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Reasons for the Low Level of IUD Use in El Salvador

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CONTEXT: *While the IUD is a safe and cost-effective method, use is very low in some countries, and the reasons for this are not well understood.*

METHODS: *To examine the reasons that the IUD is little used in El Salvador, data were collected in 1999 via three techniques. In-depth interviews were conducted with 30 providers; simulated clients made a total of 40 clinic visits; and 10 focus groups were conducted separately with sterilized women, current or past IUD users and users of other clinical family planning methods.*

RESULTS: *Most family planning clients who had never used an IUD reported a negative impression of the method, mainly because of fear resulting from rumors and myths they had heard. In contrast, nearly all IUD users viewed the method positively. Most providers interviewed reported a positive attitude. Providers agreed that rumors and myths are the biggest barrier to IUD promotion, yet simulated clients reported that providers spontaneously tried to dispel myths in only about half of visits. Most providers said they discussed the IUD with clients, but many focus-group participants said they received information only on pills and injectables. According to simulated clients, providers spontaneously mentioned pills and injectables more than any other method. While 23 of the 30 providers interviewed had been trained in IUD insertion, many felt they did not have enough practical experience.*

CONCLUSIONS: *Three main barriers impede IUD use in El Salvador: rumors and myths about the method; insufficient attention to the method during counseling sessions; and insufficient provider experience with it.*

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Modern IUDs are very safe and highly effective.[1] They are also an inexpensive family planning method that should be an important component of the contraceptive method mix in almost any national program. Use throughout the world, however, is highly variable. Whereas more than 25% of women of reproductive age use the IUD in some countries in Central Asia, Vietnam and Egypt, fewer than 1% rely on it in Brazil, Nepal and most of Sub-Saharan Africa.[2]

The IUD has the potential to fill an important niche in countries where it is not commonly used. Adding the IUD to the method mix may give women an option that suits their needs better than other available methods and may increase contraceptive use. The IUD can provide short-term protection to women who want to delay another pregnancy and has many advantages over injectables and pills. It does not require resupply visits, and it requires little action on the part of the user (although strings must be checked periodically, which some women dislike doing). In addition, the IUD is more cost-effective than other methods used to space births. Finally, the IUD can be an attractive option for women who do not want more children but are not ready or do not want to accept a permanent method. Consequently, a shift away from sterilization to the IUD can reduce regret, especially in countries where young and low-parity women are commonly sterilized.

While much has been written about the clinical aspects of IUD use and discontinuation, less is known about the reasons why use is so low in some countries. Some research has pointed to the many misconceptions providers and potential acceptors have about the IUD. In the United States, where IUD use is very low, some think that the method is an abortifacient, and that it increases the risk of pelvic inflammatory disease and ectopic pregnancy.[3] In addition, many women lack knowledge about the IUD. A 1991 survey of U.S. women found that respondents knew much less about the IUD than about other methods, but many perceived it to be unsafe. After being read a description of the method, however, 46% expressed an interest in using it.[4]

In some countries, provider training in IUD services may not be sufficient to dispel similar misconceptions and increase IUD use. Between 1993 and 1995 in Morocco, 120 providers were specially trained in IUD counseling and insertions, yet the 1995 Demographic and Health Survey revealed virtually no change in the method mix; a subsequent study revealed that women had concerns about the IUD, were worried about pregnancy and feared that it could hook onto the penis.[5] Likewise, surveys in Brazil before and after a 1990 IUD training found no change in the number of women who thought the device causes illness or moves around the body, and use remained low.[6] These studies demonstrate that to increase IUD use, it may be necessary to create demand as well as to train providers.

2

If IUD use is to increase, program planners need to understand the factors influencing clients' motivations to use the method and providers' motivations to encourage its use, as well as their skills in providing it. While earlier research focused primarily on clients' knowledge and opinions, it is also important to understand the interactions between clients and providers concerning the IUD, and how these interactions influence use. When the Ministry of Health of El Salvador and the U.S. Agency for International Development requested that Family Health International conduct a study to examine the reasons for the low use of the IUD in that country, we saw this as an opportunity to explore these issues in depth.

BACKGROUND

Contraceptive prevalence in El Salvador increased from 22% of women of reproductive age in 1975 to 60% in 1998, but the prevalence of IUD use has remained very low; in fact, the proportion of women using this method decreased from 3% in 1985 to 2% in 1998. Female sterilization has been the most popular method: In 1998, 33% of women aged 15–44—more than half of those practicing contraception—had been sterilized. Pills and injectables are the next most popular methods, each used by approximately 8% of women.[7]

Despite the popularity of female sterilization, indications that many women are not satisfied with this method suggest a need to promote other methods that provide long-term contraceptive protection. According to the 1998 El Salvador National Family Health Survey (FESAL), 9% of sterilized women said they would have preferred another method or no method at all. Among women reporting that they wanted another pregnancy, 27% were already sterilized. In addition, sterilization is the most popular method among women between the ages of 25 and 29; 40% of current family planning users in this age-group have been sterilized, as have 15% of family planning users between the ages of 20 and 24.[8] Sterilization before the age of 30 is known to be a main cause of subsequent regret.[9]

DATA AND METHODS

We used a combination of methods to collect data: in-depth interviews to examine providers' knowledge about and attitudes toward the IUD; clinic visits by simulated clients to assess the quality of interactions between providers and clients; and focus groups to explore clients' knowledge about and attitudes toward the IUD. All data were collected between May and July 1999. Only Ministry of Health clinics were included, because the ministry is the largest provider of contraceptive supplies in the country, serving nearly half of users.[10] The ministry sent authorization letters in advance of data collection to clinics participating in the focus groups and in-depth interviews.

In-Depth Interviews

The Ministry of Health compiled a list of clinics throughout the country that offered family planning services and had at least two providers who had been trained in IUD insertion or referral. The list contained 30 hospitals and 352 health units. From this list, using a table of random numbers, we selected 15 urban and 15 rural sites to create a base list. An additional eight urban and eight rural sites were chosen as alternates in case sites on the base list could not be used. One provider per site was chosen for an in-depth interview; if more than one eligible provider was at the clinic on the day of the interview, we randomly selected one to be interviewed. In all, four nurses (all women) and 26 doctors (14 men and 12 women) were interviewed.

Interviewers followed an outline with open-ended questions covering providers' IUD training, professional experience with insertions and removals, knowledge about the IUD and personal thoughts about the method.

Simulated Clients

The simulated-client component of the study took place in 20 urban clinics, which were selected randomly from among the 23 urban clinics on the base and alternate lists of sites selected for the in-depth interviews. Rural sites were excluded because it would have been difficult to simulate visits in small, rural clinics, where providers know most clients and requests for the IUD are uncommon. Two researchers were trained as simulated clients, and dressed, spoke and behaved as if they were "typical" clients. Each visited all 20 clinics; our findings are thus based on a total of 40 visits.

Like other researchers who have used simulated clients, we developed two scenarios for the simulated clients, to examine whether different client characteristics and needs influenced the quality of services received.[11] One client told providers that she had one child and was 25 years old; the other, that she had three children and was 23. Each volunteered that she was in a stable, monogamous relationship, that she had at least a primary school education, that she wanted family planning advice to help her space her children and that she wanted a long-term method (at least two years). If a provider did not spontaneously mention the IUD, the client asked about it, but she did not pretend that she wanted an insertion that day. Unfortunately, these scenarios were too similar to capture potential variations in how providers respond to women with different needs; as a result, we have combined the data for the two clients.

After each visit, the simulated client completed a questionnaire that asked about the reception she received at the clinic, the quality of the provider's assessment of her reproductive health needs and of discussions about available family planning methods, and the content of IUD counseling.

Focus-Group Discussions

We randomly selected six urban and four rural clinics from the Ministry of Health list as sites for the focus-group discussions. Users of resupply methods were recruited when they visited the clinic to obtain new supplies. IUD users were recruited when they returned for their first follow-up visit, about 4–6 weeks after insertion of the device, or for their one-year checkup. Because the level of IUD use was low, to obtain a sufficient number of participants, we also

3

TABLE 1. Percentage of family planning counseling visits by simulated clients in which providers spontaneously mentioned specific rumors about the IUD, El Salvador, 1999

Rumor	% (N=40)
Any*	**47.5**
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 causes abortion	10.0

*Percentages do not add up to the total because providers may have mentioned more than one rumor.

recruited past users, identified from clinic records. Sterilized women were recruited during their visits for post-sterilization procedures such as removal of stitches.

A total of 10 focus groups were conducted: four with women who were using resupply methods, four with women who were sterilized and two with current or past IUD users. Following norms for conducting focus groups, we selected 6–10 participants for each group.[12] Discussion groups for sterilized women and users of resupply methods were held in both rural and urban settings; a total of 37 sterilized women and 32 women using resupply methods participated. The IUD user groups were conducted in urban areas only and had a total of 20 women (18 current and two past users). Participants received refreshments, a small incentive and transportation costs.

A team of two people, a moderator and a recorder-observer, conducted the focus groups. Discussions with women using methods other than the IUD emphasized perceptions of the IUD, rumors about it and experience with other family planning methods, including barriers to obtaining methods. Among IUD users, factors of particular interest included women's reasons for choosing the method, their experience with it and why they liked or did not like it.

Data Analysis

In-depth interviews and focus-group discussions were conducted in Spanish, recorded on audiocassette and transcribed into word-processing files. After a close reading of the first several transcripts, the research team developed an initial list of codes. Using these codes, we categorized data from the text files into broad topical areas: family planning counseling, myths and taboos surrounding IUD use, and perceptions of the IUD. Researchers then added the appropriate codes in each text file, using DtSearch. The in-country team used EPI-INFO to enter data from the simulated clients. Frequencies and cross-tabulations of key variables were produced in SPSS.

TABLE 2. Percentage distribution of visits by simulated clients, by extent to which various contraceptive methods were discussed

Method	Mentioned and explained	Mentioned only	Not mentioned	Total
IUD	47.5	20.0	32.5	100.0
Injectable	77.5	17.5	5.0	100.0
Pill	67.5	25.0	7.5	100.0
Condom	7.5	55.0	37.5	100.0
Female sterilization	2.5	7.5	90.0	100.0

RESULTS

Clients' Perceptions of the IUD

Not surprisingly, given the low level of IUD use in El Salvador, most participants in the focus groups for women using resupply methods and women who were sterilized had negative opinions of the IUD. At the same time, most participants in the focus groups for IUD users had positive opinions of the method.

The most common reason for the negative impressions was fear, which was generally based on rumors or myths. Often, no specific reason was given for the fear; focus-group participants merely stated that they felt the method was "dangerous" or "harmful." One sterilized woman spoke about the effect the rumors had 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."

During in-depth interviews, providers observed that commonly held rumors and myths are the biggest barrier to IUD use. In the providers' view, the most common rumors are that the IUD causes cancer, a baby will be born with the IUD in its body, an IUD can get lost in a woman's body and the IUD becomes embedded in the uterus.

One reason for the rumors, according to providers, is that since the public has little factual information, rumors and myths circulate without being countered. Actual cases that are exaggerated can be a principal source of frightening rumors and myths. One physician described the process:

"[One rumor] has become folklore, because [women] 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 the story would change to [that] the child was born paralyzed, and they would just keep adding and adding."

Providers should help to dispel rumors and myths, and in 48% of simulated clients' visits, providers spontaneously discussed a rumor or myth—for example, that the partner can feel the IUD and the IUD causes cancer (Table1). But in 55% of visits, the provider either reinforced a rumor or did not provide adequate information to dispel it (20% and 35%, respectively—not shown). The most common rumor that providers reinforced was that the IUD can move around in the body.

Some providers told interviewers they felt that counseling to clarify misconceptions did little or no good, since many clients who received such counseling continued to fear the IUD:

"Yes, we tell them, 'Other things cause cancer. If the IUD

4

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 successfully dispelled these myths and reassured them about the safety of the IUD, indicating that providers can play an important role in promoting the method. One current IUD user explained how a doctor's reassurance had enabled her to 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."

Another current user told of a similar experience:

"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.' "

Most participants in the focus groups for IUD users reported positive experiences with the method. For example, a past user who is now sterilized related the following:

"I had it for two 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, [it] was because I wanted to have another child."

Another past user who is now sterilized agreed that the IUD was a good method:

"Evaluating all the methods I knew about, I prefer the IUD. I prefer it because it is practical. You don't have to worry...'Did I forget to take the pill or the injection?' Also, it doesn't have any emotional side effects or physical side effects."

Providers' Encouragement of IUD Use

To examine providers' encouragement of IUD use, we explored how counseling provided to potential users was affected by providers' attitudes, training and experience.

Most providers reported during in-depth interviews that they offer IUD counseling, along with counseling on other family planning methods. Some stated that they would counsel a client on the IUD only if she seemed potentially interested in it. One doctor responded that he counsels women on the IUD, but he continued:

"To be honest with you, the women come in with their minds already made up as to which method they want....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."

By contrast, findings from the simulated clients and the focus-group discussions showed that providers do not routinely initiate discussion about the IUD. In the simulated clients' visits, the injectable and the pill were the methods most likely to be mentioned overall during counseling sessions (Table 2); they also were the most likely to be explained. Most participants in the focus groups for sterilized women and users of resupply methods confirmed these findings, reporting that the injectable and the pill were the only methods mentioned during counseling.

TABLE 3. Percentage of visits by simulated clients in which the provider discussed various characteristics of the IUD

Characteristic	%
How it works	92.5
Advantages	80.0
Effectiveness	42.5
Long duration	47.5
Ease of use	37.5
Does not interfere with sex	52.5
Quick return to fertility	37.5
Disadvantages/side effects	75.0
Pain during insertion/removal	60.0
Menstrual bleeding/irregularity	50.0
Contraindications	20.0
Unexplained vaginal bleeding	12.5
Pregnancy	7.5
Infection	7.5

Some explanations as to why providers may not counsel clients on the IUD emerged during in-depth interviews. The two primary reasons were a limited supply of IUDs and a lack of time to cover all methods. Nearly one-fourth of providers stated that IUD stocks were a problem and that they had no or inadequate supplies. According to one doctor:

"If you have them, you offer them, but one doesn't have them."

One doctor explained the time constraints this way:

"Well, maybe...sometimes we're in a rush and there are many patients. Maybe...many times we choose the easiest method."

Another doctor explained that IUDs are in stock but may not be handy in every consultation room.

In most simulated clients' visits where the IUD was not mentioned spontaneously, the women asked the provider about it. In all cases, the provider responded with information. There were three visits, however, in which the client felt that she did not have the opportunity to ask about the IUD.

After their visits, the simulated clients noted the particulars of the IUD counseling they received. In the great majority of visits, the provider discussed how the IUD works and its advantages (Table 3). The advantage that was mentioned the most often (in 53% of visits) was that the IUD does not interfere with sex. The IUD's long duration and effectiveness were mentioned in more than four in 10 visits.

Since the IUD can be a long-term method, we were particularly interested in whether providers were aware of how long it could be used. The simulated clients found that only two providers correctly stated that the IUD could be effective for 10 years. Fifteen others gave responses ranging from two to six years.

Disadvantages or side effects of the IUD were discussed at three-fourths of visits by simulated clients. The most common ones mentioned were pain during insertion or removal and menstrual bleeding or irregularity. Contraindications

were discussed at only one-fifth of visits. The most common contraindications mentioned were unexplained vaginal bleeding, pregnancy and infection.

Most providers participating in in-depth interviews reported having a favorable attitude toward the IUD, and there was no evidence of widespread bias against the method. Most said they would recommend the method to both clients and friends or relatives, although a few specified that while they would recommend it, they would not use it themselves.

Providers need to be proactive in discussing the IUD and clarifying misconceptions about it.

Experience—providers' own or that of their clients—may be one factor leading to positive attitudes. A few providers indicated that they or their wives had used the IUD. Several had noticed that IUD users tend to be satisfied with the method. For example, one nurse remarked that "there are people, users, who are very satisfied with the IUD...they say this is the ideal method."

However, some providers seemed hesitant or reluctant to recommend the IUD. A few of these providers were concerned about side effects—in particular, bleeding and pain. And one stated that the IUD was against her religious beliefs, possibly a reference to the idea that the IUD acts as an abortifacient. One doctor stated that he even uses a different standard when recommending the IUD:

"Well, personally speaking, I would be more stringent with the IUD. I do not agree much with using it."

During the in-depth interviews, 23 of the 30 providers said they had been trained in IUD insertion techniques, and 21 said they had been trained in removal techniques. Twenty-three providers said they had been trained in IUD counseling, although most said this subject had been incorporated into training in family planning counseling in general. Several doctors, however, complained that they were not able to put their training to use. Nine providers said that they had never had an opportunity to insert IUDs, and an additional six said that they had inserted only a few.

DISCUSSION

Our findings identify some of the reasons for the low level of IUD use in El Salvador and suggest ways that use can be increased, not only in El Salvador, but in other countries. On the demand side, we have shown that rumors about the IUD discourage its use, but that providers can play an important role in counteracting those rumors. When they do so, clients' attitudes toward the IUD become more positive, and women who obtain an IUD become satisfied users.

Counseling, then, is key to combating rumors; however, we have found that the quality of counseling is not high. While the simulated clients reported that the IUD was discussed in many of their visits, they often had to request the information; typical family planning clients would probably not take this initiative, particularly if they have already heard negative stories about the device. Providers were reluctant to discuss the IUD because they thought that clients were not interested and because they did not feel confident in providing it. The lack of confidence was related to a lack of experience.

Providers need to be proactive in discussing the IUD and clarifying misconceptions about it. From an informed-choice perspective, providers have an obligation to provide information about the IUD as well as about other methods so that clients know about their options. Some providers indicated that they felt that rumors and myths are an insurmountable barrier, and thus they did not mention the IUD during counseling. Yet, IUD users in focus groups said that providers did dispel misconceptions, demonstrating that this barrier can be overcome by good information.

In addition, providers need opportunities to improve their skills in counseling about and in inserting the IUD. For example, some providers' lack of knowledge that it is effective for up to 10 years reduces the potential of promoting the IUD as a long-term method. In-depth interviews confirmed that few providers had substantial experience in IUD insertions and removals. Unless providers help to create demand, however, they will not accumulate enough experience inserting IUDs to feel confident promoting the method.

Programs can use our results to increase IUD use. Limited resources to purchase contraceptives are leading countries to pay more attention to promoting this method. Yet, countries with a high HIV prevalence may be reluctant to do so because of concerns that insertion of IUDs in HIV-positive women will lead to increased complications and a higher likelihood that these women will transmit the infection to their partners. With these concerns in mind, the World Health Organization and the International Planned Parenthood Federation have recommended that HIV-positive women not use the IUD,[13] but some evidence suggests that these concerns may be unwarranted.[14]

Our findings show that once countries decide to make the IUD a more important part of their method mix, they will need to do more than train providers to insert it. They will need also to encourage clients to consider it as an option and to encourage providers to offer clear and adequate information about it.

Finally, on a methodological note, we have found, as have others, that our results vary according to the source of observations. Providers say that they make available a higher level of counseling and services than the data collected from simulated clients suggest.[15] Our study also shows that results from focus groups do not agree with those from provider interviews. Thus, when information on clinic practices is needed, the client perspective is essential and can be obtained through simulated clients and focus groups. Of course, providers should be interviewed if information on their knowledge, attitudes, training and experience is needed. Therefore, this study shows the benefit of using different methods of data collection to provide a more comprehensive understanding of the situation.

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6

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RESUMEN

Contexto: *Si bien el DIU es un método seguro y eficaz en función a su costo, en algunos países su uso es muy bajo y no se conocen claramente las razones por las cuales esto sucede.*

Métodos: *Para examinar las razones por las cuales se usa muy poco el DIU en El Salvador, en 1999 se recopilaron datos mediante tres técnicas diferentes. Se realizaron entrevistas a fondo con 30 proveedores; se examinaron la experiencia de 40 visitas a la clínica hechas por clientas simuladas; y se condujeron 10 grupos focales en forma separada, con mujeres esterilizadas, usuarias actuales y exusuarias del DIU, y con usuarias de otros métodos clínicos de planificación familiar.*

Resultados: *La mayoría de las clientas de planificación familiar que nunca habían utilizado el DIU indicaron que tenían una mala impresión de este método, principalmente porque los rumores y mitos que habían escuchado les hacían temer a este método. En forma inversa, casi todas las usuarias del DIU mantenían una impresión positiva del método. La mayoría de los proveedores entrevistados tenían una actitud positiva. Los proveedores acordaron en que los rumores y los mitos son el principal obstáculo que se presenta para promover el uso del DIU; sin embargo, las clientas simuladas indicaron que los proveedores trataron de disuadirlas sobre estos rumores solamente en la mitad de las visitas que realizaron a las clínicas. La mayoría de los proveedores manifestaron que habían hablado con sus clientas acerca del uso del DIU, pero muchas participantes de los grupos focales indicaron que recibieron información sólo sobre el uso de la píldora y los inyectables. Según las clientas simuladas, los proveedores mencionaron en forma espontánea la píldora y los inyectables con mayor frecuencia que otros métodos anticonceptivos. Si bien 23 de los 30 proveedores entrevistados habían recibido entrenamiento para insertar el DIU, muchos indicaron que no tenían suficiente experiencia.*

Conclusiones: *Tres obstáculos principales impiden el uso del DIU en El Salvador: los rumores y los mitos acerca del método; la atención insuficiente que se le presta durante las sesiones de consejería; y la experiencia insuficiente que tienen los proveedores con este método.*

RÉSUMÉ

Contexte: *Bien qu'offrant une méthode sûre et économique, le stérilet est très peu utilisé dans certains pays. Les raisons n'en sont pas bien comprises.*

Méthodes: *Pour comprendre les raisons du faible usage du stérilet au Salvador, les données ont été recueillies, en 1999, selon trois techniques: des entrevues en profondeur ont été menées auprès de 30 prestataires; des clientes fictives ont obtenu un total de 40 consultations, et 10 groupes de discussion ont été organisés séparément avec des femmes stérilisées, des utilisatrices courantes ou passées du stérilet et des utilisatrices d'autres méthodes cliniques de planning familial.*

Résultats: *La plupart des clientes du planning familial qui n'avaient jamais utilisé le stérilet en avaient une mauvaise impression, résultant surtout de la peur suscitée par les rumeurs et mythes qu'elles avaient entendus. Par contre, presque toutes les utilisatrices de la méthode s'en faisaient une opinion positive, partagée par la plupart des prestataires interviewés. Les prestataires conviennent que les rumeurs et les mythes sont le plus gros obstacle à la promotion du stérilet. Selon les clientes fictives, pourtant, ils n'essayent spontanément de dissiper les mythes que dans la moitié des cas. La plupart des prestataires ont déclaré parler du stérilet avec leurs clientes, mais beaucoup de participantes aux groupes de discussion ont affirmé n'avoir reçu d'informations que sur la pilule et les injectables. Selon les clientes fictives, les prestataires avaient mentionné spontanément la pilule et les injectables plus que toute autre méthode. Des 30 prestataires interviewés, 23 avaient été formés à l'insertion du stérilet, mais beaucoup estimaient ne pas avoir suffisamment d'expérience pratique.*

Conclusions: *Trois grands obstacles entravent l'usage du stérilet au Salvador: les rumeurs et les mythes, l'attention insuffisante accordée à la méthode lors des consultations, et l'expérience insuffisante des prestataires.*

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