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# *Determining Reasons for Low IUD Use in El Salvador*

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## List of Abbreviations

| | |
|---|---|
| *A.P.I.MERC* | Asesoría en Psicología Industrial y Mercadeo |
| *FESAL* | El Salvador National Family Health Survey |
| *FGD* | Focus group discussion |
| *FHI* | Family Health International |
| *FP* | Family planning |
| *IUD* | Intrauterine device |

# EXECUTIVE SUMMARY

Asesoría en Psicología Industrial y Mercadeo (A.P.I.MERC) in collaboration with Family Health International (FHI) conducted a study to determine the reasons for low IUD use in El Salvador. Factors that affect client motivation to use the IUD and provider motivation to encourage IUD use among their clients were evaluated. Also provider skills in the delivery of IUD services, especially in counseling on the IUD, were assessed.

A combination of quantitative and qualitative methodologies was used in this study. In-depth interviews with 30 providers examined provider attitudes and knowledge towards the IUD. Interviews with the simulated clients were used to further assess IUD service provision; two simulated clients visited 20 clinics each. Finally, focus groups were conducted with current family planning users wishing to space children, women who were sterilized, current or past IUD users, and husbands of family planning users. Focus group data were used to examine client knowledge and attitudes towards the IUD.

## Key Findings

*Client Motivation to Use the IUD*

Most family planning clients and husbands of family planning users in the focus groups have negative opinions of the IUD. The exception is women who have used or who are using the IUD; most of these women have a positive opinion of the method. The most common reason given for negative opinions about the IUD is fear, often generated by rumors and myths in the community. The most common myths believed by the public include: the IUD causes cancer, a baby will be born with the IUD in his body, the IUD can get lost in the women's body, and the IUD becomes embedded in the uterus. Providers can dispel these rumors and myths during family planning sessions. During the simulated client visits, 45% of providers clarified rumors, opposed to 20% who reinforced them. Current or past IUD users in the focus groups also mentioned that providers had dispelled myths about the IUD. These women felt reassured by providers and chose to use the method.

*Provider Motivation to Encourage IUD Use*

Providers' opinions about the IUD and their skills in providing the family planning in general, and the IUD in particular, can all influence a client's decision about using the method. Twenty-six of the 30 providers in in-depth interviews expressed a positive opinion about the IUD.

The majority of providers in in-depth interviews stated that they have been trained to offer counseling on all methods and to let the client choose a method. However, simulated clients reported that not all methods were discussed during counseling sessions. The most commonly discussed methods were the injectable and pills. The IUD was mentioned and explained by 48% of providers, compared to 78% for injectables and 68% for pills.

Women in the focus groups for sterilized women and spacers also stated that not all methods, including the IUD, were presented to them during initial family planning counseling sessions. Current and past IUD users did receive more counseling on the IUD, but not necessarily on all family planning methods.

Simulated clients reported that overall, counseling on the IUD was not thorough, but the counseling received was usually correct. Over half of the providers covered what the IUD is, how it works, its effectiveness, its advantages, its disadvantages or side effects, and IUD insertion; IUD removal, who can use the IUD and who shouldn't use the IUD were covered by less than half the providers.

During the in-depth interviews, providers were asked to describe the training they had received on the IUD. Twenty-three of the 30 providers said they had been trained on IUD insertion techniques and 21 reported being trained on removal techniques. Twenty-three said they were trained on IUD counseling, or on family planning counseling in general. Most providers were satisfied with the thoroughness of the training they had received, although some felt the need for more training or more practice of the techniques learned.

**Conclusions**

Overall, the findings suggest some possible reasons for low use of the IUD in El Salvador. First, clients are afraid of the IUD because of myths and rumors surrounding the method. These rumors can be dispelled through good counseling, and through satisfied IUD users' sharing their positive experiences with the method. Second, providers do not always mention the IUD during counseling. Third, providers may lack the necessary training or practice needed to provide the method.

# I. INTRODUCTION

Although a considerable proportion of contraceptive users in many Latin American countries uses the IUD, its use in El Salvador is low. Despite the fact that contraceptive prevalence has grown from 22 percent of reproductive age women in 1975 to 60 percent in 1998, IUD use has remained very low and in fact has decreased from 3.3% in 1985 to 1.5% in 1998 (ADS, 1999). Female sterilization has been the most popular method and in 1998 was used by 32.5% of women between the ages of 15-44, i.e. more than half of all contraceptive users. Pills and injectables are the next most popular methods, each used by approximately 8% of women.

Anecdotal evidence suggests that the IUD is not being promoted, yet it could fill an important niche by providing another contraceptive option to women. The IUD can provide short-term protection to those women who want to delay another pregnancy and has many advantages over injectables and pills. First, it does not require resupply visits. Second, it requires no action on the part of the user, unlike pills which must be taken daily. Despite the popularity of female sterilization, there are indications that many are not satisfied with this method, indicating a need to promote other methods which provide long-term contraceptive protection, such as the IUD. Finally, the IUD is a very cost-effective method compared to other methods for spacing.

The IUD can also provide long-term protection to women who are uncertain if they want more children, or to women who do not want more children and do not wish to undergo sterilization. Despite the popularity of female sterilization, there are indications that many are not satisfied with this method, indicating a need to promote other methods which provide long-term contraceptive protection. Among women reporting they wanted another pregnancy at the time of the 1993 El Salvador National Family Health Survey (FESAL), 27% were already sterilized (ADS, 1994). These findings suggest either regret about choosing a permanent method of contraception or a lack of understanding that the method was in fact permanent. Promotion of the IUD could reduce this level of regret by providing another option to women who do not want or who are not ready for sterilization.

If IUD use is to be encouraged, it is important to understand the factors influencing client motivation to use the method and provider motivation to encourage its use. Factors that may affect client motivation include knowledge, experience and attitudes on the part of the user about IUDs and information about how to obtain them.

The provision of IUDs will be affected by the willingness and competence of providers to make it available, and the supporting infrastructure. Training in family planning and specifically in the IUD, past experience with providing the method, and attitudes toward the method will all affect willingness and ability to provide it. Moreover, if the user of a method is not well counseled, then both acceptance of the method and its continuation will be low.

It is within this context that Family Health International (FHI) in collaboration with Asesoría en Psicología Industrial y Mercadeo (A.P.I.MERC) conducted a study to determine the reasons for low IUD use. The results will assist the Ministry of Health in their efforts to increase IUD acceptability and accessibility for the method. Separately, the Ministry, with assistance from the

PRIME project, is assessing supplies, equipment, provider training and competency, and other logistics necessary to supply the method, through the implementation of several USAID-supported projects.

**Purpose and Objectives**

The purpose of this study is to obtain information to ascertain how to increase IUD use in El Salvador.

Specific study objectives are:

1. To determine factors that affect client motivation to use the IUD;

2. To determine factors that affect provider motivation to encourage IUD use among their clients; and,

3. To assess provider skills in the delivery of IUD services.

## II. METHODOLOGY

### STUDY DESIGN

A combination of methodologies was used including in-depth interviews, a simulated (mystery) client study, and focus group discussions. In-depth interviews examined provider attitudes and knowledge towards the IUD. Simulated client interviews were used to further assess IUD service provision. Finally, focus groups were used to examine client knowledge and attitudes towards the IUD. Table 1 summarizes how each of the methodologies was used to measure the main study components.

*Table 1. Study Components by Methodology*

| | **Provider In-depth Interviews** | **Simulated Clients** | **Focus Groups** |
|---|---|---|---|
| User Attitudes | | | X |
| Client/Provider Interaction | X | X | X |
| Provider Attitudes & Knowledge | X | X | |
| Quality of Counseling | X | X | X |

### 1. In-depth interviews with providers

Provider knowledge of and attitudes towards the IUD can influence their provision of the method. These factors were explored through in-depth interviews with family planning providers.

*Site selection and participant recruitment*
The Principal Investigator worked with a representative from the Ministry of Health to select clinics for provider interviews. In order to be selected, the clinic needed to be a Ministry of Health clinic that provides family planning services, and have at least two providers who had been trained in IUD insertion or referral. A list of eligible clinics was compiled and then sites were chosen randomly from this list. The providers interviewed at each site were chosen by the Principal Investigator in collaboration with the clinic manager in order to select providers who had been trained in IUD provision or referral. Both urban and rural sites were chosen.

Study teams traveled to selected sites during May and June 1999. Letters of introduction signed by a representative of the Ministry of Health were sent to the clinics in advance of the visits, advising clinic managers of the study and the potential for a visit. Interviewers presented a letter of introduction upon arrival and formally asked permission to interview a family planning provider. If more than one provider was eligible, the one to be interviewed was selected at random.

*Data collection*
Once both the clinic manager and the available providers granted permission, the interview took place. Most interviews were conducted at the clinic, usually in the room where providers treat patients. The room was quiet and without other interference. Two trained psychologists conducted the interviews. The Principal Investigator conducted two interviews. After obtaining informed consent, the interviewer used a discussion guide to direct the approximately hour-long conversation and an audiotape to record the conversation. Names of providers and clinics were not given on the tape or recorded elsewhere to protect the identity of the providers involved in the study.

One provider was chosen per site, for a total of 30 providers at 30 clinics. Four providers were nurses, and the rest were doctors. All had been trained in IUD provision.

*Interview guidelines*
An interview guideline with open-ended questions was used to guide the in-depth interviews and was based in part on information from the FHI IUD training module. Topics included were: training on the IUD, professional experience with IUD insertions, personal thoughts about the IUD, indications and contraindications for use, providers' concerns about the time and trouble involved to insert an IUD and to follow up on an IUD acceptor, and the availability/supply of IUDs and IUD-related expendables at their clinics.

## 2. Simulated client study

The simulated client study was conducted to examine the interactions between provider and client and to assess the quality of these interactions. Specifically, it assessed provider knowledge of the IUD, whether or not they recommend it to women who wish to limit or space their families, and whether client age and/or parity influence discussions with clients.

*Data collection*
The simulated client study took place in fifteen of the health facilities selected for the provider in-depth interviews. Simulated client visits were conducted only in urban areas, however, given the difficulties in simulating a client in smaller, rural clinics where behaviors may be quite specific and women may be well known.

Two A.P.I.MERC employees were trained as simulated clients. This allowed for collection of standardized information and ensured that providers and clients did not know each other. Twenty clinics were visited by both simulated clients, for a total of 40 clinic visits. The simulated client dressed, spoke, and behaved as if she was a potential, "typical" client. Study teams traveled to selected sites between May and June 1999.

Upon visiting a clinic, the simulated clients sought information and counseling about family planning methods and presented themselves as interested in obtaining an IUD. To assess if age and parity influence the counseling received, each claimed to be in one of two sub-groups based on age and number of children. One reported that she had one child and was 25 years old, and the other that she had three children and was 23 years old. Each simulated client volunteered that she was in a stable, monogamous relationship, that she wanted family planning advice to space her children, and that she wanted a long-term method (at least two years). Both clients stated that she had at least a primary education. The client did not volunteer any information regarding sexually transmitted disease. If the provider did not volunteer information about the IUD, the simulated client was instructed to ask specifically about the method. After the interview, each simulated client completed a questionnaire, which was supervised or reviewed immediately by the Principal Investigator.

*Simulated client guidelines and questionnaire*
The simulated clients were instructed to note the following: reception received at the clinic, the assessment of her reproductive health needs, discussions and explanations of available family planning methods and how they work, selection of the IUD as the method of choice and the content of IUD counseling. The questionnaire completed after the visit provided the correct information with which to evaluate the answers to the questions (for example, what the contraindications for IUD use are to determine if the provider knew who should not use the method), to assist in the completion of the questionnaire. A conversational guideline was developed to assist the simulated client in their conversation with the provider. The guideline was based on the FHI IUD training module.

## 3. Focus groups discussions (FGDs)

The demand for IUDs is considered among two potential user groups, women who are interested in having additional children but are using a method other than the IUD to postpone their next birth, and women who have completed their families and have been sterilized. In addition, a third group is considered: women who have previously used an IUD, to obtain their perspectives.

*Site selection and participant recruitment*
Recruitment of focus group participants was conducted at Ministry of Health clinics. Private clinics were excluded due to their small numbers, possible collaboration difficulties, and because these clinics usually provide services to people of higher income levels. The Principal Investigator provided selected clinics with a letter of authorization from a representative of the Ministry of Health. Prior to conducting the focus group sessions, the clinics were visited and given guidelines as to their role and how to recruit the participants. An appropriate venue for conducting the FGD was also selected. Clinics that had been selected for the provider interview and simulated client components were chosen randomly for focus group discussions. Also, clinics in regions not represented in the other components of the study were added.

A nurse at the clinic served as the study contact. The nurse reviewed clinic records to identify women who were using reversible family planning methods, who were current or past IUD users, and who had been sterilized at their clinics. These lists provided names of the potential participants to be recruited at each clinic. Women who were using re-supply methods were recruited when they visited the clinic to obtain new supplies of the method. Women who had recent IUD insertions were recruited when they returned for their first follow up visit or for their 1 year check up. Sterilized women were recruited during their visits for post-sterilization procedures such as removal of stitches.

*Data collection*
A total of thirteen focus groups were conducted at ten clinics: four with women who wish to space children, four with women who were sterilized, two with current or past IUD users, and three with husbands of family planning users. The latter group was added after completion of data collection since it was determined that the husbands' perspectives' could add an important determinant of method selection. The women's groups took place in June and July 1999, and the men's groups in August.

Focus groups ranged from 5-10 participants. The discussion groups for sterilized women and spacers were held in both rural and urban settings and a total of 37 and 32 respectively participated. The IUD user groups were only conducted in urban areas since use is almost non-existent in rural regions. These groups had a total of 20 women. Finally, 18 men attended the discussions for husbands; two of these groups were in a rural setting and one in an urban one.

Informed consent was obtained verbally prior to conducting the focus group discussions. The sessions were taped with the verbal consent of the participants. A team of two people conducted the FGDs, and consisted of a moderator and a recorder/observer. Participants were provided with refreshments, a small incentive, and transportation costs.

*Focus group guidelines*
Focus group guidelines focused on perceptions of IUD acceptability and availability. Focus group discussions among spacers and sterilized women included the following topics: perceptions and rumors, experience with other methods of family planning, any experiences they may have had with providers in attempting to obtain the methods, and difficulties, if any,

obtaining the methods. Participants also discussed whether or not they have given any thought to using an IUD, why or why not, and if they think they will do so in the future.

Among women who chose IUDs, factors of particular interest included the reasons for choosing it, their experience with the IUD, why they like it, how they feel it could be promoted, and their perceptions as to why other women may or may not elect to use it. Due to the low level of IUD use, both current and past users were included in order to obtain a sufficient number of FGD participants. In the discussions with men, topics included: general thoughts on family planning, the role of the woman in the decision to use family planning, current method use and satisfaction with current method, men's experience with counseling, and perceptions and rumors about the IUD.

## QUALITY ASSURANCE AND DATA MANAGEMENT

Prior to initiation of data collection, a training session was conducted for focus group leaders and observers and a separate training was conducted for provider interviewers and simulated clients. All study staff were given an overview of the project and a review of procedures to maintain participant confidentiality. In addition, focus group staff discussed the following topics: procedures for focus group recruitment, guidelines on how to successfully monitor a focus group discussion, and a thorough review of all questions that appear in the focus group guidelines. In addition, focus group leaders and observers observed the actual conduct of a focus group. The training for provider interviewers and simulated clients included a thorough review of the data collection instruments which they would use. The simulated clients practiced in two clinics in order to validate the questionnaire and the behavior of the simulated clients. Also, the interviewers conducted two preliminary interviews to validate the interview guidelines.

All data forms, including clinic profile data, master lists containing names and IDs of study participants, consent forms, completed provider interviews, data forms completed by the simulated clients, and focus group transcripts were kept in a locked filing cabinet at the office of the Principal Investigator. All forms containing study participant identifiers, such as the master lists and any client record data were kept separate from the focus group transcripts and completed surveys. Study personnel were thoroughly briefed on the importance of maintaining study subject confidentiality and all procedures related to maintaining that confidentiality.

## DATA ANALYSIS

In-depth interviews and focus group discussions were conducted in Spanish, recorded on cassette, and transcribed and typed into separate word processing files. After a close reading of the first several transcripts, the research team developed an initial list of codes. Using these codes, data from the text files were categorized into broad topical areas such as: family planning counseling, myths and taboos surrounding IUD use, and perception of the IUD. Researchers then added the appropriate codes in each text file using DtSearch. This software package allows the analyst to search for words or combinations of words in a large number of files very rapidly. This allows the researcher to analyze each newly created file for ideas, concepts or experiences

that were common across groups, and those that differed from one group to another, or within groups.

The local in-country team used EPI-INFO to enter the simulated client data. Analysis was conducted by FHI. Frequencies and cross-tabulations of key variables were produced in SPSS.

## III. RESULTS

In selecting a contraceptive method, a family planning client will assess the relative advantages and disadvantages of the different methods available and known to her and determine which best suits her needs. This assessment will be based on her knowledge and attitudes towards the method, which may be influenced by information she receives both through personal contacts and family planning providers. Often this information includes rumors or myths or reports of the experiences of the users of a method. Providers can have an effect on client choice through what they tell clients about method options. This may be influenced by their opinions and their knowledge, which also may be affected by rumors and myths, and by the training they receive.

The results will be divided into two sections. First we will explore client motivation to use the IUD and examine some of the reasons which may account for the low number of users in El Salvador. Second, we will examine the provider motivation to encourage IUD use and consider the factors that may influence their opinions and service delivery practices.

### A. Client Motivation to Use the IUD

To examine client motivation we will look at client opinions towards the IUD, rumors and myths that may cause negative opinions and the impact of dispelling rumors and myths.

#### 1. Clients' opinions

Not surprisingly, given the low use of the IUD in El Salvador, most family planning clients and husbands of family planning users in the focus groups have negative opinions of the IUD (Table 2). The exception is women who have used or who are using the IUD; most of these women have a positive opinion of the method.

*Table 2. Overall Opinion of the IUD*

| Group | Total | Positive | Negative | N/A or Mixed |
|---|---|---|---|---|
| Sterilized women | 32 | 3 | 24 | 5 |
| Spacers | 37 | 2 | 26 | 9 |
| Current/past IUD users | 20 | 17 | 0 | 3 |
| Husbands of FP users | 18 | 0 | 13 | 5 |

The most common reason for the negative impression of the IUD was fear. This fear is based on specific rumors or myths about the method or bad experiences that they had heard others had with the method. Often, no specific reason was given for the fear; participants merely stated that they felt the method was "dangerous" or "harmful."

Husbands also expressed fear about the method and similarly have a negative impression of the method that could influence their wives' contraceptive choices. Of 18 husbands in focus groups, not one had a positive opinion of the IUD while 13 had a negative one. The rest either had no opinion or a mixed one.

## 2. The influence of rumors and myths on clients

During the provider interviews, providers stated that the biggest barrier to IUD use in El Salvador was the commonly held myths and rumors surrounding the IUD. According to the providers, the most popular rumors believed by the public include: the IUD causes cancer, a baby will be born with the IUD in his body, the IUD can get lost in the woman's body, and the IUD becomes embedded in the uterus. One doctor discussed the myth that the IUD causes cancer, *"Well, the opinion of most of the people which I offer this method to believe that it causes cancer moving around in there. Having that in their bodies doesn't seem right. They should feel sick. Really they have never used the IUD but they still say it will make them feel sick and their husbands say they can't have that in their bodies."* Another doctor describes what she feels are the most common myths, *"The most popular myth that exists is that the baby will be born with the IUD in its head. This is the most commonly circulated myth, right. Or at least this is what I have heard from my patients. But there is another myth floating around here and it is that the IUD causes cancer. But they are myths."*

Focus group participants confirmed that these are the most commonly believed rumors. One sterilized woman told about a friend's experience, *"Once a friend of mine told me that the IUD had embedded itself and that she had it for six years. When they went to remove it they couldn't find it. It had ingrown into her uterus."* Another sterilized woman spoke about the effect the rumors have on her impression of the IUD: *"Well I have heard the same as the others have mentioned; it causes cancer, you can get pregnant and the baby will be born with the IUD. Those things are what frighten people."* Often the rumors include actual "cases": *"They say that thing is dangerous, the IUD. Where we live there was a case of a woman with an IUD and while she was having relations with the man; the man got stuck on the IUD."*

Actual cases that are then exaggerated can be a principal source of rumors and myths, according to providers. One doctor described a possible origin, *"While I was studying, I remember it was mentioned at the University. They mentioned that there had been cases where the IUD became encrusted. Also, even though rare, some women have become pregnant while having the IUD. I think that it has been said for so long that maybe the doctors themselves have created some myths or rumors. These are things that can happen but not as frequently as many may think or believe, to the point of becoming propaganda."* Another described the process of one case becoming a frightening myth: *"This has become folklore, because they heard that someone became pregnant while using the IUD. That was passed on from person to person. By the time the information has gone from the first person to the fifth person the information has already been distorted. So the story is no longer that the person became pregnant while using the IUD, but that the baby was born with an IUD in its head. From that point it would change to the child*

*was born mentally retarded. From that point the story would change to the child was born paralyzed and they would just keep adding and adding."*

One reason for the rumors, according to providers, is a lack of information to the public. One doctor explained this problem, *"I think it's a lack of, how would you say, proper information. When this program began, inserting the IUD, proper information was not supplied, general information was not given to everyone. The information was given to a few select groups, including myself. I knew little about the IUD. Here was where I was able to actually use the information provided."*

Finally, the church is blamed for the origin and perpetuation of some myths. One nurse explained the church's impact on public belief: *"the church does not allow the use of the IUD. Many followers obey their leader or pastor. During the service he will tell them not to use the IUD because it will cause cancer. They have been told not to use the IUD for so long."* A doctor also blamed the church for myths about the IUD: *"The majority says that it is not a method approved by the church. Another reason is religion. Many women do not accept that method because the church does not accept it. They believe it is abortive."* However, some churches and religious groups may be raising consciousness about the IUD, by dispelling the rumor that the IUD is an abortifacient.

### 3. Dispelling rumors and myths

One opportunity to dispel rumors and myths would be during the family planning counseling sessions. During the simulated client visits, some providers spontaneously discussed a taboo or myth (Table 3). Other providers responded to clients' questions about rumors or myths surrounding the IUD. The most commonly discussed myth is that the partner can feel the strings or that there is discomfort during intercourse. More providers clarified rumors (45%) than reinforced them (20%). Providers dispelled the myths that the partner can feel the IUD and that the IUD causes cancer. The most common rumors that were reinforced by providers were that the IUD can fall out, that the IUD can move around in the body, and that the partner can feel the IUD. Two providers also mentioned that the IUD is an abortifacient.

| *Table 3. Rumors about the IUD discussed during counseling* | |
|---|---|
| **Item** | **Simulated clients (n=40)** |
| Provider spontaneously mentioned taboo or myth | 47.5 |
| Myths discussed:* | |
| IUD can move and get lost inside body | 15.0 |
| IUD can fail and will be in baby's head | 10.0 |
| Partner can feel IUD, discomfort | 42.5 |
| IUD can "fall out" | 20.0 |
| IUD causes cancer | 20.0 |
| IUD is abortive | 10.0 |
| ***Provider clarified rumors*** | 45.0 |
| Provider reinforced rumors | 20.0 |
| Inadequate or no discussion | 35.0 |

* More than one response possible.

Some providers felt that counseling to clarify rumors and myths did little or no good. Many clients who received such counseling continued to fear the IUD. *"Yes, we tell them other things cause cancer. If the IUD caused cancer, it would have been discovered long ago. We are here to protect you not to cause you harm. So don't believe these things. But even with all the reassurance they still believe that."*

Yet during the focus group discussions, some current or past IUD users mentioned that providers had dispelled these myths and reassured them about the safety of the IUD. An injectable user describes counseling she received on the IUD: *"With the IUD, my mother says, it causes cancer. Well I asked the doctor and he told me, 'no, if you keep your follow-up visits and are getting checked there isn't any danger.'"* Two current IUD users explained how doctors reassured them so they could choose the IUD without fear: *"I attended a talk where they said there was a possibility of you becoming pregnant. The baby could be born with the IUD and it would need an operation. I spoke to the doctor about that and was told 'no, that is not possible'. From that point I decided." "People say it becomes embedded, others say their babies are born with it. But the doctor explained all that to me. He said, 'Don't go around thinking that you will end up pregnant. If you end up pregnant it is because you don't have an IUD."*

## 4. IUD users' experiences

Once these rumors and myths are dispelled, IUD users are generally satisfied with the method. Most clients who had used the IUD had a positive experience and would recommend it. A past IUD user who is now sterilized described her experience with the IUD: *"I had it for 2 years, maybe longer. It was inserted and I didn't feel anything that would hinder me, not a string hanging, nothing. When I decided to have it removed was because I wanted to have another child."* Another past IUD user who is now sterilized agreed that the IUD was a good method and that she would recommend it: *"evaluating all the methods I knew about, I prefer the IUD. I*

*prefer it because it is practical. You don't have to worry about did I forget to take the pill or the injection. Also, it doesn't have any emotional side effects or physical side effects."*

However, there were some cases of dissatisfaction from past IUD users who had had side effects. A current injectable user described her problems when she was using the IUD: *"I had my IUD removed because I was in constant pain."* A woman who is now sterilized also complained of side effects with the IUD: *"I really didn't like that because it caused too much pain especially when I had my period. Goodness gracious! I finally went to have it removed."*

## B. Provider Motivation to Encourage IUD Use

Providers can influence the demand for IUDs in two ways. First, their own opinions about the method may come through during counseling sessions. Second, their skills in providing the method may impact what the client ultimately decides about it.

### 1. Provider opinions about the IUD

Most providers in in-depth interviews seem motivated to provide the IUD and indicated that they had a favorable opinion of it. Of the 30 interviewed, 26 reported a positive opinion and two a negative one. The remaining two either expressed no opinion or a mixed one.

Most providers said they would recommend the method to both clients and friends or relatives. One doctor stated her positive opinion of the IUD, *"Look, the IUD is a method that well I am very interested in and I like. I feel that it is one of the most adequate methods for women. The woman decides when to have it inserted and to have it removed. Best of all there aren't any side effects. This is the reason why I prefer the IUD. Unfortunately, I have yet to insert the IUD in a patient."*

A few providers did say they would recommend the method only if the client met appropriate medical criteria or if no other methods were appropriate. One doctor indicated her tentative approval of the method: *"I really am not against the IUD. I am not against the IUD, I believe it can be used. If the woman doesn't have any contraindications and has check-ups periodically, then she may have it inserted."* Another doctor would be very reluctant to recommend the IUD to anyone: *"Well, personally speaking I would be more stringent with the IUD. I do not agree much with using it."*

Several providers have noticed that IUD users tend to be satisfied with the method, which may influence their motivation to provide it. One nurse pointed out that many users are happy with their IUDs: *"There are people, users, who are very satisfied with the IUD.... they say this is the ideal method."* A doctor stated, *"The few patients I have seen with the IUD have been satisfied."*

<u>The influence of rumors and myths on providers</u>
Rumors and myths not only influence client demand, but can also influence the provision of services. Some providers stated that other providers believed some of the myths and rumors

about the IUD. Three providers stated that colleagues believed the IUD was an abortifacient, one provider stated that he believed it to be an abortifacient, and one provider said it was taught in the University that the IUD was an abortifacient. It is also possible that some teachers in the universities used to state opinions contrary to the use of the IUD. One doctor described his colleagues' belief, despite having received training: *"When we were in the family planning training session, many of the colleagues came already believing the myth of the IUD being microabortive, even after four days of training...."* Another provider claimed that some of her colleagues believed the IUD can cause cancer.

## 2. Provider skills for IUD provision

We examined service provision through the quality of family planning counseling in general and the IUD in particular. Overall, clients should be treated respectfully, feel free to ask questions and should make the choice of method herself. Furthermore, a client history should be taken. Good counseling should include at least a mention of all methods, and specifics about any method of interest. Provider knowledge of the IUD was assessed through information given during in-depth interviews and counseling received by simulated clients. Finally, we asked providers about their training on the IUD, which can influence the quality of service provision as well as provider knowledge.

General counseling

Overall, the general counseling received by simulated clients was of mixed quality (Table 4). Most of the clients were greeted by providers and were counseled in private, and few clients felt that providers ignored their questions. However, most providers did not attempt to learn which method clients were interested in or did not help clients to choose a method appropriate to their needs. Also, providers did not generally take a thorough client history (Table 5). Some differences are noted between the two clients and general counseling was marginally better for the client with one child though the difference were not as pronounced in the client history.

*Table 4. General counseling received*

| Item | All simulated clients (n=40) | Simulated clients with 1 child (n=20) | Simulated clients with 3 children (n=20) |
|---|---|---|---|
| Provider greeted client | 85.0 | 90.0 | 80.0 |
| Provider asked questions about client's age, marital status, number of children, etc. | 70.0 | 80.0 | 60.0 |
| Provider asked reasons for wanting a method | 25.0 | 30.0 | 20.0 |
| Provider helped client choose a method based on individual needs | 25.0 | 30.0 | 20.0 |
| Provider ignored client's questions | 7.5 | 0.0 | 15.0 |
| Provider told client which method to use | 45.0 | 60.0 | 30.0 |
| Provider asked what method client was interested in | 32.5 | 50.0 | 15.0 |
| Client was counseled in private | 67.5 | 75.0 | 60.0 |

Most providers claimed that they do not try to force a method on clients. Instead, they say that they have been trained to offer counseling on all available methods. If a client requests the provider's opinion, the provider may make a suggestion. One doctor said, *"Well, during consultation sessions you tend to let the patient choose a method, right. You offer all the methods available, but you tend to let the patient decide."* Another stated, *"we are not going to impose a method on them. We explain the advantages and disadvantages and let each patient make their decision."* A doctor described the impact a recent training session had on her counseling skills, *"Well now they have taken that away, the decision is completely up to the person right. We explain it to them. At this workshop we were told to only explain the methods, what are the benefits, right what are the.... or the effects that could arise. Then it is up to her. She decides because we can't force anyone to make a decision."* These results show some discrepancy with the results of the simulated client visits as shown above where clients were told what method she should use in 45% of the visits.

Some providers did state, however, that they felt the decision was basically theirs. One doctor claimed that the choice of a method was not up to the client, but the provider. She used an example of a recent client who did not agree with the doctor's choice: *"For example, today I saw a woman with four children, I told her she should get the IUD you already have four children... 'no she responded, I want the pill,' but look, 'no, I want the pill,' But I always make the final decision."* No clients, however, in the focus groups claimed that they felt coerced or forced to choose a certain method.

While client preferences are important, a client history needs to be taken to assure the method selected by the client is clinically appropriate. Table 5 shows what providers asked simulated clients about their medical and family planning history during their visits. The most common

pieces of information requested by providers were the number of births and their outcomes and menstruation. No providers asked about family medical problems, client satisfaction with past method, or STD history or exposure.

*Table 5. Client history discussed during counseling*

| Item | All simulated clients (n=40) | Simulated clients with 1 child (n=20) | Simulated clients with 3 children (n=20) |
|---|---|---|---|
| Provider asked for personal history | 20.0 | 15.0 | 25.0 |
| Provider asked about past medical problems | 12.5 | 5.0 | 20.0 |
| Provider asked about menstruation | 55.0 | 85.0 | 25.0 |
| Provider asked about number of births and outcomes | 65.0 | 75.0 | 55.0 |
| Provider asked about past FP use | 47.5 | 65.0 | 30.0 |
| Provider asked about problems with past method | 12.5 | 25.0 | 0.0 |
| Provider asked about sexual history, sexual behavior | 10.0 | 15.0 | 5.0 |

Discussion of the IUD and other family planning methods

Injectable and pills were the most commonly discussed methods during counseling sessions and far more likely to be mentioned to the simulated clients than the IUD (Table 6). Given the popularity of female sterilization, it is surprising how seldom it was mentioned as a method of contraception. Methods such as spermicides, Norplant and natural family planning were mentioned in fewer than 10% of the visits.

*Table 6. Methods discussed during counseling of simulated clients*

| | Simulated clients (n=40) | | |
|---|---|---|---|
| Method | Mentioned and Explained | Mentioned only | Not Mentioned |
| IUD | 47.5 | 20.0 | 32.5 |
| Injectables | 77.5 | 17.5 | 5.0 |
| Pills | 67.5 | 25.0 | 7.5 |
| Condoms | 7.5 | 55.0 | 37.5 |
| Tubal ligation | 2.5 | 7.5 | 90.0 |

Yet, most providers reported that they did offer counseling on the IUD, along with counseling on other family planning methods. When asked if she counsels clients on the IUD, one doctor replied, *"Of course! I always tell them. I mean it doesn't seem like much from what I have noticed, but it is the method I present first and emphasize that I prefer this method. I believe I prefer the IUD to injectables and oral contraceptives."* Other providers stated that they did counsel clients on the IUD, if the client seemed potentially interested in the method. Another doctor responded that he does counsel on the IUD, *"but to be honest with you the women come in*

*with their minds already made up as to which method they want. For example, if a woman wants the pill she will come to me and ask me to explain how the pill works. They will only ask questions regarding the pill or the injectables. However, if a patient comes in and asks me for family planning assistance and an explanation of each method, I then go on and mention the IUD. I mention all the advantages; whether or not this is the right method for her. I also mention the IUD when I notice that the patient has doubts about the method they have selected."*

This was contradicted by most women in the focus groups for sterilized women and spacers who said that they were not offered information on all methods when they first received family planning counseling. Often, the only methods mentioned were the injectable and pills. One woman described her counseling session: *"The doctor explained to me that only the pill or the injection, but I had already decided on the injection because it is better. I would forget to take the pill."* Another one stated that she got little or no family planning counseling at all, *"When I came to obtain a method, I was not told any of that. The nurses only asked me what method I was going to use for family planning and I told her the injection. That was all."* Another woman who is now sterilized reported that she also received very little counseling, *"Well all I was told was that it would be better to get sterilized."*

Providers in in-depth interviews did offer some explanations as to why some providers may not counsel on the IUD. The two primary reasons include a lack of time to cover all methods and a limited supply of IUDs. None of the providers stated that they did not discuss the IUD because they did not approve of the method. One doctor explained why she rarely talks about the IUD, *"Well, maybe... sometimes we're in a rush and there are many patients, maybe...many times we choose the easiest method."* Another doctor stated, *"No, I don't do that. First of all I don't have the time. Secondly, they are not handy, we have them in stock though. We use different consultation rooms. Maybe there may be some in that room, but because of the rushing, well. I only explain that it is something that will remain in your uterus; it is small and it's this way and this will happen."*

There were, however, many family planning clients who did receive some counseling on the IUD, either during individual visits to the clinic or in clinic-sponsored talks about family planning. Current and past IUD users had received the most exposure to the method during counseling sessions. However, receiving counseling on the IUD did not guarantee thorough counseling on all family planning methods or even complete counseling on the IUD itself. One spacer said, *"I was told there are injectables, the pill and the IUD, right. It would arrive on a certain date and to come back with my mind made up as to which method I would like. I was told it is up to you whether you would like the IUD, injectables or the pill."* A current IUD user stated, *"I wanted advice from the doctor because I didn't know anything about family planning. But the doctor told me or explained to me the three possibilities, the pill, injectables, and the IUD. At the same time she told me that because of my age and complications I have had she would recommend the IUD."*

Simulated clients were instructed to ask about the IUD if the provider did not volunteer information about the method. Table 7 shows that in nearly half of the simulated client visits, the client had to ask the provider about the IUD, but did receive counseling on the method in

response to their request. There were some differences in the number of times the IUD was mentioned to the two different clients. Surprisingly, the client with more children was less likely to be told about it. It was not mentioned at all by nine providers to this client while only four didn't mention it to the client with one child. There were three visits where the client felt that she did not have the opportunity to ask for information on the IUD; it was only the client with three children who reported this experience. These results suggest that factors other than age and parity are influencing the discussion of the IUD by providers.

*Table 7. Provider discussion of the IUD during counseling sessions*

| | **All simulated clients (n=40)** | **Simulated clients with 1 child (n=20)** | **Simulated clients with 3 children (n=20)** |
|---|---|---|---|
| Provider discussed and explained IUD spontaneously | 47.5 | 65.0 | 30.0 |
| Client had to ask provider to explain IUD | 45.0 | 35.0 | 55.0 |
| Provider did not discuss IUD and client could not ask | 7.5 | 0.0 | 15.0 |

Counseling on the IUD

After their visits, the simulated clients noted if the counseling they received on the IUD and how it works was correct or incorrect (Table 8). Particulars about a method discussed during counseling should include use of the method, advantages and disadvantages, contraindications and potential side effects. In most cases, if the topic was not discussed correctly, the provider did not mention it at all. However, there were instances when incorrect information was conveyed. IUD insertion was the topic that was most often covered incorrectly, with six providers reportedly discussing it incorrectly. What the IUD is, its effectiveness, and its disadvantages or side effects were each covered incorrectly by four providers, according to the simulated clients.

*Table 8. Counseling received on the IUD*

| Item | All simulated clients (n=40) | Simulated clients with 1 child (n=20) | Simulated clients with 3 children (n=20) |
|---|---|---|---|
| Provider talked about the IUD and how it works | 92.5 | 100.0 | 85.0 |
| Provider correctly covered: | | | |
| What the IUD is | 72.5 | 90.0 | 55.0 |
| How the IUD works | 55.0 | 80.0 | 30.0 |
| Effectiveness of the IUD | 50.0 | 70.0 | 30.0 |
| Who can use the IUD | 45.0 | 90.0 | 0.0 |
| Who shouldn't use the IUD | 32.5 | 55.0 | 10.0 |
| Advantages of the IUD | 75.0 | 90.0 | 60.0 |
| Disadvantages/side effects of the IUD | 62.5 | 65.0 | 60.0 |
| IUD insertion | 72.5 | 95.0 | 50.0 |
| IUD removal | 37.5 | 75.0 | 0.0 |
| Mean number of items covered correctly (out of a total of 9) | 5.1 | 7.1 | 3.0 |

*Advantages and Disadvantages*

We examined what providers know about the IUD and what they consider to be its advantages and disadvantages. The most common advantage, mentioned by 17 providers in in-depth interviews, was that the IUD does not require a daily regimen or does not need to be remembered. The next most frequently mentioned advantage, mentioned by 16 providers, was that the IUD has few side effects and is non-hormonal. Other advantages mentioned by several providers include: length of use, only need to visit the clinic once per year, and efficacy.

Thirteen of the 30 providers mentioned length of use as an advantage. However, among those 13 providers, it was not clear how many knew the true length of effective use of the IUD. Seven of these providers did specify a time period, but only three stated that the IUD could be used for up to ten years. The others stated much more conservative time frames, ranging from three to seven years. The simulated clients found a similar lack of specific knowledge on the IUD's length of efficacy. Only 17 of the 40 providers visited by the simulated clients discussed how long the method was effective; of those, only two correctly stated that the IUD could be effective for ten years. The other 15 providers gave responses ranging from two to six years.

Data on discussion during simulated client visits of advantages of the IUD is presented in Table 9. Eighty percent of providers did discuss advantages of the IUD with the simulated clients. The advantage that was mentioned the most often was that the IUD does not interfere with intercourse. The IUD's long duration was mentioned by almost half of the providers and its effectiveness was mentioned by more than 40 percent. Again, there is a large difference in the counseling received by the two simulated clients.

*Table 9. Advantages of the IUD discussed during counseling*

| Advantage | All simulated clients (n=40) | Simulated clients with 1 child (n=20) | Simulated clients with 3 children (n=20) |
|---|---|---|---|
| Provider discussed advantages of IUD | 80.0 | 95.0 | 65.0 |
| Advantages discussed | | | |
| It is very effective | 42.5 | 70.0 | 15.0 |
| It has a long duration | 47.5 | 85.0 | 10.0 |
| Doesn't need resupply | 25.0 | 50.0 | 0.0 |
| Easy to use | 37.5 | 75.0 | 0.0 |
| Doesn't interfere with intercourse | 52.5 | 70.0 | 35.0 |
| Quick return to fertility | 37.5 | 50.0 | 25.0 |
| No systemic effects | 7.5 | 15.0 | 0.0 |

Disadvantages or side effects of the IUD were discussed by three-fourths of the providers at simulated client visits (Table 10). The most common ones mentioned were pain during insertion or removal and menstrual bleeding or irregularity. The differences between the two types of simulated clients are not as striking for these discussion topics.

*Table 10. Disadvantages of the IUD discussed during counseling*

| Item | All simulated clients (n=40) | Simulated clients with 1 child (n=20) | Simulated clients with 3 children (n=20) |
|---|---|---|---|
| Provider mentioned disadvantages/ side effects of the IUD | 75.0 | 75.0 | 75.0 |
| Disadvantages/side effects mentioned | | | |
| IUD is dependent on provider | 25.0 | 50.0 | 0.0 |
| Pain (insertion/removal) | 60.0 | 70.0 | 50.0 |
| Menstrual bleeding/irregularity | 50.0 | 55.0 | 45.0 |
| Possible expulsion | 27.5 | 35.0 | 20.0 |
| Possible complications | 22.5 | 40.0 | 5.0 |
| Infection | 10.0 | 10.0 | 10.0 |

Abnormal bleeding was the most common disadvantage of the IUD mentioned by the providers in in-depth interviews, with 22 citing it. Other frequently mentioned disadvantages were pain and the risk of pelvic inflammatory disease or other infections. Some of the "disadvantages" mentioned by providers may indicate a lack of understanding of the method. Three doctors mentioned possible problems during intercourse; two doctors stated that a disadvantage was that the method was a micro-abortive; two others cited the risk of perforation. Finally, one doctor mentioned that the IUD could cause "organic harm" and another stated that the IUD can get "lost" in the woman's body.

Only a few of these misconceptions were noted during the simulated client visits. A client at one visit was told that the IUD is an abortifacient. At another visit, one client stated that the provider said it can interfere with intercourse.

*Contraindications*

The most frequently cited contraindication during in-depth interviews was pregnancy, reported by thirteen providers. Many said that they would need a client to be having her period or for her to take a pregnancy test before they would provide the IUD. The next most commonly mentioned contraindication was multiple sexual partners, mentioned by 12 providers. Other frequently mentioned contraindications include: a history of pelvic inflammatory disease and uterine tumors, mentioned by 11 and ten providers respectively. Ten providers said they considered nulliparous women to be contraindicated for the method and six stated that a history of abnormal bleeding would be a contraindication.

Contraindications were discussed at only eight of the simulated client visits (20%). The most common contraindication mentioned was unexplained vaginal bleeding (12.5%), followed by pregnancy and infection (7.5% each).

IUD Training

Training can dispel myths and rumors and increase knowledge so as to enable providers to see the advantages of the IUD, and give them the skills needed to provide it. During the interviews, providers were asked to describe the training they had received on IUD insertion and removal and on counseling about the IUD. Twenty-three of the 30 providers said they had been trained on IUD insertion techniques and 21 said they were trained on removal techniques. Twenty-three providers said they were trained on IUD counseling, although most said they had received training on family planning counseling in general, and not specific sessions on the IUD.

Most providers who were trained felt that their training was thorough. A doctor described his training this way: *"The patient's risks were explained to us as well as when to insert and when not to. What is the most important is that we must explain to the patient. The talks that are conducted throughout the city address the patient's needs, even what could happen on a microscopic level within the cervix and all that."* Another doctor described her training on counseling as being thorough and updating old counseling techniques: *"In counseling we should, most importantly, try to explain to the person the benefits and problems that may arise with the insertion of the IUD. You have to teach them to come in for check-ups because sometimes you may get pregnant and there could be complications. When they decide to have the IUD removed it is their option. The amount of time they should keep the IUD inserted and when to come back to have another one inserted."*

However, several doctors complained that, although they had been trained on the IUD, they were not able to put their training to use. One doctor stated, *"Well we have been trained; right, but I have never had the opportunity to perform the procedure, right."* Another agreed, *"theoretically we have been trained, even though I have not inserted one."*

Three providers reported that they had received no formal training on IUD insertion, removal, or counseling. One of these providers described her lack of training, *"I do not feel that I have been trained. I am new and do not feel that I have been trained on the insertion of the IUD."*

Some felt that better, more thorough training was needed in order to offer safe provision of the IUD. A doctor explained why training is so important, *"Training because learning at the university is one thing and actually doing the procedure on a patient is something else."* One doctor described a situation where training is necessary: *"... then when you start practicing as the new doctor in the unit and are required to insert an IUD which you never have done before, sometimes you don't even do the procedure because you don't know how nor have been taught how. That is why I believe training should occur at hospitals where residents are doing their first year, right..."* She also suggested that training be offered to all level of staff: *"Also increase the amount of training in all areas of family planning because a lot of times many of the people, doctors, nurses and other staff, are not able to advise the patients properly because their knowledge is limited or they do not know what they are supposed to be advising on."* Another doctor recognized the importance of refresher training, *"I believe that medicine is constantly changing. There could also be new variations in techniques or maybe easier IUD insertion procedures and less discomfort to the patient."*

## IV. DISCUSSION

The results from this study reveal three main barriers to IUD use in El Salvador: 1) there are rumors and myths about the IUD which create fear among potential IUD users; 2) the IUD is not always given enough attention during counseling sessions; and, 3) providers do not receive enough training about the IUD. These three factors are interrelated and reinforce each other.

To increase IUD use, clients must be motivated to initiate use. This is unlikely in El Salvador if negative images of the IUD persist. Because clients do not have a positive image of the IUD, if providers don't discuss it in sessions, these perceptions will continue. While the simulated clients had it discussed in most of their visits, they often had to request the information and regular family planning clients would probably not have the initiative to ask. Since they hear a lot of rumors and myths about the IUD, they probably dismiss it as a potential method and since IUD use is so low it is unlikely that many hear about the good experiences of IUD users. Some providers have indicated that they feel that rumors and myths are an insurmountable barrier, which is why they don't mention the IUD during counseling. Yet, IUD users in focus groups did say that providers did dispel them, demonstrating that with information these barriers can be overcome.

One way to increase demand is to improve the provision of services. Providers need to counsel clients thoroughly and correctly on all aspects of a method. While clients were offered counseling on advantages of the IUD, there was limited counseling about side effects. This is especially important since side effects is a leading cause of method discontinuation and good counseling has been shown to improve continuation rates. Two of the focus group participants who had discontinued the IUD specifically mentioned discontinuing because of pain.

To fully improve the provision of services, providers need more training and practical experience in providing the IUD. Providers who are not trained or not very experienced with the IUD may not feel comfortable counseling clients on its use. Providers were clearly not fully informed about the IUD and most did not know that it is effective for up to ten years. In-depth interviews confirmed that few providers had experience in IUD insertions and removals.

A limitation of this study is that the scenarios used by simulated clients may not have been different enough to capture real disparities that may be found in service provision because of variations in ages or number of children. For instance, it was surprising that neither client was told much about sterilization but perhaps both were considered either too young or because the 25 years old only had one child, the providers did not consider it an appropriate choice. Yet, differences in the amount of information provided was noted and can't be explained by age or parity. It is possible that the clients were not equal in how they recorded information. Another possibility was that they received disparate treatment based on looks or dress. A study in Bolivia found that clients who wore traditional clothes felt that they were not treated as well as other clients compared to clients who wore modern clothes (Velasco et al., 1999). Anecdotal evidence suggests there may be similar bias in El Salvador attributed to racial differences.

Despite these findings, it is promising that most clients who have used or who are using the IUD are satisfied with the method. Also, most providers reported that they have a good opinion of the IUD. Therefore, if these barriers can be overcome, there is potential for increased used.

Training and education are the two main ways to promote the IUD. Providers need more training and practical experience with providing IUD services and as they feel more comfortable they should be more likely to discuss and promote its use. Education is needed in the general public through both written materials and media campaigns to dispel rumors and myths. Satisfied users could be a useful asset to dispel the negative image of the IUD and demonstrate that IUD use can be positive.

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