A survey to assess knowledge and acceptability of the intrauterine device in the Family Planning Services in Cape Town, South Africa

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Abstract

Introduction Despite reliable evidence of the safety and effectiveness of intrauterine devices (IUDs), this contraceptive method remains under-utilised in many countries due to persistent fears that it causes pelvic infection. The aim of this study was to assess the knowledge and acceptability of IUDs among clients and providers in our family planning services and to attempt to identify barriers to use.

Methods A descriptive cross-sectional survey was conducted at eight family planning clinics in Cape Town, South Africa. A total of 216 clients and 30 providers from the same clinics were interviewed using structured questionnaires.

Results Awareness of the IUD among clients was low: 41% (n = 88) had heard of this contraceptive method. Ever and current use were very low. Only 4% (n = 9) had ever used an IUD, and three women were still using this method. Lack of knowledge was cited by many women as an obstacle to use. Among providers, factual knowledge about IUDs was limited, and infection (47%, n = 14) and increased menstrual bleeding (40%, n = 12) were frequently mentioned as disadvantages of the method.

Discussion and conclusions Although the IUD is available free of charge in our public sector services, it is not being utilised. Clients lacked knowledge of this method, and research evidence had not impacted on the knowledge and practice of providers. Ongoing education of both clients and providers is essential in order to improve accessibility and acceptability of this safe and effective contraceptive method.

Keywords acceptability, intrauterine device, knowledge, South Africa, survey

J Fam Plann Reprod Health Care 2010; **36**(2): 73–78
(Accepted 12 November 2009)

Introduction

The intrauterine device (IUD) is a highly effective, safe and reversible contraceptive method with efficacy similar to that of tubal ligation.[1] With appropriate counselling and screening for the presence of sexually transmitted infections (STIs), the IUD can be used safely by most women, including nulliparous women and healthy HIV-positive women using antiretroviral therapy.[2–5]

Despite this, statistics from the United Nations on contraceptive prevalence in women of reproductive age in marital or consensual union who are currently using contraception indicate that IUD use is low in many countries (eg, USA 1.8%, UK 7%). There are some significant exceptions where the IUD is a frequently used contraceptive method (eg, Cuba 43.5%, Vietnam 37.7%, Egypt 36.5%) and it is the most commonly used method in China (44.9%).[6]

Evidence of the safety of IUDs has not been able to dispel the misperceptions that have limited use of the method in many countries. Fear of litigation, lack of adequate skills and experience in inserting the device, and a persistent belief that the IUD causes infection have been significant reasons why providers do not discuss or recommend the IUD to women.[7–9] Often, service delivery issues such as a lack of adequate equipment or devices, and time constraints when counselling clients, influence whether providers discuss IUDs as a contraceptive option.[10,11]

Key message points

- **Low use of intrauterine devices (IUDs) by clients is, in part, secondary to their lack of knowledge about this method.**
- **IUDs are not frequently discussed with clients or suggested as a reliable contraceptive option.**
- **Evidence from research has not impacted on providers' knowledge and practice.**
- **Continuing education and adequately trained health care providers are essential in providing and maintaining contraceptive services.**

In South Africa, IUD use is low and declined from 1% in 1998 to 0.6% in 2003.[12,13] Two studies by the Contraceptive Development Network (CDN) in 1999 (n = 468) and 2003 (n = 201), found current use among women interviewed in public sector clinics in Cape Town to be 5% and 0%, respectively.[14,15]

According to South African National Contraception Policy, IUDs should be available to clients on request at a clinic, and if they are not, women should be referred to a trained service provider, usually a doctor, for insertion of the device.[16] In reality, provision of IUDs is restricted in some areas, often due to a lack of suitable facilities and adequately trained personnel, and almost half (46%) of the women who use an IUD access it through private sector health services which only serve 14% of all contraceptive users.[12,16] In addition, the levonorgestrel-releasing intrauterine system (LNG-IUS, Mirena®), which has several features that might make it some women's first choice, is not available for contraceptive use in the public sector services.[16]

Aside from service delivery challenges, there is little information about attitudes towards IUD use in the public health services in South Africa. In order to promote safe and reliable contraception for women in our population it was necessary to understand what these attitudes are and how they affect uptake of this method.

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The aim of this study was to determine the knowledge and acceptability of the IUD as a contraceptive method among family planning clients and providers in the family planning services in Cape Town and to identify barriers to the use of this very effective contraceptive method.

Methods

A descriptive cross-sectional questionnaire survey was undertaken among women attending eight public sector Reproductive Health or Community Health Clinics in the Cape Metropolitan Area. The providers at the same facilities were also surveyed. The intent was to select clinics that had previously been part of contraceptive surveys conducted in collaboration with the CDN, which would provide a sample representative of the larger ethnic groups in Cape Town.

Non-random convenience sampling was used to recruit women aged 18–50 years inclusive, who were attending the clinics at the time of data collection. All women were invited to participate if they were attending for any reproductive health care (ie, first-time contraception, contraception follow-up and counselling, cervical smears, pregnancy testing or STI services) and were using or had ever used contraception. A minimum of 25 women was sampled from each clinic. Women were approached in the order in which they arrived in the waiting area, and interviewed while they were waiting to be seen by the service providers. Alternatively, the service providers would direct women to the interviewer once their consultation was over.

All the doctors, nurses and health advisors working at the eight clinics were invited to participate in the study.

Two questionnaires, one for clients and the other for providers, were designed for this survey. Both were piloted before implementation and translated into Afrikaans and Xhosa, thus covering the dominant languages spoken in Cape Town. This enabled us to conduct interviews in the language of the client's choice.

Data were collected over a period of 5 months (November 2006 to March 2007). A verbal explanation of the study and an information leaflet were given to all participants before written consent was obtained. Confidentiality was guaranteed. Both the questionnaires were administered by three experienced interviewers. Questions were read to the participant and the answers recorded on the questionnaire. If anyone requested information about the IUD this was provided once the questionnaire had been completed. The client questionnaire was not revealed to the providers.

Ethical approval

Consent to conduct the study was granted by the Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town (REC Reference 207/2006). The relevant authorities (Provincial Government of the Western Cape and the City of Cape Town) permitted access to the clinics.

Statistical analysis

Calculation of the client sample size was based on statistics of reproductive health visits to public sector clinics in the greater Cape Town area (provided by the Provincial Government of the Western Cape Reproductive Health programme) and on estimations of IUD knowledge (50%), ever-use (10%) and current use (2%) from the South African Demographic and Health Survey (SADHS) of 1998 with an acceptable margin of error of 5%.[12] A sample size of 200 family planning clients provided an 80% power to estimate the proportion of women who had knowledge of the IUD, 95% power to estimate the proportion of women who had ever used an IUD and 99% power to estimate the proportion of women who were currently using an IUD.

All questionnaires were reviewed and checked for completion and accuracy by the principal investigator. The majority of the questions had pre-coded answers, and open-ended questions were coded prior to data entry into databases using Microsoft Excel™ . The electronic data of one in every ten entries were checked for accuracy by a second person.

Data analysis was carried out using STATA Version 8.0 software.[17] Proportions were calculated to describe sociodemographic and reproductive characteristics, knowledge and acceptability of the IUD and current practices and barriers to use. A bivariate analysis of associations between sociodemographic and reproductive characteristics and specific variables of interest (eg, education and knowledge of the IUD) was performed using Chi-square tests.

Results

A total of 216 women and 30 providers participated in the survey. Thirty-seven clients who were approached declined

Table 1 Sociodemographic and reproductive characteristics: clients (n = 216)

Characteristic	*n* (%)
Age (years)	
<20	13 (6)
20–29	118 (55)
30–39	59 (27)
40–50	26 (12)
Marital status	
Single (including divorced, widowed)	117 (54)
Married (including cohabiting)	99 (46)
Highest level of education	
Primary (up to 7 years education)	16 (7)
Secondary: (incomplete and complete)	164 (76)
Tertiary: (certificate, diploma, degree)	36 (17)
Employment	
Employed	131 (61)
Unemployed	67 (31)
Student/scholar	18 (8)
Ethnic group	
Black	99 (46)
Coloured	100 (46)
Indian	2 (1)
White	5 (2)
Unclassified	10 (5)
Frequency of menstruation	
Regular	115 (53)
Irregular	35 (16)
Contraception-induced amenorrhoea	66 (31)
Menstrual problems	
No	89 (41)
Yes (irregular, heavy, prolonged, painful, other)	61 (28)
Contraception-induced amenorrhoea (not considered a problem)	66 (31)
Pregnancies (n)	
0	41 (19)
1	62 (29)
2	63 (29)
3	28 (13)
4	15 (7)
5	4 (2)
>5	3 (1)
Termination of pregnancy (n)	
0	200 (93)
1–3	16 (7)
>3	0 (0)
Intention to have (more) children	
Yes	96 (44.5)
No	96 (44.5)
Don't know	24 (11)

Table 2 Knowledge about intrauterine devices and the levonorgestrel-releasing intrauterine system: clients (n = 216)

Characteristic	*n* (%)
Self-assessed level of knowledge about IUDs	
Nothing	117 (54)
A little	96 (45)
A lot	3 (1)
Knowledge of contraceptive action: IUD[a]	
Don't know	128 (59)
Device/object inserted into vagina/uterus	56 (26)
Spermicidal	3 (1)
Other	30 (14)
Knowledge of LNG-IUS	
Yes	5 (2)
No	211 (98)
Knowledge of contraceptive action: LNG-IUS	
Don't know	214 (99)
Device/object inserted into vagina/uterus	2 (1)

[a]Some clients gave more than one answer.
IUD, intrauterine device; LNG-IUS, levonorgestrel-releasing intrauterine system.

to participate, for two reasons: time constraints (n = 33) and unavailability of the Xhosa-speaking interviewer to conduct the interview (n = 3). One woman cited her lack of knowledge about IUDs as a reason for not wanting to participate. No providers declined to participate. All data were complete, except for two questions (from the client questionnaire), each of which had a single response missing (n = 215).

Clients

The majority of clients were aged between 20 and 39 years and single (including divorced and widowed women). Most had some formal education but only 17% (n = 36) had completed any tertiary education. Approximately one third were unemployed (Table 1).

Thirty-one percent (n = 66) of the clients had contraception-induced amenorrhoea and were unable to comment on their menstrual pattern. Half of all the participants (53%, n = 115) reported regular menses and only 28% (n = 61) indicated that they were experiencing menstrual problems (irregular or prolonged menses, heavy flow, dysmenorrhoea) (Table 1). Fifty-nine percent (n = 127) of women had menses lasting less than 7 days and 51% (n = 110) described their menstrual flow as light to moderate.

Equal numbers (44.5%, n = 96) indicated that they did or did not want (more) children in the future and 11% (n = 24) were ambivalent about future fertility (Table 1).

IUD use was very low. Four percent of these women (n = 9) had ever used an IUD and only 1% (n = 3) were currently using this method.

Knowledge of the IUD was limited. Fewer than 50% of clients had heard about this method, and those who knew of it had little factual information about it. Two percent (n = 5) of the clients had heard of the LNG-IUS but none had knowledge of the contraceptive action of this method (Table 2).

Contrary to the opinions of providers in our services only 3% (n = 7) of the women mentioned any 'myths' which influenced them. These were migration of the device within the body (n = 2), harm to the fetus if pregnancy resulted (n = 2), belief that their partner would feel it during intercourse (n = 2) and fear that it could cause diseases such as cancer (n = 1).

Despite their lack of prior knowledge of the IUD, clients were asked to indicate the acceptability of the contraceptive characteristics (effectiveness, long-term efficacy, non-hormonal action) and potential side effects (increased menstrual bleeding, increased dysmenorrhoea) of the IUD. These women had a positive view of the contraceptive characteristics, although many found the side effects potentially unacceptable (Table 3).

Approximately two-thirds of women (69%, n = 148) thought that they might be interested in using an IUD in the future. Thirty-six percent (n = 77) expressed an unequivocal interest in this method and 33% (n = 71) were ambivalent.

In order to assess barriers to IUD use, participants were asked to recall if anyone had ever suggested that this method would be suitable for them. Their responses indicated that although the IUD was not specifically discouraged, it had not been discussed actively or recommended by providers. Fifteen percent (n = 33) recalled that this method had been recommended to them, but not always by a service provider. Eight percent (n = 16) recalled that they had been discouraged from using an IUD by a service provider or a personal acquaintance. Of these women, half (n = 8) were told that it was an unreliable method and would fail to prevent pregnancy.

A bivariate analysis indicated that women between the ages of 30 and 50 years were more likely to have knowledge of the IUD than younger women (p = 0.002), while white and coloured women were more likely than black and Indian women to have knowledge of this method (p<0.001). Women with a tertiary education were more likely than women with a primary or secondary education to have knowledge of the IUD (p = 0.042), and unemployed women and students were less likely to know about the IUD than employed women (p = 0.007).

Interest in future use of this method was associated with being aged under 40 years (p<0.001) and being black or coloured (p = 0.047). Women who had never been pregnant or who had had fewer than four pregnancies were more likely to be interested in future use of an IUD than women who had been pregnant four or more times (p = 0.014). Women with fewer than four live children were also more

Table 3 Acceptability of the contraceptive characteristics of intrauterine devices and the levonorgestrel-releasing intrauterine system: clients (n = 216)

Characteristic	Acceptability [n (%)]			
	Very acceptable	Quite acceptable	Unacceptable	Very unacceptable
Almost as effective as sterilisation but reversible	132 (61)	64 (30)	14 (6)	6 (3)
Long-term effect, up to 10 years	146 (67)	54 (25)	10 (5)	6 (3)
Non-hormonal action	138 (64)	58 (27)	14 (6)	6 (3)
LNG-IUS contains hormones	49 (23)	55 (25)	94 (44)	18 (8)
IUD may cause increased menstrual bleeding	7 (3)	15 (7)	112 (52)	82 (38)
IUD may cause increased menstrual pain	3 (1)	10 (5)	107 (50)	96 (44)
LNG-IUS decreases menstrual bleeding	76 (35)	86 (40)	43 (20)	11 (5)
LNG-IUS may cause menstruation to cease	47 (22)	40 (19)	76 (35)	53 (24)

IUD, intrauterine device; LNG-IUS, levonorgestrel-releasing intrauterine system.

Table 4 Knowledge about intrauterine devices and infection risk: providers (n = 30)

Characteristic	*n* (%)
Self-assessment of level of knowledge	
Excellent	1 (3)
Good	19 (63)
Fair	8 (27)
Poor	2 (7)
Period of greatest risk of infection	
Within 3 weeks	15 (50)
1–3 months	1 (3)
1 year	2 (7)
The longer the IUD is *in situ*	5 (17)
No risk	7 (23)
Routine endocervical swabs for STIs prior to IUD insertion	
Yes	17 (57)
No	7 (23)
Only if she has symptoms of an infection	3 (10)
Don't know	3 (10)
Routine antibiotics after IUD insertion	
Yes	1 (3)
No	21 (70)
Only if she has an infection	8 (27)
Duration of use: copper IUD	
1 year	0 (0)
5 year	12 (40)
10 years	1 (3)
5–10 years depending on the device	12 (40)
Don't know	5 (17)

IUD, intrauterine device; STI, sexually transmitted infection.

likely to be interested in using this method of contraception than women with more than four children (p = 0.002).

The group of clients who had ever used an IUD was small (4%, n = 9), as was the group of clients currently using an IUD (1%, n = 3). No significant associations were found between sociodemographic characteristics and ever-use of an IUD, and it was not possible to analyse an association between participant characteristics and current use.

Providers

Knowledge about the IUD was limited and often not consistent with current recommendations for IUD use. Only one provider felt that she had excellent knowledge of IUDs, and there was limited awareness of the LNG-IUS, with only 50% (n = 15) of providers aware of both of these intrauterine contraceptive methods (Table 4).

When asked to compare the effectiveness of the IUD with other commonly used methods, 76% (n = 23) considered the IUD more effective than combined oral contraceptives and male condoms, while 23% (n = 7) stated that the IUD was less effective than injectable progestogens and tubal ligation, and 20% (n = 6) said it had an equivalent effectiveness to injectable contraceptive methods.

With regard to understanding the relationship between IUD use and pelvic infection, only 50% (n = 15) knew that the period of greatest risk for infection was within the first 3 weeks after insertion and 17% (n = 5) of providers still believed that the risk increased the longer the IUD was in situ (Table 4). Infection (vaginal or pelvic) was commonly mentioned as a disadvantage of using an IUD (47%, n = 14).

Knowledge about the need to exclude the presence of STIs at the time of insertion of the device was mixed. Fifty-seven percent (n = 17) of the providers in this study stated that endocervical swabs should be taken routinely, 10% (n = 3) said this was only necessary if a women had symptoms of infection, 23% (n = 7) felt it was unnecessary and 10% (n = 3) were unsure. Two-thirds (70%, n = 21) did not support routine antibiotic prophylaxis (Table 4).

In order to assess acceptability of the IUD as a primary contraceptive method, providers were asked about their counselling practices in relation to this method. Referrals for insertions of IUDs were low. Ninety percent (n = 27) of providers had referred fewer than 10 clients for IUDs in the previous year. In addition, the IUD was not being widely recommended or discussed with clients. Only 47% (n = 14) of providers indicated that they always discussed the IUD during contraceptive counselling, and 43% (n = 13) always discussed this method during counselling for sterilisation.

Providers were asked to identify barriers to wider use of the IUD. The most frequently mentioned obstacles were a lack of skilled providers to insert the IUD (50%, n = 15), clients' lack of knowledge (50%, n = 15), myths and rumours among clients about the IUD (50%, n = 15) and IUDs not being promoted by providers (60%, n = 18).

The small provider sample allowed only a very limited analysis of associations between the professional category of the providers and three outcome variables (knowledge of IUDs, knowledge of infection risks, and recommendation of IUDs). The analysis revealed no significant associations, except for referral of women for insertion of an IUD. Family planning trained doctors were more likely than other categories of doctors, nurses or health educators to have referred more than 10 women for insertion of an IUD in the previous 12 months (p = 0.028).

Discussion

To our knowledge, this study is the first in South Africa to examine attitudes and knowledge about the IUD among potential clients and providers in public sector contraceptive services, and has confirmed results from previous surveys in our unit indicating low use of the IUD among family planning clients.[14,15]

Based on the World Health Organization (WHO) medical eligibility criteria for use of an IUD or LNG-IUS, the IUD was a suitable method for the majority of the women in this survey, yet only 4% (n = 9) had ever used this method and just 1% (n = 3) were currently using one.[5]

Knowledge of the IUD

There was a lack of knowledge among these clients regarding the IUD, and of those who were either ambivalent or uninterested in future use (60%, n = 130), half (n = 68) mentioned their lack of knowledge of the method as the main deterrent to its use. Despite this they were willing to speculate about the relative effectiveness and indications for use of the IUD, and the desirability of preventing pregnancy appeared to be an important criterion for considering this method.

In addition, and contrary to opinions among service providers in South Africa, the existence of myths and rumours about the IUD, was not obvious among our sample of clients. Failure to identify myths and rumours among this group of clients is inconsistent with studies from around the world.[8,10,11,18–20] These other studies have typically used a combination of both qualitative and quantitative methods, and while our quantitative information is valuable, the addition of qualitative techniques may have provided additional information. Further insights into the personal factors that inhibit use of the method would be useful in planning health promotion and provider training.

Evidence from research and current recommendations do not seem to have made an impact on the knowledge and practice of providers within the clinical services we accessed. In common with other studies, this survey suggests a persistent belief that the IUD plays a role in causing infection. This appears to be based on a non-

specific fear of vaginal or pelvic infection in the presence of an IUD, rather than on an understanding that the risk of infection is related to the presence of STIs (specifically chlamydia and gonorrhoea) during instrumentation of the cervix.[2,21]

Providers also seemed to be unaware of the WHO medical eligibility criteria, which state that women with current purulent cervicitis, gonorrhoea, chlamydia or pelvic inflammatory disease (PID) should not start using an IUD (Category 4).[5] Ideally these infections should first be excluded by laboratory testing, but if these resources are not available, and bearing in mind that some women display no symptoms, providers should at the very least do a STI risk assessment and physical examination to attempt to exclude current infection.[7]

Understandably, the high prevalence of HIV/AIDS in our clinical population has made many providers concerned about infection risks despite WHO recommendations. These state that most women with an HIV infection can start using an IUD even if they have AIDS, provided that they are well and using antiretroviral therapy (Category 2), and that an IUD need not always be removed if a woman develops HIV or AIDS (Category 2), or an STI or PID (Category 2), as long as the woman is monitored closely and any infection is treated successfully.[5,22]

The limited knowledge among providers in this study is of concern since it indicates that clients are inadequately counselled about the IUD, and while this method would be suitable for many women who may wish to use it, it is not being recommended to them as a primary contraceptive option.

Acceptability and barriers to use

The contraceptive characteristics of the IUD were viewed positively by the women in this survey, and almost two-thirds of them indicated that they would consider using this contraceptive method in the future, provided they were supplied with more information. This suggests that the IUD is potentially an acceptable method for clients using our services.

This level of interest is contrary to information from the 1998 SADHS, which found that only 4% of women interviewed would choose to use an IUD in the future.[12] This discrepancy may simply be due to participants overstating their interest in order to please the interviewers, but it may also reflect the obvious lack of knowledge that we identified and a genuine interest among clients in alternative contraceptive methods. Interest in a method does not, however, necessarily translate into its use. A positive attitude towards the IUD could be undermined by possible side effects, as was reflected by the number of women (90%, n = 194) who found the potential for increased menstrual bleeding to be unacceptable.

More than half (59%, n = 129) of the participants in our study indicated that the amenorrhoea associated with use of the LNG-IUS would be unacceptable to them, yet at least two-thirds were using injectable contraceptives and a third were experiencing amenorrhoea as a result. This attitude towards amenorrhoea was inconsistent with the study by Glasier *et al*.,[14] which demonstrated that, except for black women in Cape Town and Nigeria, more than half the women in their multicentre survey disliked having periods. However, despite the black women's preference for monthly menses, more than half of all the participants in Cape Town were willing to consider using a contraceptive method that would result in amenorrhoea.[14]

Lack of acceptability of the IUD to providers as a primary contraceptive method was reflected in their practices. Referrals for insertions of IUDs were low, and they were not being offered routinely as an alternative to tubal ligation. Providers discussed this method selectively, with less than half of them indicating that they would always include the IUD when counselling women about contraception (47%, n = 14) or sterilisation (43%, n = 13). Very few providers identified their own lack of knowledge and personal attitudes as creating a barrier to use, and their perception of why this method was not being used was not entirely consistent with the reasons that the clients themselves presented.

Study limitations

This was a descriptive cross-sectional survey and we used non-random sampling (described under Methods) to select the client sample. This process has potential problems. First, due to the length of the interviews (approximately 20–30 minutes), consecutive women in the queue were sometimes missed and, secondly, the service providers may have been selectively referring women who had expressed an interest in hearing more about the IUD or who were currently using it, despite not being asked to do so. It is possible that these women would have expressed a more positive attitude than women who were not interested in or had never used an IUD.

All the providers at all the clinics agreed to be interviewed, eliminating the possibility of selection bias in this group of participants. The sample was smaller than we had expected to recruit, and there was a large variation in the professional training of the participants, from the level of health promoter to family planning trained doctor. In addition, all the doctors were based at a clinic in a tertiary level facility, and their knowledge and experience differed from those of providers in the primary level clinics. This may have contributed to some of the inconsistencies in knowledge that were noted, and without more representatives from each category of provider there were not enough data to clearly reveal any true trends in knowledge.

Similarly, the number of current and ever users of an IUD was very small, reflecting the failure of promotion of this method. The information from these women regarding their choice and experience of the IUD cannot be generalised to the larger community of family planning clients.

The clinics that were included in the survey were all public sector facilities, and the client sample was representative of women aged 20–49 years from the larger ethnic groups in Cape Town (black and coloured women) who predominantly use the public sector services.[23] According to the 1998 SADHS, although 84% of our population access their contraception through the public sector, almost half (46%) of the women who use an IUD obtain it through private sector health services.[12,16] These clients may have different sociodemographic and reproductive characteristics to those in our sample and could have different attitudes towards the IUD. The results from our survey cannot necessarily be generalised to that population of contraceptive users.

Conclusions

This study provides new information about the lack of awareness and information about the IUD in our public sector services, and provides some insight into the factors that contribute to its lack of popularity relative to other contraceptive methods.

Further qualitative research to explore the attitudes of clients and providers in greater depth, particularly those in the private sector, would be valuable and would augment the insights of this survey.

The IUD is highly effective and is available free of charge in our public sector family planning services, but it is not utilised. In addition, the LNG-IUS is not available to women accessing these services and until this changes, access to the full spectrum of contraceptive choice will remain limited.

Better education of both clients and providers is essential in order to improve accessibility and acceptability of the IUD. The IUD needs to be promoted and clients must be made aware of the availability of this option, while providers need to explore the opportunities to update their knowledge and skills in order to deliver an effective service.

Acknowledgements

The authors acknowledge the clients and providers who willingly gave of their time to participate in this survey, and the relevant authorities – Department of Health, Provincial Government of the Western Cape, and Department of Health, City of Cape Town – for permitting access to the family planning services. The assistance of Sister Rosemary Jacobs (Umtha Strategy Planning and Development Consultancy), who performed the interviews with Xhosa-speaking clients and providers, and Sister Anne Hoffman (Reproductive Medicine Unit, Department of Obstetrics and Gynaecology, University of Cape Town) is gratefully acknowledged.

Statements on funding and competing interests

Funding The research was supported by a grant from the JS Scratchley Fund, University of Cape Town.
Competing interests None identified.

References

1 Mishell DR. Intrauterine devices: mechanisms of action, safety, and efficacy. *Contraception* 1998; **58**: 45S–53S.
2 Grimes DA. Intrauterine device and upper-genital-tract infection. *Lancet* 2000; **356**: 1013–1019.
3 Hubacher D, Lara-Ricalde R, Taylor DJ, Guerra-Infante F, Guzman-Rodriguez R. Use of copper intrauterine devices and the risk of tubal infertility among nulligravid women. *N Engl J Med* 2001; **345**: 561–567.
4 Morrison CS, Sekadde-Kigondu C, Sinei SK, Weiner DH, Kwok C, Kokonya D. Is the intrauterine device appropriate contraception for HIV-1-infected women? *Br J Obstet Gynaecol* 2001; **108**: 784–790.
5 World Health Organization (WHO). *Medical Eligibility Criteria for Contraceptive Use* (3rd edn). 2004. http://apps.who.int/rhl/fertility/contraception/mec.pdf [Accessed 12 October 2009].
6 United Nations. *World Contraceptive Use 2007*. Washington, DC: Department of Economic and Social Affairs: Population Division, 2007. http://www.un.org/esa/population/publications/contraceptive2007/WallChart_WCU2007_Data.xls [Accessed 12 October 2009].
7 Salem R. *Population Reports*: *New Attention to the IUD: Expanding Women's Contraceptive Options to Meet Their Needs*. The Info Project. Johns Hopkins Bloomberg School of Public Health. Series B (7): XXX111 (2). http://www.population reports.org/b7/ [Accessed 12 October 2009].
8 Katz KR, Johnson LM, Janowitz B, Carranza JM. Reasons for the low level of IUD use in El Salvador. *Int Fam Plan Perspect* 2002; **28**: 26–31.
9 Stanwood NL, Garrett JM, Konrad TR. Obstetrician-gynecologists and the intrauterine device: a survey of attitudes and practice. *Obstet Gynecol* 2002; **99**: 275–280.
10 Brambila C, Taracena B. *Availability and Acceptability of IUDs in Guatemala*. 2003. http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Guatemala_IUD.pdf [Accessed 12 October 2009].
11 Gyapong J, Addico G, Osei I, Abbey M, Kobinah DA, Agyarko HO, *et al. An Assessment of Trends in the Use of the IUD in Ghana*. 2003. http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Ghana_IUD.pdf [Accessed 12 October 2009]
12 Department of Health. Contraception and fertility preferences (Chapter 4). *South African Demographic and Health Survey, 1998*. http://www.doh.gov.za/facts/1998/sadhs98/chapter4.pdf [Accessed 12 October 2009].
13 Department of Health. II: *Reproductive Health. South African Demographic and Health Survey*. Preliminary Report, Part One. 2004. http://www.doh.gov.za/facts/index.html (select: South African Demographic and Health Survey – 2003) [Accessed 12 October 2009].
14 Glasier AF, Smith KB, van der Spuy ZM, Ho PC, Cheng L, Dada K, *et al*. Amenorrhea associated with contraception – an international study on acceptability. *Contraception* 2003; **67**: 1–8.
15 Glasier AF, Smith KB, Cheng L, Ho PC, van der Spuy Z, Baird DT. An international study on the acceptability of a once-a-month pill. *Hum Reprod* 1999; **14**: 3018–3020.
16 Department of Health. *National Contraception Policy Guidelines*. 2001. http://www.doh.gov.za/docs/index.html (select: Fact Sheets/Guidelines; Miscellaneous; National Contraception Policy Guidelines – Part 1 and Part 2) [Accessed 12 October 2009].
17 StataCorp. Stata Statistical Software: Release 8.0. College Station, TX: Stata Corporation, 2003.
18 Forrest JD. US women's perceptions of and attitudes about the IUD. *Obstet Gynecol Surv* 1996; **51**: S30–S34.
19 Gilliam ML, Warden M, Goldstein C, Tapia B. Concerns about contraceptive side effects among young Latinas: a focus-group approach. *Contraception* 2004; **70**: 299–305.
20 Asker C, Stokes-Lampard H, Beavan J, Wilson S. What is it about intrauterine devices that women find unacceptable? Factors that make women non-users: a qualitative study. *J Fam Plann Reprod Health Care*. 2006; **32**: 89–94.
21 Guillebaud J. Intrauterine devices. In: Guillebaud J, *Contraception: Your Questions Answered* (4th edn). Edinburgh, UK: Churchill Livingstone, 2004; 357–450.
22 Rinehart W. *WHO Updates Medical Eligibility Criteria for Contraceptives: Info Reports*. The Info Project. Johns Hopkins Bloomberg School of Public Health. 2004; 1: 1–8. http://info.k4health.org/inforeports/mec/mec.pdf [Accessed 12 October 2009].
23 Western Cape Provincial Government: Department of Environmental Affairs and Development Planning. *Census 1996 & 2001: Provincial Population Statistics in the Western Cape*. 2006. http://www.capegateway.gov.za/other/2006/6/wc_census_1996_&_2001_population_optimised2.pdf [Accessed 12 October 2009].

Fast Facts: Contraception (3rd edn). Ailsa E Gebbie, Katharine O'Connell White. Oxford, UK: Health Press, 2009. ISBN-13: 978-1-905-83250-7. Price: £6.00. Pages: 115 (paperback)

This Fast Facts book provides a well-structured introduction to contraception, from choosing a method to details on various methods of contraception. It provides a sound knowledge base for newcomers to family planning, as well as further reading through the references provided at the end of each chapter. The range of topics and the detail of explanation are suitable for primary care physicians, family planning practitioners, trainees and nurse specialists.

The book details vital questions to be asked by health professionals during time-restricted consultations in clinic, which help establish a suitable and compliant method of contraception tailored to each woman. The chapters discuss a variety of preparations, mechanisms of action, benefits, contraindications, side effects and risks of combined hormonal contraception, progestogen-only methods, intrauterine devices and systems. The book also addresses issues around the barrier and biologically based methods of contraception. Chapters are also included to discuss surgical methods of male and female sterilisation, which is a useful aid for community health physicians as an introduction to procedures done within hospital care. A very useful chapter is the one on postpartum contraception, particularly after a Caesarean section. One chapter also discusses the physical, social and emotional risks associated with an unplanned pregnancy.

The book addresses the complexities of contraception by dissecting the knowledge required into easily digested, bite-sized chapters. An advantage is the inclusion of a glossary of abbreviations at the beginning that provided a clear understanding throughout the book. The explanations through the chapters maintained a good pace to allow understanding of the different themes. The data were presented using a diverse mix of colourful tables, graphs, pictures and flow charts.

There was a good reference section and explanation of the UK Medical Eligibility Criteria (UKMEC) for contraceptive use. It would have also been beneficial to include the Pearl indices for different contraceptive methods. A salient point to include in the chapter on female sterilisation is the common grievance of women who cease hormonal methods of contraception post-sterilisation, and associate heavier menstrual bleeding as a side effect of the procedure.

In conclusion, this is a concise book containing easy to read information, ideally addressed to primary care and family planning physicians, trainees and nurses, in the UK and USA.

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