NFHS-5

Data Analysis: Quantitative and qualitative data to be analyzed using MS-EXCEL. Codes will be prepared appropriately, and data entered accordingly

Ethical considerations: All respondents will be asked for their written, informed consent. All participants will receive a brief description of the study's goals and the data gathering process. Privacy will be protected when collecting data.

MS Excel was used for data compilation and analysis for all the districts. Analysis will be undertaken to study the counselling session on contraception which are to be conducted as per the government, consent being taken for the placement of the IUDs, complications post IUD placement and if they provide any compensation for the procedure. Basic percentages were calculated, and graphs plotted for each district and in total to the ease of analysis as it was the requirement of the Organization of my internship.

Some of the key parameters studied in each section are –

Before Contraception Procedure – Number of ANC visits by the ASHA workers during pregnancy, counselling session for both husband and wife related to contraceptives, Cu-T placement based on when the Cu-T was inserted, any complications during delivery, information and awareness about other contraceptive procedures, consent taken before undertaking the procedure

During Contraceptive Procedure – were the women comfortable while getting the Cu-T inserted, did they pay money and if yes, what was the amount they had to pay to get the Cu-T inserted

Post Insertion of Copper – T – After how many months did they come to know about Cu – T insertion, scheduled follow up after Cu – T insertion and the complications they had after the procedure

Chapter 4: Results

Background study of the women's surveyed

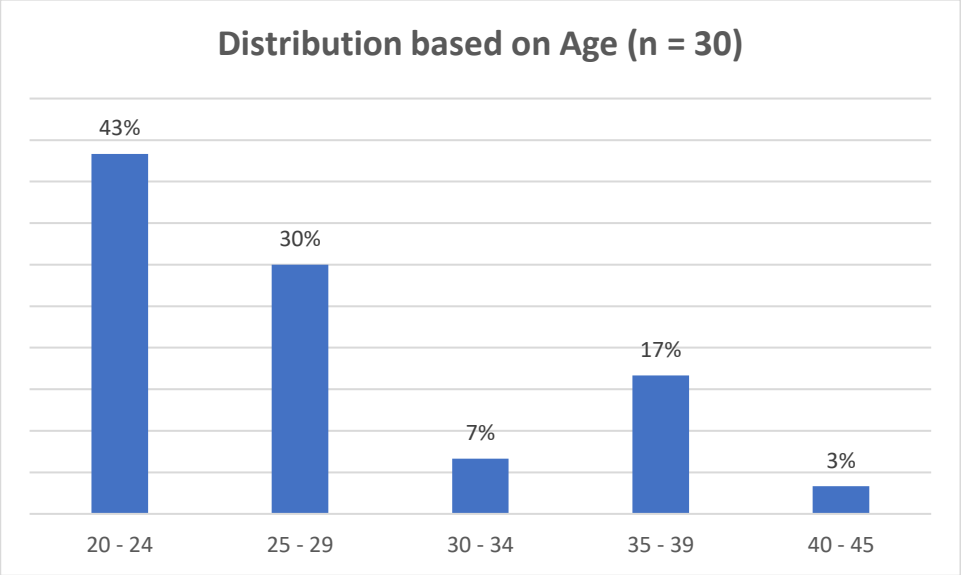

Fig 4.1: Distribution based on Age

For ease of analysis the age groups were divided into 5 classes with class interval of 5 starting from 20 year to 45 year. As we can see, the maximum number of ladies belonged to the age group of 20 – 24 and only 3% of them belonged to the 40 – 45 year of age group.

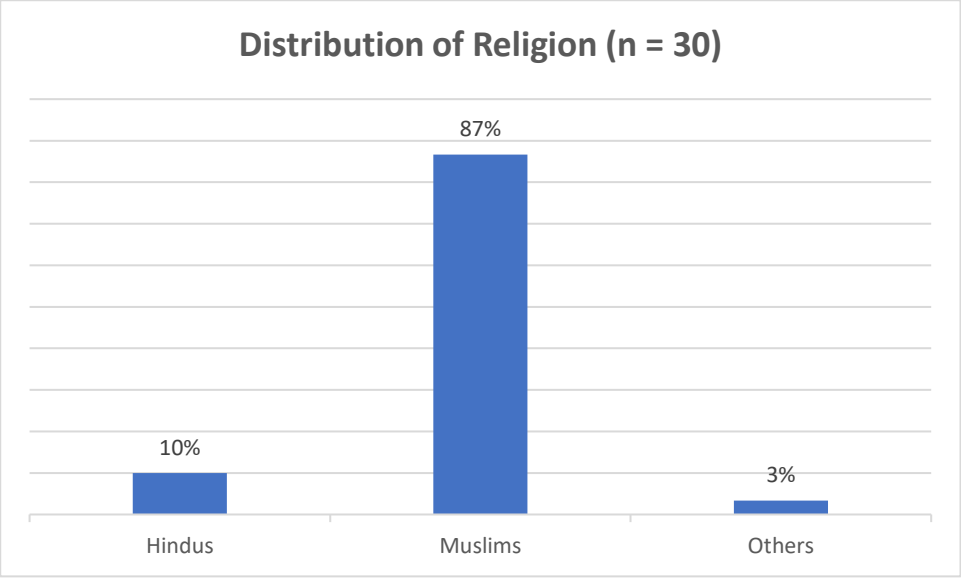

Fig 4.2: Distribution based on Religion

Approximately 87% of the women surveyed were Muslims and only 10% of them were Hindus with other religion in a minority with 3%

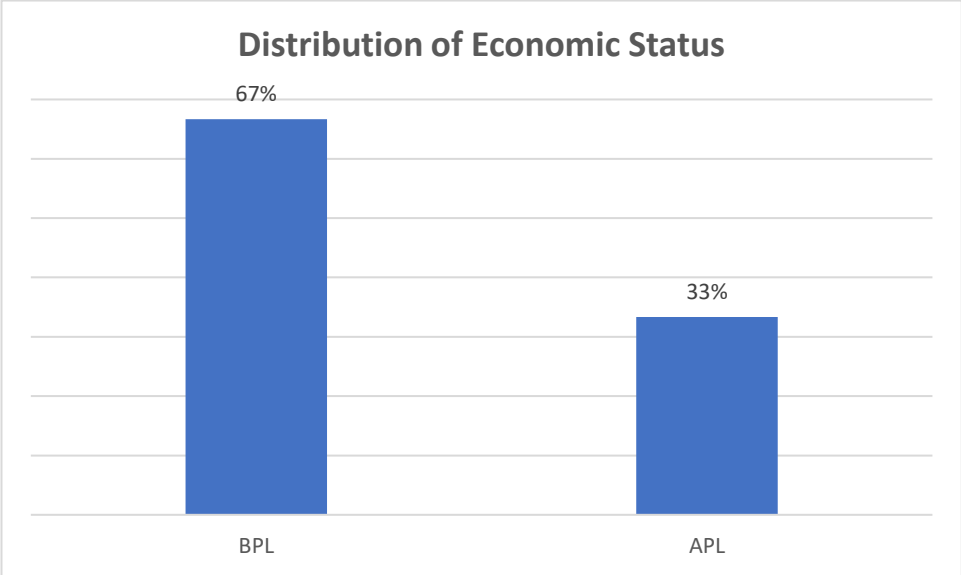

Fig 4.3: Distribution based on Economic status

Most of the women belonged to the below poverty line with 67% and only 33% belonged to the above poverty line.

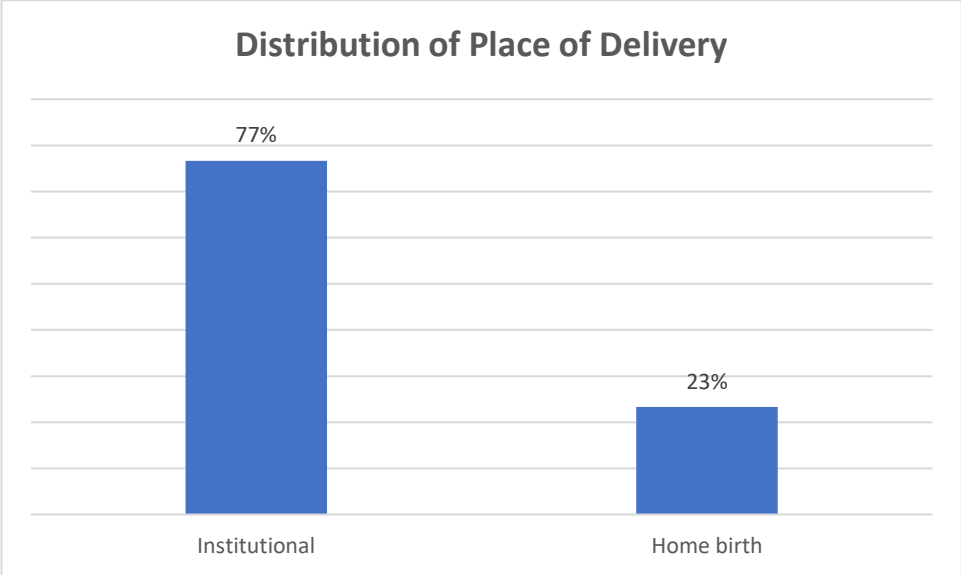

Fig 4.4: Distribution based on Place of Delivery

Maximum number of births were institutional, which includes government hospitals and dispensaries at 77% and approximately 23% of them had home births which were assisted by dai/ midwives.

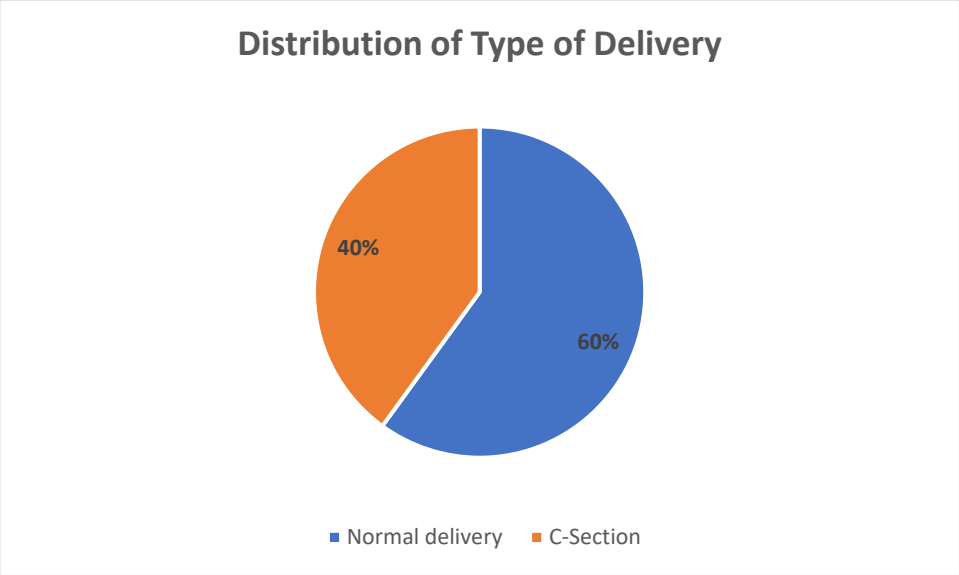

Fig 4.5: Distribution based on type of delivery

Most of the women had normal delivery at 60% and those who had C-section was 20% lesser than the later.

Before Contraceptive Procedure:

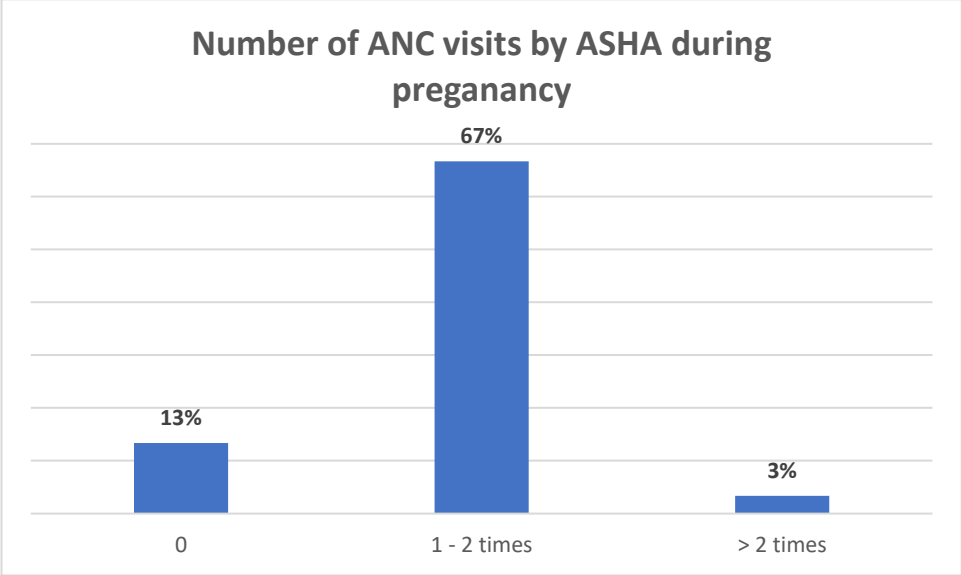

Fig 4.6: Number of ANC visits by ASHA during pregnancy

For computing this data, we have sub-grouped it into never visited, visited 1 – 2 times and >2 times. Most of the women have been visited 1 – 2 times during their whole pregnancy duration and sadly only 3% of them were visited more the 2 times and 13% of them had not been visited at all by the ASHA workers.

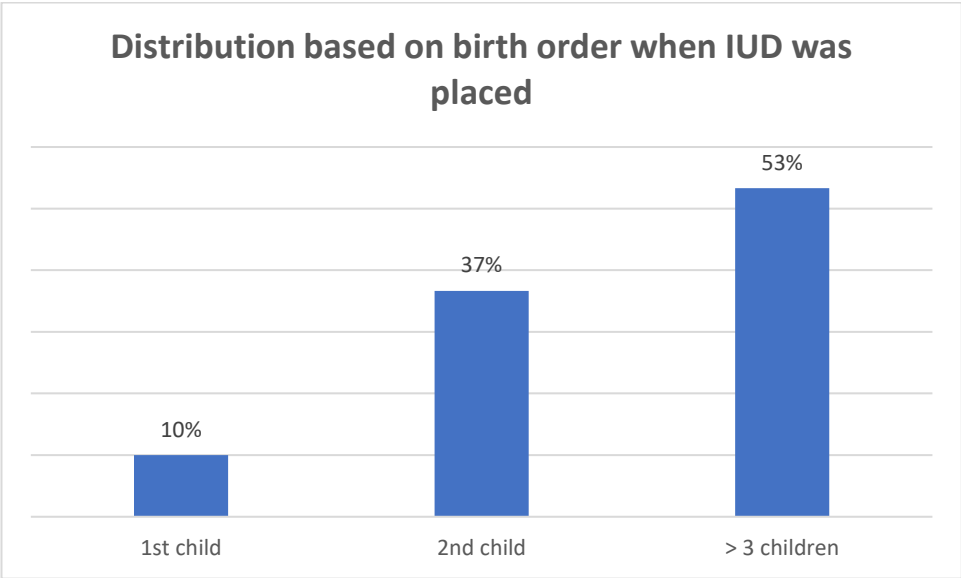

Fig 4.7: Distribution based on birth order when IUD was placed

We can see that majority of the women who have had their 3rd or more children have been inserted with IUD, which is almost half of the surveyed women, approximately 53%. It is followed by two-fifth of the women having their 2nd child and around one-tenth of them got it placed after their 1st child was born.

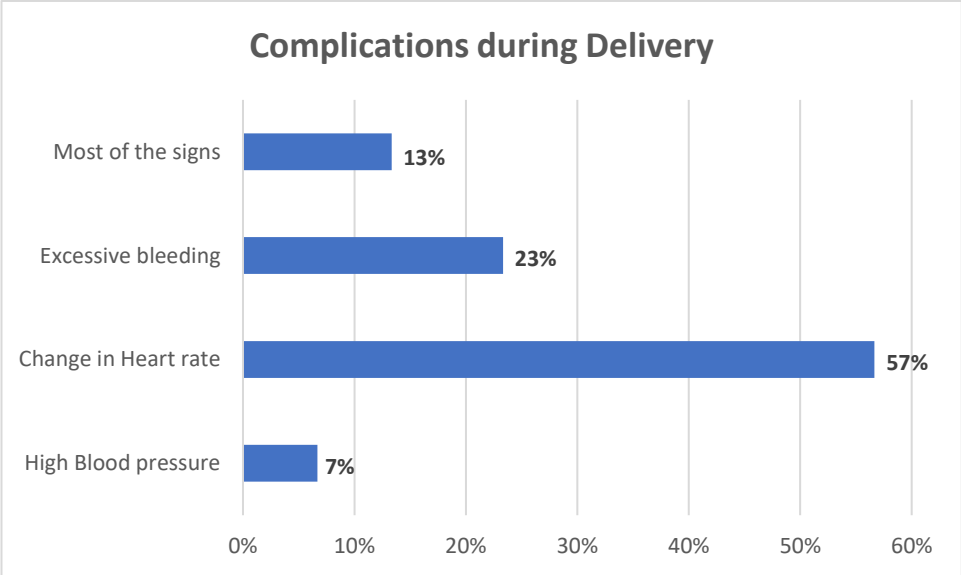

Fig 4.8: Distribution based on complication during delivery

During our survey, we observed 3 major complications that the ladies had and there were: excessive bleeding, change in heart rate, high blood pressure and some of them even had two or more of these complications combined. Three-fifth of the women showed signs of change in heart rate during delivery which is followed by 23% of them having excessive bleeding.

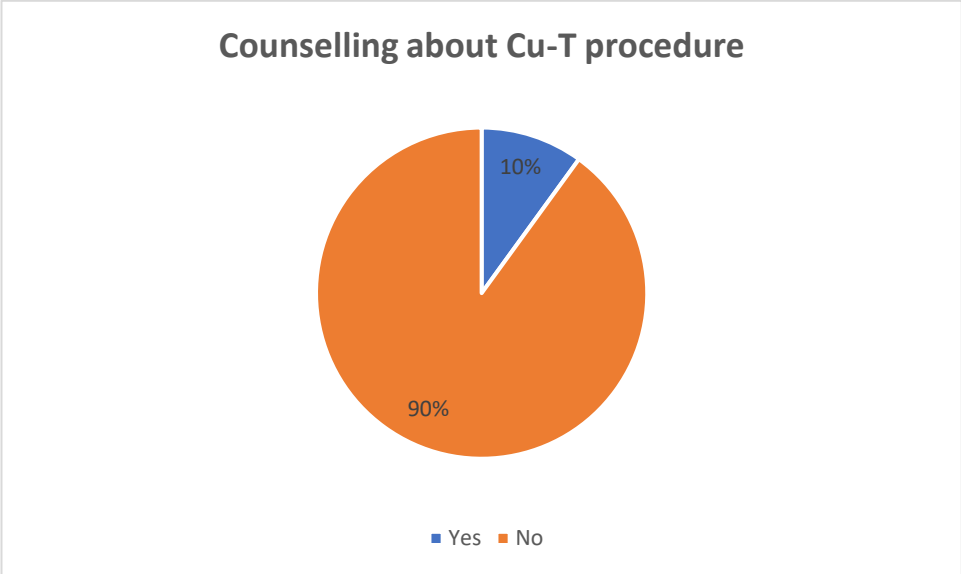

Fig 4.9: Distribution based on counselling about Cu-T procedure

Around 90% of the surveyed women stated that they had not been counselled about Cu-T procedure and nor were their husbands educated about it. And the 10% of them who had the knowledge was given by their relatives or close family members and not the ASHA workers/ doctors as they are supposed to.

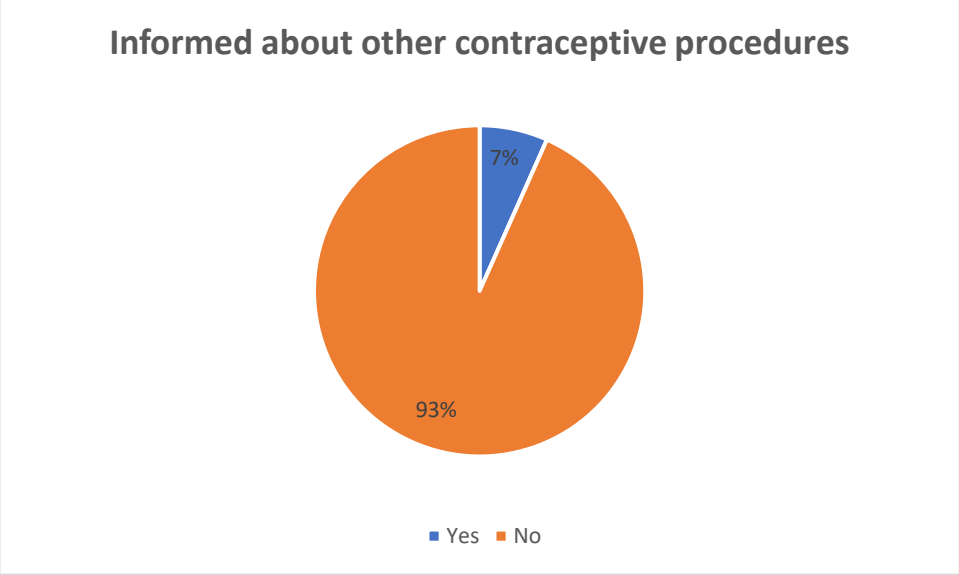

Fig 4.10: Distribution based on information about other contraceptive procedures

Approximately 93% of the women had no knowledge or awareness about contraceptive procedures with just 7% having information about them, specifically condoms

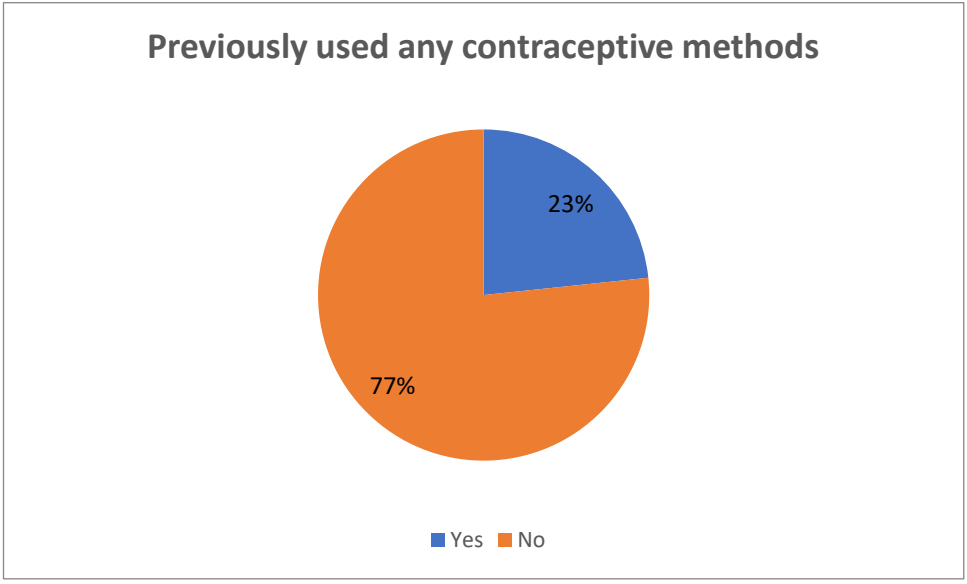

Fig 4.11: Distribution based on previously used contraceptive methods

About four-fifth of the women had never used a contraception, includes condoms, pills, etc. previously and slightly lower than one-fourth of them had used condoms before

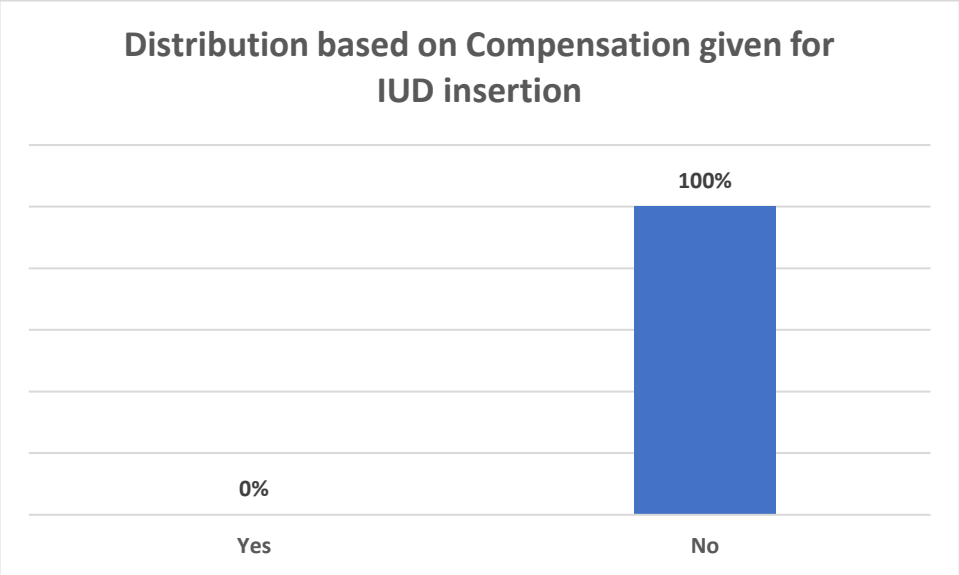

Fig 4.12: Distribution based on compensation given for IUD insertion

None of the women were given the monetary compensation which is mentioned in one of the government issues notice on the revised compensation

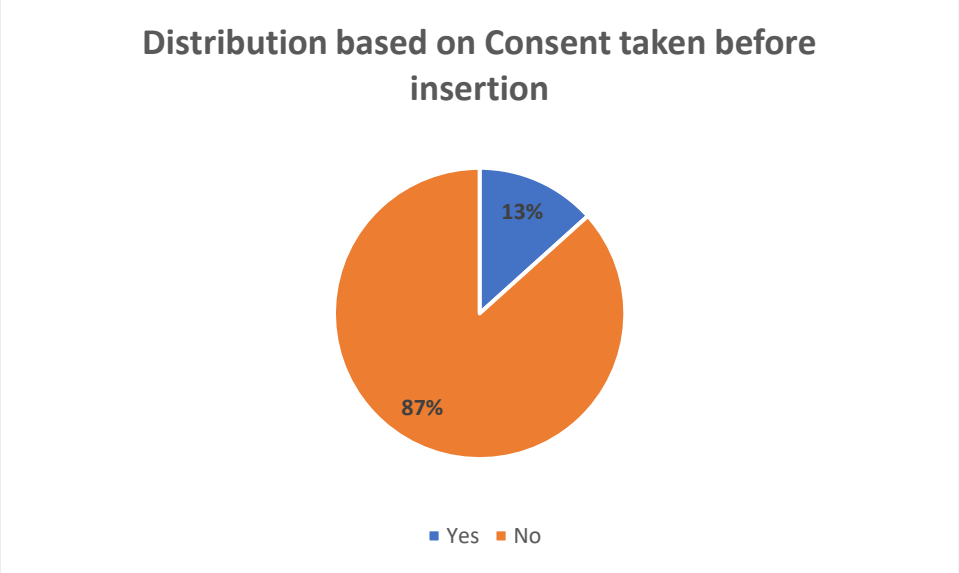

Fig 4.13: Distribution based on consent taken before Cu-T insertion

Roughly 87% of the women were not asked for permission before being inserted with the Cu-T and slightly higher than one-tenth of them had been consented to get the procedure.

The consented women include the ones who had planned to get the Cu-T and approached the physicians herself

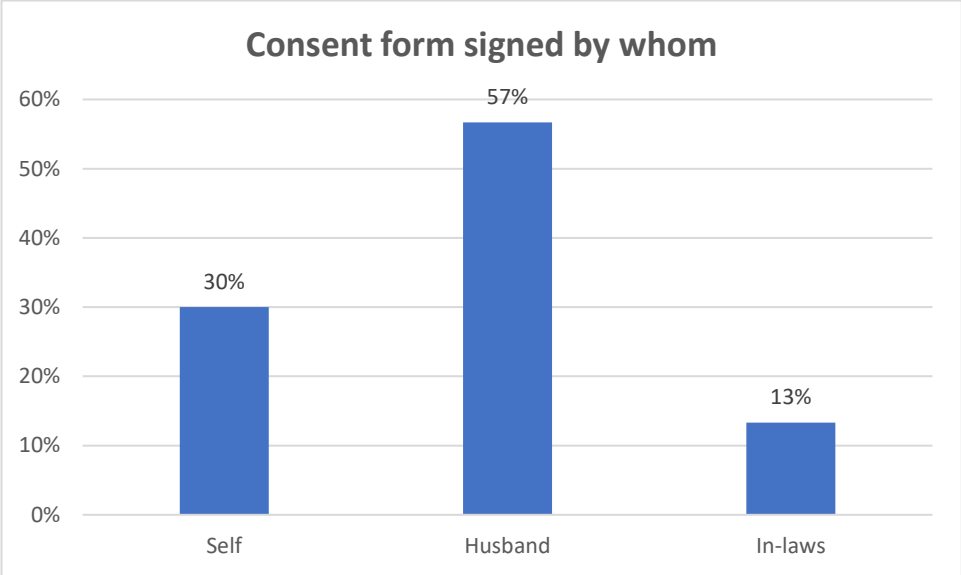

Fig 4.14: Distribution based on who signed the consent form for the women

For majority of the women, their husbands had to sign the consent form which is approximately one-fifth of the women we surveyed followed by slightly higher than one-third of them who signed it for themselves after the procedure was carried out and for a mere 13% it was signed by their in-laws

During contraceptive procedure:

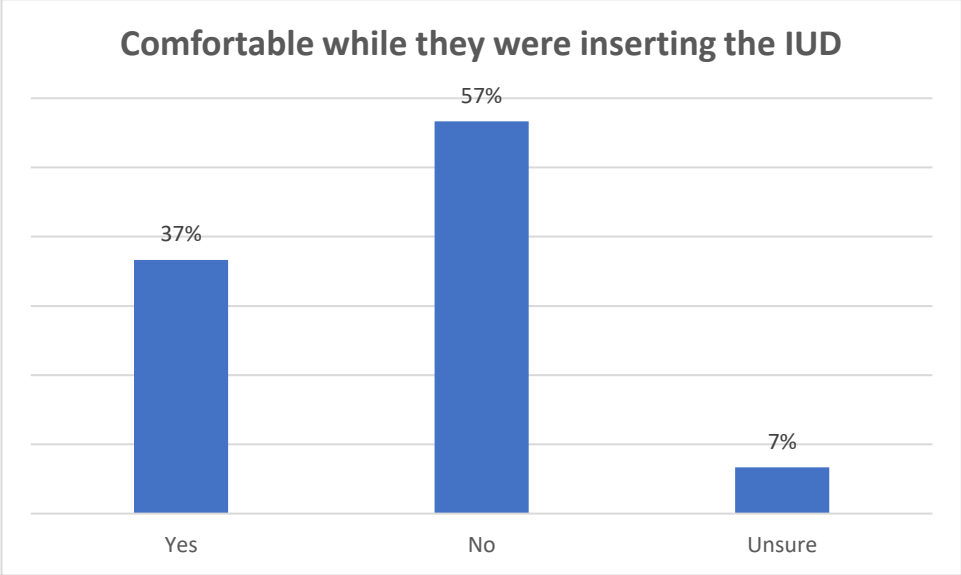

Fig 4.15: Distribution based on were they comfortable while undergoing the Cu-T insertion procedure

Slightly lower than three-fifth of the women said that they were not comfortable while getting the Cu-T inserted as the hospital staff was abusive, and forceful the whole time. Around two-fifth of them said that they were comfortable and approximately 7% of them were unsure as they were unconscious

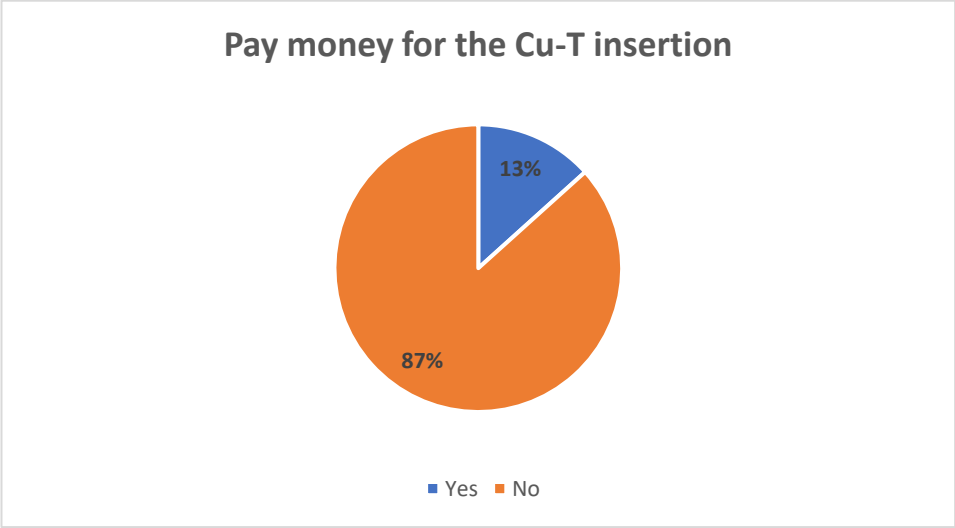

Fig 4.16: Distribution based on money paid to get the Cu-T inserted

87% of the women did not have to pay any amount to get the Cu-T inserted which is because the procedure was carried out in the hospital after she delivered whereas 13% of them did pay some amount to get the Cu-T inserted and these cases are the consented ones

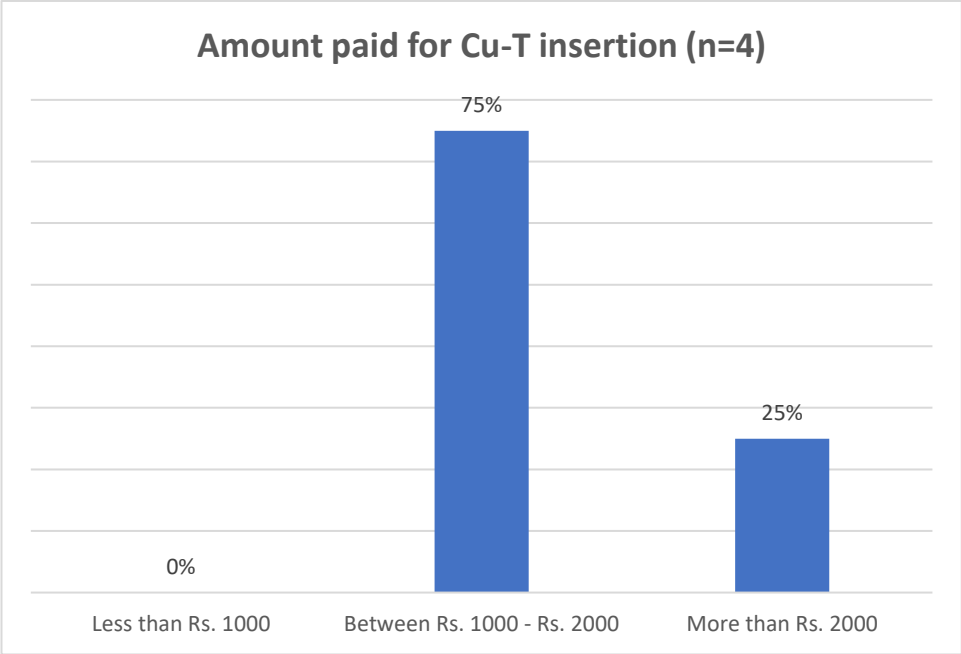

Fig 4.17: Distribution based on amount paid to get the Cu-T inserted

The total number of women included here is 4 and three-fourth of them had to pay between Rs. 1000 – Rs. 2000 to get the Cu-T inserted and one of them had to pay more than Rs. 2500. These procedures were conducted in private clinics

Post insertion of Copper-T:

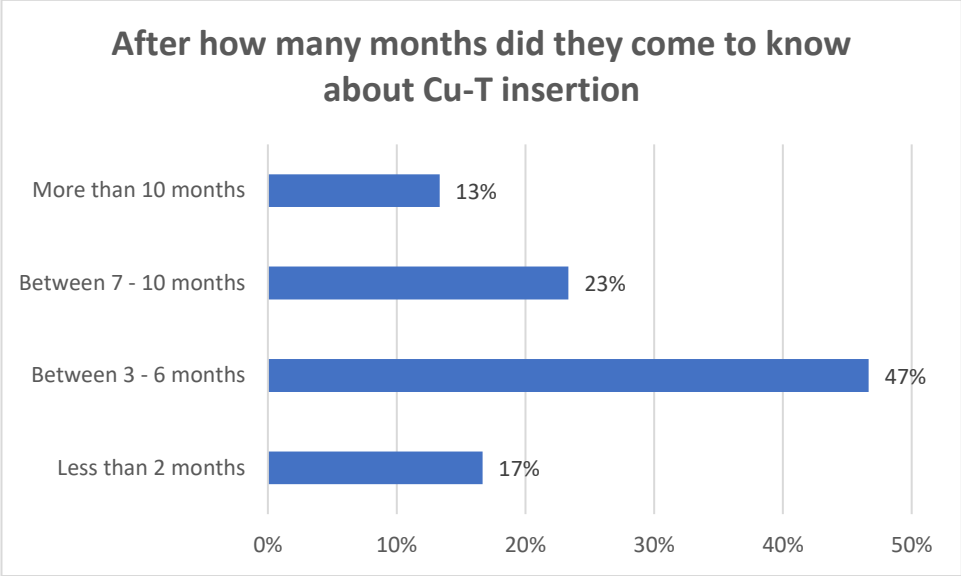

Fig 4.18: Distribution based on after how many months did they come to know about the Cu-T insertion

Around half of the women got to know that they have Cu-T inserted after 3 – 6 months of delivery followed by one-fourth of them who realized it after 7 – 10 months.

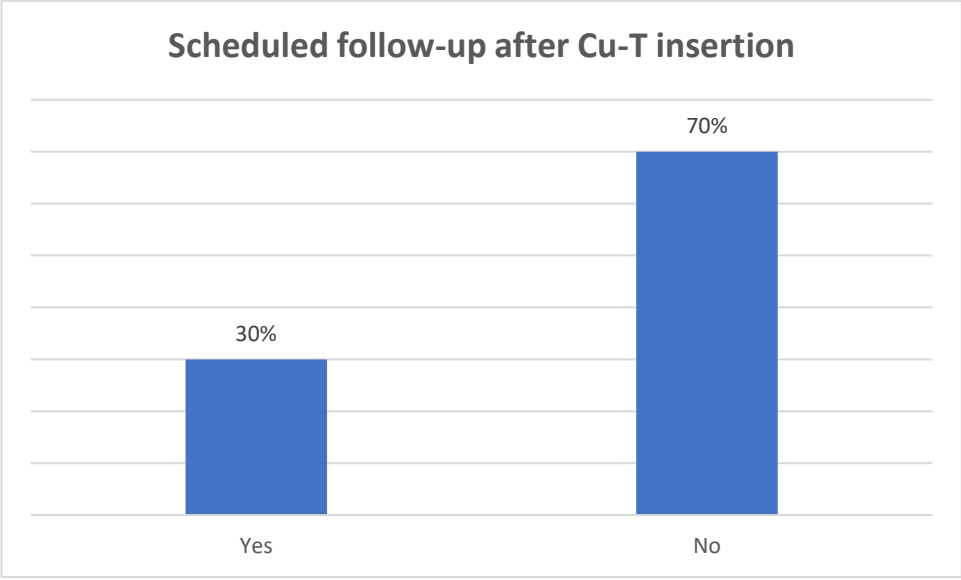

Fig 4.19: Distribution based on scheduled follow-up after Cu-T insertion

70% of the women did not have any scheduled follow-up in the hospital whereas 30% of them did which is mostly in the private hospital/ clinic settings

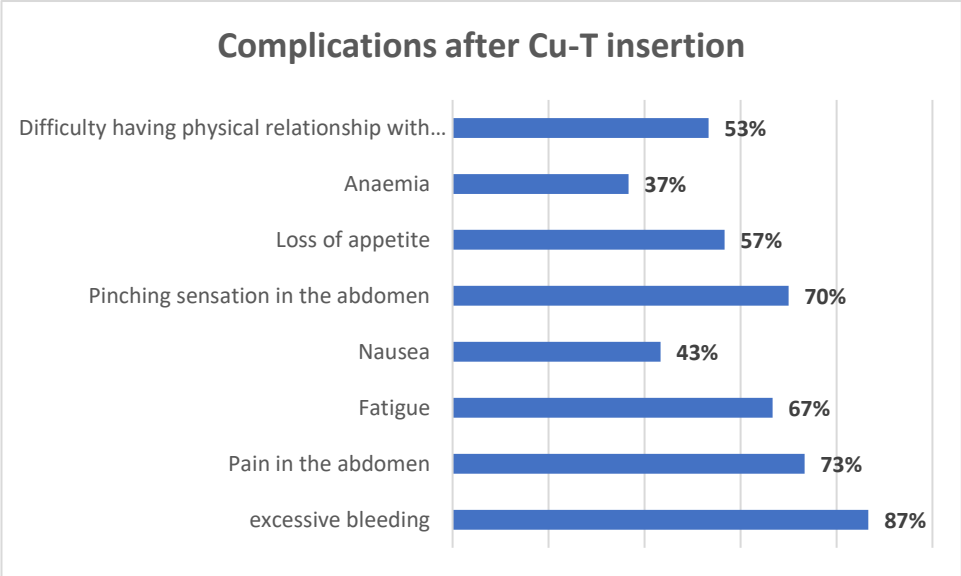

Fig 4.20: Distribution based on complications after Cu-T insertion

Maximum number of women here complained of excessive bleeding which spanned over weeks followed by pain in their lower abdomen and pinching sensation due to the incorrect placement of the Cu-T. Around 67% of them mentioned feeling tired and fatigued. Around 50% of them said that they had lost their appetite and difficulty having any kind of physical relationship with their husband due to constant pain.

Chapter 5: Discussion

The result of the analysis shows us that the women lack awareness and knowledge regarding the various contraceptive methods.

Ninety percent of the women who responded to the survey said neither their husbands nor they had received any counselling on the Cu-T procedure. And instead of receiving it from ASHA employees or doctors as they are supposed to, the 10% of those who had the knowledge received it from their relatives or close family members.

Approximately 87 percent of the women were not asked for consent before having the Cu-T inserted, and barely more than one-tenth of them had given it. The women who approached the doctors themselves and wanted to acquire the Cu-T are among those who gave their approval.

We can observe that the majority of the women who have had three or more children—roughly half of the women who were surveyed—had had an IUD implanted. About one-tenth of the women received it after the birth of their first kid, and two-fifths of them then had their second child.

A little less than three-fifths of the women reported that the hospital staff was harsh and violent throughout the procedure, making them uncomfortable. Seven percent of them were unsure since they were unconscious, but almost two-fifths of them reported being comfortable.

87% of the women did not have to pay any amount to get the Cu-T inserted which is because the procedure was carried out in the hospital after she delivered whereas 13% of them did pay some amount to get the Cu-T inserted and these cases are the consented ones

Chapter 6: Conclusion

From the study we can clearly see that the women lack awareness about contraception and family planning. The ASHA workers need to be trained and talked about their responsibilities towards the women especially during their pregnancy and after the delivery of their baby.

We need more robust policies and plans to strengthen the family planning techniques in the urban slum areas of the metropolitan cities. The mistreatment of the ladies during delivery or when they visit the hospitals to get their Cu-T removed should be highlighted and they need to speak up against such behaviour towards them.

Over the last few years the use of Cu-T or any kind of a IUCD has significantly increased which shows us that we need to promote use of condoms in people belonging to the BLP or underdeveloped areas of the city as well as inform them about male sterilization techniques.

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Annexures

CONSENT FORM

Purpose of the Study

Hi, My name is Sushmita

We are doing this small study to understand experiences of women who are using IUD/ PPIUCD. This study is part of my course dissertation and are doing it along with CHSJ - SEHER. Any information given by you doing the interview will not be shared with anyone expect the study team and all data remains confidential in the reports. In the course of the interview if you feel you do not want to answer the question or want to stop your participation you are most welcome to do so.

Your participation in this study will be highly appreciated and will help us in taking your experiences to have a larger discourse on current practice regarding IUDs. We will be recording the interview for documentation purpose and once they are put on paper all recordings will be deleted.

Summary

I voluntarily agree to participate in this study. I am aware that the purpose of the study is to gather information on IUDs and women's experiences with them. The information gathered from this questionnaire to be incorporated into an MBA dissertation and contribute to a greater understanding of the use of IUDs in government hospitals in Delhi's North-East area.

1. I attest to having received, read, and fully understood a copy of the participant information document.
2. I understand that my participation in this project is completely optional. I won't get paid for taking part. I'm allowed to leave the project whenever I want, without explanation
3. I have read the disclaimer and understand that any information I give will be kept in the utmost of confidence. My name will be made anonymous. I understand that my data will be kept securely

4. I've read and understood the explanation of the research study that was provided to me. Any queries I had could have been asked, and they were all appropriately addressed.

I accept to participate in this research study and the aforementioned written statements by continuing to fill out this form. Before starting, I will discuss any remarks with the lead researcher that concern me.

QUESTIONNAIRE

A. BACKGROUND:

(Hi first we will ask you regarding your basic information)

a. District:

b. Block:

c. Village/ Mohalla:

d. Name of the woman:

e. Age:

f. Religion:

g. Caste:

h. Economic Status:

i. Name of husband/ father:

B. BIRTH:

Now we will go into details regarding the childbirth and procedure. Some of the questions may be intimate, we once again assure you that all information will be kept confidential

a. Place of delivery:

b. Name of Institution:

c. Type of Institution:

d. Birth Order of Child:

e. Total children alive:

f. Total miscarriages:

g. Date of recent delivery:

h. Type of delivery:

i. Result of delivery:

j. Who conducted the delivery:

k. Any complication during delivery:

C. BEFORE CONTRACEPTION PROCEDURE:

a. Were you counselled about the procedure during pregnancy? Were you told about any other methods during pregnancy by any frontline worker? If yes who and where did it take place?

b. Was your husband also counselled about any contraceptive methods that he could use?

c. Were you told about the pros and cons of this method before insertion by any health worker?

d. Have you previously used any contraceptive method?

e. Were you tested for any infection of other problems before IUD?

f. Was couple counseling done for you and your husband?

g. Were you informed after the insertion of Cu-T?

h. Were you told about any compensation given for insertion of IUD?

i. Were you told about any compensation in case of failure?

D. DURING CONTRACEPTION PROCEDURE:

a. Was your consent taken before insertion of Cu-T?

b. Did you read the consent form or was it read/ explained to you?

c. Who did the signature for you, or did you do it willingly?

d. When was your signature taken? Did the husband sign on the same day of the delivery?

e. Who carried out the procedure for you?

f. Were you comfortable while they were doing the IUD insertion?

g. Was there any bad behaviour by staff? (elaborate): During delivery

h. Did you have to pay any money for the procedure?

E. AFTER INSERTION OF CONTRACEPTION:

a. (For those who did not know at all that it was inserted)- when did you come to know that IUD was there in your body? After how many months? How did you come to know? Who did you tell? How did husband respond? Other family members respond? (Sometimes husbands may not know)

b. Did you get paid any money as compensation to get a Cu-T inserted? How much? When did u receive what was the procedure for receiving this money?

c. Was a follow up scheduled before you left the hospital? If yes, after how many days was the follow up scheduled? What was the advice given to you? (Also ask if husband/ mother-in-law was given instead)

d. Did you have any complications after IUD insertion? What were the complications that you had started noticing?

e. After how many days/ months of your hospital visit did you start noticing any complications? What did you do about it?

f. Have you visited any health care person since you had any problem who were they, where? which hospital? What did they advise?

g. (If removed) Have you removed the IUD? Reason for removal? Cost of removal? place of removal, person who removed. was there any resistance from the doctors to get it removed?

h. (If still using) Do you continue to check the thread? DO you know how to check the thread? Was it explained to you by the health worker/nurse/doc?

i. Has the insertion of IUD hampered your sexual relationship or other relationship with husband?

j. What are the other contraceptive methods you know about? DO you discuss with your husband on family planning and use of contraceptives?

k. What method do you think is the best and why?

l. Any other thing you want to share or tell us about?

If there is any other information that you want regarding contraceptives, you can always contact the team here or come to the Centre.