

Utilization of Intrauterine Contraceptive Device in Teso North Sub County

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ABSTRACT

Purpose. The purpose of the study was find out causes of low utilization of Intra-uterine contraceptive device among women of child bearing age in Teso north Sub County, specifically determine level of awareness and assess barriers associated with intra-uterine device uptake

Methodology. The study adopted a cross sectional-descriptive study design to collect data through a researcher administered questionnaires. A total of 353 participants were interviewed from the selected facilities in Teso north Sub County which were purposively chosen. Systematic random sampling was used to select primary respondents at a predetermined interval of 8. Quantitative data was cleaned and entered into a Microsoft excel database before being analyzed by SPSS version 22.0. Descriptive statistics were presented using percentages, frequency tables, graphs and pie-charts. Inferential statistics were calculated to establish the association between study variables using chi-square tests done at 95% confidence interval.

Results. The results revealed that only 4.8% of respondents utilized intra-uterine contraceptive device. The study established low awareness levels on intrauterine device among women in Teso north Sub County. Awareness levels were significantly associated with utilization of intra-uterine contraceptive device ($p=0.047$). A number of factors were identified as possible barrier which hindered intra-uterine contraceptive device uptake included facility reception ($p=0.026$), provision of information ($p=0.002$), culture/religion ($p=0.004$) and spouse allows use ($p=0.002$). Enough health personnel to offer the service $p=0.794$, time factor during IUCD insertion affect its uptake $p=0.055$ were non-significant

Conclusion and recommendation. The study concludes that there were low utilization rates and low awareness levels on intra-uterine contraceptive device. The national /county governments should invest heavily in health promotion activities aimed at addressing existing myths and misconception and provide a platform for demand creation on the use of IUCDs. Service providers should encourage male involvement, use community health promoters in creating awareness and demand creation regarding IUCD utilization and above all make health services attractive to users

1.0 INTRODUCTION

Worldwide, 14.3% of women of reproductive age use intrauterine contraceptive device (IUCD), but the distribution of IUCD users is amazingly non uniform. Contraception has a vital role in reducing unplanned pregnancies, unsafe abortions, and associated mortalities (WHO, 2020). Globally, IUDs are a recognized to be a modern long-term reversible contraceptive method which is suitable to prevent unwanted pregnancies for women of all reproductive ages (Alemayehu, *et al.*, 2022). In some countries, the percentage of women using IUCD is < 2%, whereas in other countries, it is > 40%. Reasons for this large disparity are not well known. Countries with the higher number of IUCD user includes Cuba (43.5%), Vietnam (37.7%), Egypt (36.5%) and China (44.9%). Intrauterine method of family planning is underutilized in Sub Saharan African countries despite the method being safe, long acting, reversible and effective in preventing unintended pregnancies (Alemayehu, *et al.*, 2022; WHO, 2022). The developed areas have an uptake of 9.2% while the less developed countries have 15.1% (Ali *et al.*, 2019; Daniele *et al.*, 2017) This can be attributed to lack of training among health care workers, cost differences and medico-legal environment (Daniele *et al.*, 2017). Intrauterine Contraceptive Device uptake in Africa is generally low, with rates often under 2% in Sub-Saharan Africa. While some regions like Northern Africa see higher use, according to international journals and the World Bank, the overall prevalence remains relatively low across the continent. Factors contributing to low IUCD uptake in Africa includes low awareness, cultural and religious beliefs. However the Northern region of Africa has the highest IUCD use (18.1%) and Egypt and Tunisia being the hotspots (28.8% and 36.1%) (Buhling *et al.*, 2014; Ali *et al.*, 2019). Intrauterine contraceptive device utilization in Namibia has been stagnant at below 1% for more than two decades now, while injectable stand at 21% and male condoms 19%, while use of pills, female and male sterilization, and other modern contraceptive methods are all below 5%. In Kenya according to 2022 KDHS report, the uptake of IUCD in the general population was 3.4%. Some studies have shown even lower rates, with one finding IUCD use at just 3.8%

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Factors influencing uptake included misconceptions and myths, limited access and provider knowledge and counseling regarding IUCD as a family planning method.

Busia county currently has 30% contraceptive uptake which is low compared to 57% nationally and more than 19% of the women have unmet needs of family planning one percent higher than the nation which is increasing their risk of maternal and neonatal deaths from unplanned pregnancies (KDHS, 2022). In Busia County, Intrauterine Contraceptive Device (IUCD) utilization is relatively low compared to other modern family planning methods like injectable and implants. Studies show IUCD use among family planning clients is at 9%, while service providers report 22% IUCD use, both higher than the national average of 4%. Injectable and pills are more prevalent, with prevalence rates of 43% and 20%, respectively. Teso north is one of the Sub County in Busia that is not doing well on IUCD uptake of family planning method (KHIS, 2024).

1.1 The statement of the problem

Worldwide, 14.3% of women of reproductive age use intrauterine contraceptive device (IUCD) but the distribution of IUCD users is amazingly non uniform (WHO, 2020). In some countries, the percentage of women using IUCD is < 2%, whereas in other countries, it is > 40%. Reasons for this large disparity are not well known. Intrauterine method of family planning is underutilized in Sub Saharan African countries despite the method being safe, long acting, reversible and effective in preventing unintended pregnancies (Alemayehu, *et al.*, 2022; WHO, 2022). Kenya according to 2022 KDHS report, the uptake of IUCD in the general population was 3.4%. Some studies have shown even lower rates, with one finding IUCD use at just 3.8%. F. Busia county currently has 30% contraceptive uptake which is low compared to 57% nationally and more than 19% of the women have unmet needs of family planning one percent higher than the nation which is increasing their risk of maternal and neonatal deaths from unplanned pregnancies (KDHS, 2022). In Busia County Intrauterine Contraceptive Device (IUCD) utilization is relatively low compared to other modern family planning methods like injectable and implants. Prevalence of IUCD among family planning clients is at 9%, while injectable and pills are 43% and 20%, respectively (KHIS, 2024). Despite the availability of IUDs, unintended pregnancy continues to be a major public healthcare issue in Busia County. With this report, reducing maternal and neonatal mortality ratio to less than 70 per 100 000 live births and reaching the SDG 3 target by 2030 is proving to be a serious challenge. This study therefore seek to understand reasons affecting utilization of IUCD in Teso north Sub County, Busia County.

1.2 Objective

1.2.1 The main objectives

The main objective of the study was to find out causes of low utilization of Intra-uterine contraceptive device among women of child bearing age in Teso north Sub County

1.2.2 Specific objectives

- i) To determine level of awareness affecting utilization of IUCD in Teso north sub county health facilities
- ii) Assess barriers hindering utilization of IUCD in Teso north sub county health facilities

1.3 METHODOLOGY

Study design. The research adopted a cross-sectional descriptive design. This design enabled the researcher to identify and classify elements and data collected at one point in time. It was mainly an observational study where outcome and the exposure in study participants were measured at the same time (Setia, 2016). This kind of study is inexpensive and faster.

Location of the study. The study was carried out in teso north Sub County covering 16 health facilities. The study sites were chosen because they all licensed to offer family planning services.

Study population. The study population included women of child bearing age 15-49 years attending family planning services in Teso north Sub County who consented to participate.

Sampling technique. Purposive sampling was done to determine the selection of facilities for data collection which are the 16 immunizing facilities in Teso north Sub County. Systematic random sampling was then done in the selected centers so as to get the sample population that was the population size by desired sample size.

$$K = \frac{2790}{372}$$

$$\sim 7.5$$

Every 8th person existing the family planning clinic was selected for interviewing. The first respondent was selected through simple random sampling using yes/no raffles. Then subsequent respondents were selected using systematic random sampling where every 8th respondent exiting the family planning clinic was picked for interviewing until the required number of respondents per facility was reached.

Sample size determination. Fishers *et al* (1998) formula was used to calculate the sample population

$$n = \frac{Z^2 p q}{d^2}$$

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Where: n = the desired sample size (if the target population is greater than 10,000) z = the standard normal deviate at the required confidence level (1.96) p = the proportion in the target population estimated to have characteristics measured (0.5) $q = 1 - p$ d = degree of accuracy (statistical significance) 0.05 $n = \frac{(1.96^2)(0.5)(0.5)}{(0.05)^2}$

$$\frac{(0.05)^2}{=384}$$

Calculation of the population less than 10,000 $nf = \frac{n}{1 + (n/N)}$

$$1 + (n/N)$$

Where nf = the desired sample size if the target population is less than 10000 n = the desired sample (when the target population is greater than 10000)

N = the estimate of the population size (2790) $nf = \frac{384}{1 + (384/2790)}$

$$1 + (384/2790)$$

$$n = 337.7$$

$$\sim 338$$

10% of respondents were added to cater for non-responses. Therefore 372 respondents were selected for interviewing.

Research Instruments. The study used self-administered semi-structured questionnaires for collection of quantitative data from the selected respondents. The contents of the questionnaires covered sociodemographic, utilization, knowledge and barriers towards IUCD.

Data Management and Analysis. Quantitative data was entered and stored in Microsoft Excel program. Data cleaning and editing was done where extreme, missing and inconsistent values were identified and corrected. Coding and verification of the data was done for easy manipulation, analysis and presentation. Data was then exported to Statistical Package for Social Sciences (SPSS) software version 22.0 for analysis. Descriptive analysis was presented in form of percentages, frequency tables, charts and graphs. Inferential statistics were computed using Pearson's Chi-square and Fisher's Exact Test presented in cross tabulations. This was done at 95% confidence interval and p-values of less than 0.05 considered significant in testing the association between study variables.

1.4 RESULTS AND DISCUSSION

IUCD utilization

Utilization of IUCD among respondents

Figure 1 Shows utilization of IUCD among the respondents. The results revealed that majority 274 (91.9%) of the respondents had not used IUCD while the rest 24 (8.1%) had used IUCD.

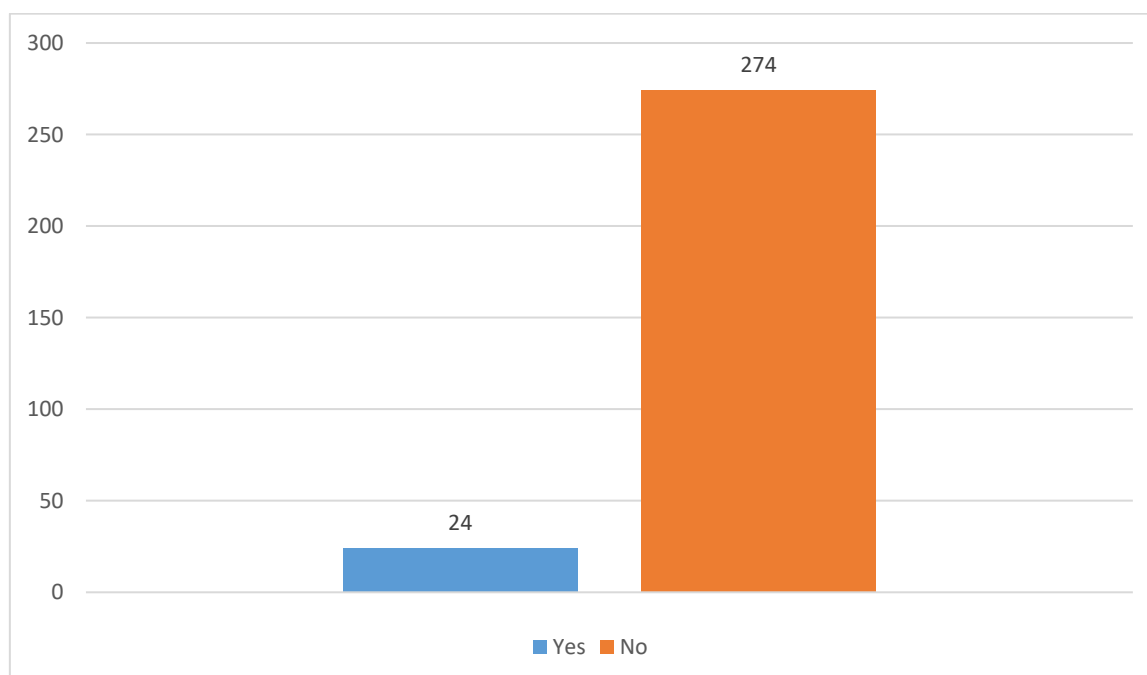


Fig 1: Utilization of IUCD among respondents

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Reasons for using IUCD

The study sought to further understand the reasons for IUCD usage among the respondents. The results showed that 9 (37.6 %) of the respondents used IUCD so that they can have the children at the time they felt is appropriate for them. This was followed by 6 (25%) who used IUCD because they felt that they can get pregnant immediately it is removed. The other reasons for usage were 4 (16.6%) IUCD did not have effect on their weight and 5 (20.8%) one didn't need to go to clinic every time. The results were as shown in the table 1 below:

Table 1: Reasons for using IUCD among respondents (N=38)

	Respondent response	Per cent (%)
To have children at the time I feel	9	37.6
One does not need to go to clinic every time	5	20.8
Does not have effect on my weight	4	16.6
I can get pregnant immediately it is removed	6	25

Duration of IUCD use

The study sought to find out how long the respondents had been using IUCD. The results indicated that 11 (45.8%) of the respondents had been using IUCD between 1-3 years followed by 6 (25%) who had been using IUCD between 6-8 years, 4-5 years 4(16.7%), 9-12 years 3(7.8%) The results were as presented in the figure 2 below:

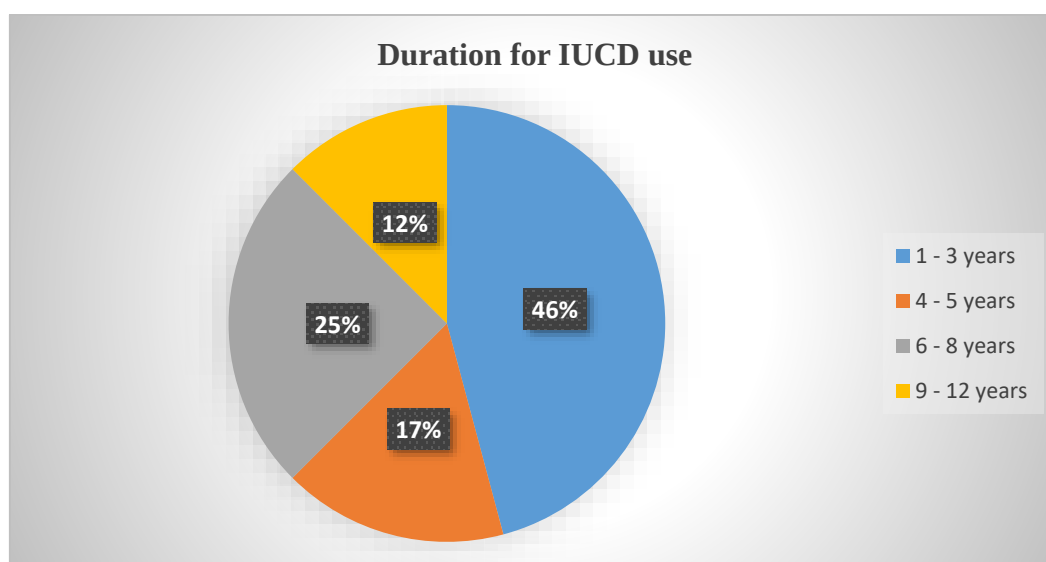


Fig 2: Duration of IUCD use among respondents

Awareness factors on IUCD utilization

Responses on IUCD awareness factors

Regarding respondents' awareness on IUCD, the study participants were given seven (7) responses on IUCD. They were supposed to indicate whether the statements were true or false according to them. Their responses were recorded as either correct or wrong. Regarding the meaning of IUCD, results revealed that majority 256 (85.9%) of the respondents had correct knowledge while the rest 42 (14.1%) had wrong knowledge. More than half 261 (87.5%) of the respondents had correct knowledge and 37 (12.5%) of them had wrong knowledge on whether there should be Investigations done before IUCD insertion.

Concerning the type of investigations that should be done before IUCD insertion, results indicated that majority 162 (54.3%) of the respondents had correct knowledge and 136 (47.5%) had wrong knowledge on the types of investigations. On whether one can get pregnant when IUCD is not inserted well, results showed that majority 196 (65.8%) of the respondents had wrong knowledge while the rest 102 (34.2%) had correct knowledge on the same.

Study findings revealed that majority 171 (54.4%) of the respondents had wrong knowledge and 127 (42.6 %) had correct knowledge on the duration in years the non-hormonal IUCD can help prevent one from getting pregnant. Results further showed that majority 180 (60.5%) of the respondents who had ever heard of IUCD had wrong knowledge on the types of IUCD with the rest 118(39.5%) having correct knowledge. Regarding the possibility of IUCD causing cancer, the results indicated that slightly

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more than half 179 (60.1 %) had wrong knowledge while the rest 119 (39.9%) had correct knowledge. The results were as presented in the table 2 below:

Table 2: Responses on knowledge factors on IUCD among respondents

Variable	Respondent response	Frequency (N)	Percentage (%)
IUCD meaning	Correct	256	85.9
	Wrong	42	14.1
	Total	298	100.0
Investigations are done before IUCD insertion	Correct	261	87.5
	Wrong	37	12.5
	Total	298	100.0
Type of investigations done	Correct	162	54.3
	Wrong	136	45.7
	Total	298	100.0
One can get pregnant when IUCD is not inserted well	Correct	102	34.2
	Wrong	196	65.8
	Total	298	100.0
Non-hormonal IUCD if not needing a child	Correct	127	42.6
	Wrong	171	57.4
	Total	298	100.0
Types of IUCD if ever heard	Correct	118	39.5
	Wrong	180	60.5
	Total	298	100.0
Do you think IUCD causes cancer	Correct	119	39.9
	Wrong	179	60.1
	Total	298	100.0

Level of awareness on IUCD

This section consisted of results concerning knowledge on IUCD among respondents. The Seven questions on knowledge had scores which ranged from 0-7 marks. Each correct answer was awarded a score of 1 while a wrong answer was awarded a score of zero (0). The scores of awareness were further divided into two categories; low awareness level ranged from 0-3 scores while high awareness level ranged from 4-7 scores. The results revealed that more than a half 284 (95.4%) of the respondents had low awareness level on IUCD while the rest 14 (4.6%) had high awareness. The results were as shown in the figure 3 below:

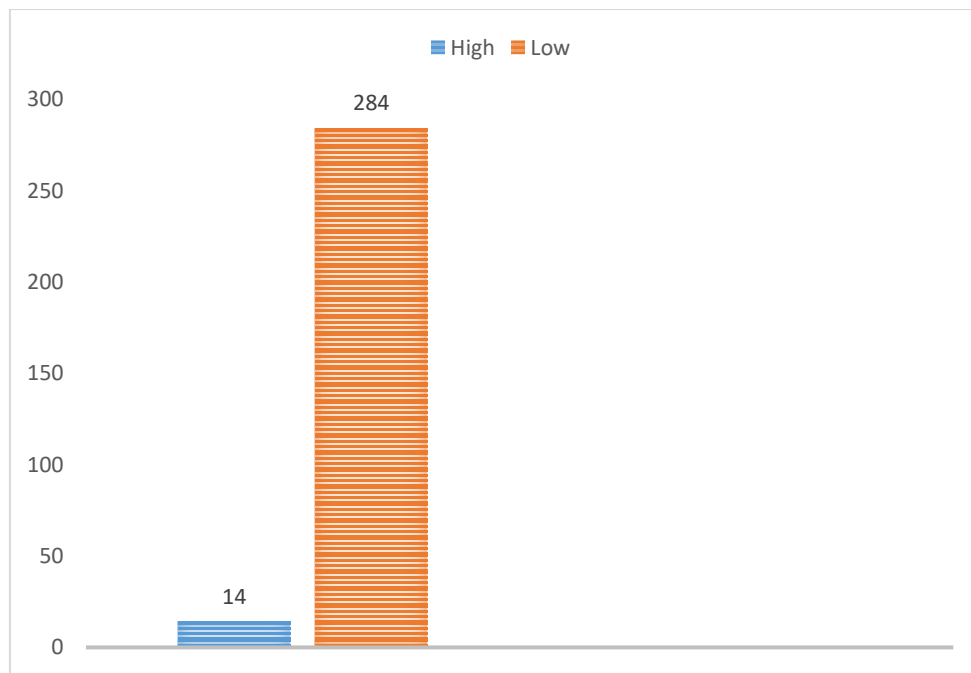


Fig 3: Level of awareness on IUCD among respondents

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Influence of awareness level on uptake of IUCD among respondents

The study sought to determine the influence of awareness level on uptake of IUCD among the respondents. The results revealed that majority 8 (51.7%) of the respondents who had high knowledge level on IUCD had used IUCD device. There was a statistical association between level of knowledge and IUCD uptake among the respondents ($p=0.047$). The results were as in the table 3 below:

Table 3: Association between awareness level and IUCD uptake among participants (n=298)

Independent variable	Respondent response	IUCD uptake		Statistical significance
		Yes (N=14)	No (N=284)	
Level of knowledge on IUCD	Low	6(42.9%)	168 (59.2%)	$\chi^2=2.169$ df=1 $p=0.047$
	High	8 (57.1%)	116 (40.8%)	

Barriers towards utilization of IUCD

The researcher sought to establish the influence of barriers on uptake of IUCD. The results revealed that majority 10 (58.8%) of the respondents who reported that IUCD was affordable had used IUCD. There was no statistical association between affordability of IUCD and IUCD uptake ($p=0.345$). The results indicated that more than half 144 (50.7%) of the respondents who did not like the reception had not used IUCD. There was a significant association between liking the reception at the facility and IUCD uptake ($p=0.026$). Most 8(57.1%) of the respondents who reported to have been given information on FP before service had used IUCD. There was an association between being given information on FP service and IUCD uptake ($p=0.002$). Concerning culture/religion allowing use of IUCD, results revealed that majority 10 (71.4%) of the respondents who reported that it allowed used IUCD. There was a significant statistical association between culture/religion allowing use of IUCD and IUCD uptake ($p=0.004$).

The study findings showed that majority 9 (64.2%) of the respondents who reported that their spouse allowed them to use IUCD had used IUCD. There was a significant statistical association between being allowed by the spouse to use IUCD and IUCD uptake ($p=0.002$). Majority 11 (76.5%) of the respondents who revealed that myths on IUCD affects usage did not use IUCD with $p=0.001$. The results were as shown in the table 4 below:

Table 4: Association between barriers and utilization of IUCD among respondents (n=298)

Independent variable	Respondent response	Dependent variable (IUCD uptake)		Statistical significance
		Yes (N=14)	No (N=284)	
Affordability of IUCD	Yes	8 (57.1%)	164(58.0%)	$\chi^2=0.890$ df= 1 $p=0.345$
	No	6 (42.9%)	120 (42.0%)	
Liked reception at the facility	Yes	8 (57.1%)	140 (49.2%)	$\chi^2=0.009$ df= 1 $p=0.026$
	No	6 (42.9 %)	144 (49.8%)	
Given information on FP before service	Yes	8(57.1%)	188 (66.1%)	$\chi^2=1.295$ df= 1 $p=0.002$
	No	6 (42.9 %)	96 (33.9%)	
Culture/religion allows use of IUCD	Yes	10 (71.4%)	151 (53.0%)	$\chi^2=0.006$ df=1 $p=0.004$
	No	4(26.6%)	133 (47.0%)	
Spouse allows use of IUCD	Yes	9 (64.2%)	115 (40.5%)	$\chi^2=9.399$ df= 1 $p=0.002$
	No	5 (35.8%)	169 (59.5%)	
Myths/misconception on IUCD affects usage	Yes	11(76.5%)	191 (67.6%)	$\chi^2=3.364$ df= 1 $p=0.067$
	No	3 (23.5%)	93 (32.4%)	
Enough health personnel to offer services	Yes	6 (47.1%)	143 (50.3%)	$\chi^2=0.068$ df=1 $p=0.794$
	No	8 (52.9%)	141 (49.7%)	
Time factor during IUCD insertion affect its uptake	Yes	6 (41.2%)	131(46.1%)	$\chi^2=0.351$ df=1 $p=0.0550$
	No	8 (58.8%)	153 (53.9%)	

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DISCUSSIONS

Uptake of IUCD

The study findings showed that majority of the respondents had not used IUCD. The rate of IUCD utilization was found to be 8.1 % which was fairly high in comparison with the national which stands at 3.4% but less than the global rate of 14.3% and Busia county rate of 9% utilization. The results are consisted with findings of a study conducted among women in rural Uganda which showed that IUCD use remained as low as 7.8%, and the low utilization was attributed to low awareness, lack or inadequate skilled or trained staff to perform procedures of inserting or removing the device and also poor access to family planning in developing countries, (Anguzu *et al.*, 2018). However, the study findings are contrary to findings by (Ali *et al.*, 2019; Daniele *et al.*, 2017), which showed that less developed countries have 15.1% utilization of IUCD. In other parts of India such as central India the IUCD utilization is 11.98%) and south India 19.72% (Gadre *et al.*, 2015)

Knowledge on IUCD

Majority of the respondents reported to have had heard about IUCD. The findings are similar with findings of a study done on awareness of IUCD amongst women in Ethiopia which reported 97% IUCD awareness amongst the study population. Contrary results were observed in South Africa where study findings showed low rates of IUCD awareness among the women of reproductive age despite it being available and free in the public sector. Low knowledge levels have been associated with low utilization rates of IUCD across the world (Todd *et al.*, 2016).

Regarding the source of information on IUCD among those respondents who reported to have heard about it, the results revealed that more than a third of them reported to have heard about IUCD from their peers for the first time. This may be due to the fact that women share a lot about their sexual and reproductive health issues when they are in groups with their peers hence a major source of information. The results were contrary to a study done in rural Lagos in South-west Nigeria on non-use, use and source of information on contraceptive use which showed that the major source of information on IUCD was health facilities (Afolabi *et al.*, 2015).

Concerning whether investigations are done before IUCD insertion, majority of the respondents reported that examinations are done before its insertion. This means they had had correct information since in most cases pregnancy tests are done before an IUCD is inserted. The results aligns with another study which was done in Nepal on knowledge on IUCD which revealed that majority of the respondents had correct knowledge since they said that pregnancy tests is a mandatory test that is done before IUCD insertion (Chakraborty *et al.*, 2019).

The findings of this study revealed that majority of the respondents had wrong knowledge on the duration in which the non-hormonal IUCD prevents conception. This is due to the fact that majority of the respondents said that the duration of non-hormonal IUCD prevents pregnancy is 8 years. This may attributed to the fact that most of the respondents are selective on the information they want regarding IUCD since they prefer short-acting family planning methods thus overlooking IUCD. The results are contrary to another report which indicated that the long acting copper T (non-hormonal) is licensed for ten years hence one can stay with it without removal for such a duration.

According to the study results it was revealed that majority of the respondents had low knowledge levels among women living in selected facilities in Kenya. This probably explains the reasons for its low utilization rates among this group of individuals. There was a significant statistical association between level of knowledge and IUCD uptake as majority of the respondents who had high knowledge level had used IUCD. Poor perceptions on IUCD could also play larger part in lowering the knowledge levels of those interviewed. This study findings were contrary with the Ministry of Health report which showed that the level of knowledge on IUCD among all women in Kenya is high but they are unable to use it due its perceived risks (KDHS, 2014). Low knowledge levels were with low utilization rates were also reported by a study done in South Africa among women of reproductive age despite the device being available and free in the public health facilities. They lack correct IUCD knowledge leading to women not using the method since they fear of their safety. In another study done in Singapore on knowledge factors determining choice of contraceptive use among women, consistent results were also reported where majority of respondents had poor/low knowledge levels (Gosavi *et al.*, 2016).

Barriers towards utilization of IUCD

Reception and utilization of IUCD among respondents was statistically significant. This is because when clients are not handled well by healthcare providers they are likely to be reluctant from using the available services thus significantly affecting utilization of the service. Similar results were reported by a study done in Nyamira County on health seeking behavior towards prostate cancer screening services for men above forty years where the nature of client reception affected health seeking behavior among clients (Matoke, 2018). Consistent findings were also observed by Muckle *et al.*, (2016) in their study on barriers to access of maternity care in Kenya showed that, fear of harsh treatment from the nursing staff at health facilities was one of the reasons why women feared to seek maternity services hence affecting utilization of the service.

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There was a significant statistical association between provision of information and utilization of IUCD services. The results aligns to a study on women social communication about IUCD which the respondents revealed that information provision influences IUCD utilization (Anderson *et al.*, 2014).

Most of the respondents reported that culture/religion allows them to use IUCD as a method of family planning. This may be explained by the fact that majority of the respondents were Protestants where their religion does not prohibit family planning in spacing their children. The results further revealed that there was a significant statistical association between culture/religion and uptake of IUCD in the current study. The study results were similar to a study in EThekwin district on factors influencing the uptake of long acting reversible contraceptives among women at primary healthcare clinics where religion was significantly associated with their uptake (Nhlumayo, 2017). In India a study was done and results showed that 19.8% of participants rejected IUCD use as a contraceptive because of religious beliefs (Gonie *et al.*, 20216). Mishra *et al.*, (2018), had similar findings where 24.4% of women of reproductive age among the study population stated religious beliefs as the reason behind not accepting IUCD in Odisha, India.

Majority of the participants reported that spouse would allow them use IUCD. In a true African society men are the sole decision makers when it comes to family issues as they are the heads of the families. This means that in places where men are against use of such family planning methods, it is difficult for their wives to use them. There was a significant statistical association between being allowed by the spouse to use IUCD and its uptake. The results were inconsistent with another study done in an urban setting in Uganda which revealed that acceptability of IUCD use for family planning by spouses of men was the major reason for non-acceptance (Tusiime, 2014). A study done in Nepal by Khatri *et al.*, 2016 showed that 48.25% of participants were unwilling to use IUCD due their husband's opposition. Nearly all of the participants who reported partner opposition did not use the device (Melissa *et al.*, 2012).

The findings revealed that majority of the respondents reported that myths and misconceptions affected IUCD usage. This has proven to be a major barrier when it comes to IUCD usage. There exists misperceptions and gossips about IUCD usage in our communities and their associated effects. The results were similar to another study done on use of long acting reversible contraceptives to reduce the rate of teen pregnancy where it was revealed that myths and misconceptions remains the common reported barrier for low IUCD utilization (Rome, 2015). However, there was no existence of a significant statistical association between myths and misconceptions and uptake of IUCD among respondents. This means that myths and misperceptions plays an indirect role on IUCD usage among respondents. According to May *et al.* (2011) knowledge of the IUD in many countries is relatively high compared to knowledge of any modern method but the key barrier hampering demand at the consumer level is the prevalence of misinformation and frightening negative myths and rumors about its use, combined with a lack of knowledge about the method's benefits.

CONCLUSIONS

The study findings revealed that there was low utilization of IUCD in Teso north sub county health facilities by women of reproductive age. However, its utilization was slightly above the national average but at the same time lower than the global rate. Culture/religion, reception at the facility, information on family planning and spousal recommendation were the main barriers to IUCD utilization in Teso north among others.

RECOMMENDATIONS

National/county government

1. The national /county governments should invest heavily in health promotion activities aimed at addressing existing myths and misconception regarding IUCD utilization
2. The national/county governments should provide a platform for demand creation on the use of IUCD

Service providers should;

1. Encourage male involvement in maternal health care services to address barriers associated with utilization of IUCD in Teso north sub county
2. Use all platforms including social media, radio, churches, chief's barazas to create awareness regarding IUCD as a form of family planning to clear existing myths and misconception.
3. Use community health promoters in creating demand for IUCD utilization in the community
4. Have a positive attitude towards all clients seeking utilization of any health service to make services attractive to users.
5. Discuss IUD when counselling all FP clients and allay fears concerning IUD with proper counselling and accurate information.

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