

ORIGINAL RESEARCH ARTICLE

Barriers and facilitators influencing utilization of intrauterine contraceptive device (IUCD) in Zimbabwe

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Abstract

IUCD (Copper-T) is a safe, effective and long-acting reversible contraceptive and its uptake in Zimbabwe is currently less than 1%. Interventions to improve the uptake of IUCD require evidence on key factors contributing to its low uptake. The study was conducted to identify the gaps and offer opportunities for evidence-based family planning aimed at improving demand for IUCD, supply-side conditions, and influencing attitudes towards IUCD. A descriptive qualitative study design was conducted to explore and understand the perceptions of 169 women, 22 men, 16 community leaders and 20 health care providers regarding the use of IUCDs (Copper-T). In-depth interviews, Key informant interviews and focus group discussions with IUCD users, former IUCD users, and users of modern contraceptives (15-49 years) and men were conducted. Rural women showed reluctance to use IUCD because of myths, misconceptions and fears associated with the method which include barrenness, cancers, birth deformities and pregnancy complications. Negative community perceptions, dominant social norms, religious and socio-cultural beliefs, limited awareness of IUCD among men and weak health service delivery platforms were the major barriers to IUCD uptake in Zimbabwe. Evidence-based strategies on demand generation, supply-side interventions, advocacy and communication for development (C4D) are crucial in improving the uptake and provision of IUCD in Zimbabwe. (*Afr J Reprod Health* 2023; 27 [1]: 13-21).

Keywords: Contraception use; intrauterine contraceptive device (IUCD); long-acting reversible contraceptives (LARCs); family planning; reproductive health

Résumé

L'IUCD (Copper-T) est un contraceptif réversible sûr, efficace et à longue durée d'action et son adoption au Zimbabwe est actuellement inférieure à 1 %. Les interventions visant à améliorer l'utilisation du DIU nécessitent des données probantes sur les principaux facteurs contribuant à sa faible utilisation. L'étude a été menée pour identifier les lacunes et offrir des opportunités de planification familiale fondée sur des preuves visant à améliorer la demande de DIU, les conditions du côté de l'offre et à influencer les attitudes à l'égard du DIU. Une étude qualitative descriptive a été menée pour explorer et comprendre les perceptions de 169 femmes, 22 hommes, 16 dirigeants communautaires et 20 prestataires de soins de santé concernant l'utilisation des DIU (Copper-T). Des entretiens approfondis, des entretiens avec des informateurs clés et des discussions de groupe avec des utilisateurs de l'IUCD, d'anciens utilisateurs de l'IUCD et des utilisateurs de contraceptifs modernes (15-49 ans) et des hommes ont été menés. Les femmes rurales ont montré une réticence à utiliser le DIU en raison des mythes, des idées fausses et des peurs associées à la méthode, notamment la stérilité, les cancers, les malformations congénitales et les complications de la grossesse. Les perceptions négatives de la communauté, les normes sociales dominantes, les croyances religieuses et socioculturelles, la sensibilisation limitée au DIU parmi les hommes et la faiblesse des plateformes de prestation de services de santé étaient les principaux obstacles à l'adoption du DIU au Zimbabwe. Les stratégies fondées sur des données probantes sur la génération de la demande, les interventions du côté de l'offre, le plaidoyer et la communication pour le développement (C4D) sont essentielles pour améliorer l'adoption et la fourniture de l'IUCD au Zimbabwe. (*Afr J Reprod Health* 2023; 27 [1]: 13-21).

Mots-clés: Utilisation de la contraception; dispositif contraceptif intra-utérin (IUCD); les contraceptifs réversibles à longue durée d'action (LARC); planification familiale; la santé reproductive

Introduction

Intrauterine Contraceptive Device (Copper-T) is a safe, effective and long-acting reversible

contraceptive method in which 14.3% women aged 15-49 globally, in marriage or in union are using IUCD. In Sub-Saharan African countries, Zimbabwe has one of the most successful family

planning programs¹. The trends in contraceptive choice in Zimbabwe highlight the increase in the use of modern contraceptive methods matching with the marked increases in contraceptive prevalence rate (CPR)².

Approximately 66% of women currently married or in union are using a modern contraceptive method in Zimbabwe. The Pill remains the commonly preferred modern contraceptive method (41%) followed by Injectable (10%) and Implants (10%). Only 0.4% of women aged 15-49 in marriage or union use IUCD, and thus reflecting extremely low uptake and utilization of IUCD³. The poor uptake of IUCD, a long-acting reversible contraceptive method with long-term impact on spacing and limiting the number of births, remains a concern in Zimbabwe. The IUCD is a safer and effective method of contraception than short-term methods (Oral Pills, Condoms and Injectable) which are predominantly used in the country.

IUCD has proved to have several benefits. It offers medium to long-term contraception (5-10 years of protection) but also provides short-term protection against pregnancy. After initial insertion, it hardly requires attention on the part of the user and does not depend on daily action or monthly action for effectiveness, and thus resulting in low failure rate. It is appropriate for all women of reproductive age (15-49 years, including adolescents and young women) and any parities⁴. Users can immediately return to fertility after its removal and it is very effective (99%), inexpensive, cost effective family planning method⁵. Despite these benefits, IUCD remains extremely under-utilized in Zimbabwe, and therefore the need to qualitatively explore and describe factors affecting its uptake taking into account factors at individual, community, socio-cultural environment, institutional, and health system levels⁶.

The number of children per woman is 4.3 (total fertility rate) with an unmet need for family planning (10.4%) in Zimbabwe³. The proportion of adolescents and young women who have begun childbearing below the age of 18 remains high at 108/1000 women. All these factors contribute towards high maternal mortality. Thirty-three percent of married women in Zimbabwe do not use a method of contraception. All these factors reflect huge gaps in family planning interventions and poor uptake of long-term contraception, reversible

methods or long-acting methods (LARCs) given that only 0.4% and 10% of women of reproductive age (15-49 years) use IUCD and Implants respectively³. Such low uptake of IUCD and the unmet need for contraception among married women indicate demand-side and supply-side challenges and barriers towards the uptake of IUCD. Other studies in the African context show that the low uptake of IUCD is commonly driven by barriers⁷ and contextual influences such as geographical characteristics, community-level cultural beliefs, the presence and quality of reproductive health services, transport routes and modalities, household and individual-level factors, and institutional factors⁸. In addition, fears, misconceptions, misinformation, lack of accurate information, side-effects, socio-cultural and religious beliefs and practices have been associated with low uptake of IUCD^{9,10}. Despite the evidence in other African countries, little is known in terms of factors influencing low uptake and utilization of IUCD among women and men of reproductive age (15-49 years) in Zimbabwe⁹. Therefore, a study was conducted to explore why IUCD uptake is low and to describe the factors influencing low utilization of IUCD in the selected study sites.

The evidence generated through this study seeks to strengthen understanding of reasons for low utilization of long-term, reversible methods of contraception as well as identify demand-side and supply-side factors influencing use of IUCD: users' perceptions, service providers and health professionals-related issues, community dynamics, socio-cultural and religious factors and institutional arrangements for family planning service delivery (especially IUCD and Implants). Such evidence strengthens interventions that seek to increase use of IUCD, empower women's contraceptive choices within the long-term contraceptive method mix, and improve demand-generation and family planning service delivery.

Methods

Sampling and data collection

This study was conducted in purposively selected six provinces, Harare, Bulawayo, Manicaland, Mashonaland Central, Matabeleland North, and Masvingo and in 6 districts one from each province. The specific sites at sub-district level were

Table 1: Study sites, type and number of interviews and focus group discussions

Province	District	Key Informant Interviews	Focus Group Discussion	In-depth Interviews
Bulawayo	Bulawayo urban	3	1	6
Mat. North	Bubi	3	4	6
Manicaland	Mutare Rural	2	2	6
	Buhera	2	2	3
Masvingo	Masvingo	2	2	7
	Chiredzi	2	2	4
Mash. Central	Mt. Darwin	2	4	8
Harare	Harare Urban	4	1	6
Service Provider Sites (PSZ, PSI, ZNFPC, MoHCC)		10		
Total		30	18	46

determined by their proximity to a health facility (catchment areas within 5 kilometers), their distance further away from a health facility and main roads (to ensure coverage of areas without easy access to the facility), and opportunities to understand religious and socio-cultural issues, and institutional arrangements in family planning (especially Implants and IUCD) programming. Participants were selected through purposive sampling in both rural and urban areas, and data collection was conducted over a two-month period. A total of 191 participants were interviewed with 115 participating in FGDs and 76 interviewed as KII and IDIs. The participants were grouped into six categories: (1) 131 women of reproductive age 15-49 years (excluding un-emancipated minors); (2) 27 women who are current and past users of IUCD; (3) 22 men aged 15-49 years (excluding un-emancipated minors); (4) 8 religious and traditional leaders; (5) 5 community cadres and leaders (village health workers, community-based distributors, behavior change facilitators, traditional birth attendants); and (6) 17 health professionals and family planning service providers. Data was collected using in-depth interviews and focus group discussions with community members, and key informant interviews with health professionals, family planning providers, community cadres and religious and traditional leaders. Interviews and FGDs with community members, religious and traditional leaders were conducted by an interviewer and the moderating team (facilitator and note-taker) of the same gender as the participants. Participants for FGDs were recruited across several settings using health workers at health facilities including hospitals, family planning and postnatal care clinics and community members who assisted the research

team in visiting women, men and community leaders at community centers, churches, and homes. The semi-structured interview guides contained questions covering relevant themes / topics. Interview guides were specific to health care providers, community leaders, and male partners however covering similar topics, with variations in some questions to gain unique perspectives from the different interviewee categories. Table 1 summarises the sampled provinces, districts and participants in each province.

Data analysis

The in-depth interviews, key informant interviews and focus group discussions materials (digital audio recordings and field notes) were fully transcribed and translated from local language to English. This initial analysis condensed the information into categories as part of the coding process. The categories were then abstracted into sub-themes, and ultimately into key themes. The typed English transcripts (in MS Word) were entered into NVivo 10 (qualitative data analysis software) for coding and analyzing the data as well as identifying patterns. The coding classified data into key categories and recurrent themes related to contraceptive use, experiences, fears and misconceptions, barriers and facilitators of IUCD uptake. Illustrative quotes were selected to reinforce the analysis. Socio-demographic characteristics were described using frequencies and percentages

Limitations

Non-random sampling was adopted, and therefore places limitations on generalizability of the findings.

Ethical consideration

All study participants gave written informed consent as per Medical Research Council of Zimbabwe (MRCZ) study approval requirements. The rights of the participants were upheld, confidentiality and anonymity ensured. Permission to record interviews and FGDs on digital audio recorders was sought. The research protocols (proposal, consent forms and data collection tools) were reviewed and approved by MRCZ. Permission to conduct the study was also granted by the Ministry of Health and Child care in Zimbabwe.

Results

The modal age group for the women was the 25-29 years, the same age for men constituted 31.8%. The majority of the participants were residents in rural areas and had secondary education. Most of the respondents were affiliated to apostolic sect religion (both men and women). The majority of female and male participants had 1-2 children (Table 2).

The majority of the key informants were registered nurses (80%), and others were Family Planning Specialists, General Medical Practitioner, Obstetric and Gynecologist, etc. Approximately 50% of the key informants stated that they had excellent knowledge of IUCD while 35% claimed to have good knowledge. Only 15% of the key informants rated their knowledge of IUCD as fair.

Participants' knowledge of contraception

The majority of the community members (95%) who participated in this study were aware of modern contraceptive methods, and knew at least four methods commonly the Pill, Depo Provera (injectable), Jadelle (Implant), and condoms. Participants were able to identify modern methods (short-term and long-acting methods) and other natural methods – Lactational Amenorrhea, withdrawal, and rhythm or 'safe period', herbs and abstinence with tubal ligation and vasectomy mentioned by a few community members.

Four main themes

Four main themes were identified from this qualitative study which covers factors affecting low use of IUCD in Zimbabwe as shown in Table 3.

Fears, myths, rumors and misconceptions: The negative impressions on IUCD were largely driven by fear, which was generally based on myths, rumors and misconceptions. The common fears, myths, rumors and misconceptions about IUCD shared by participants were that IUCD led to cancers, fibroids and uterus decay given that the Copper-T IUCD corrodes, rusts or decays in the body,

“That gold thing which they insert inside the womb is the one that causes Cancer. Where else can it go when it dissolves? That is what they said causes Cancer” (BUH_Muyangirwa Village_IDI LAM User_TL)

IUCD causes infertility, and a woman may never regain fertility after using it. Men cited that IUCD interferes with sex as it, pricks the penis during sex.

“In our Shona culture, the elders can say the issue of waiting for 10 years on a family planning method (loop), with that thing; you can fail to conceive...because they say it can affect your system” (MAS_Urban-Runyararo_IDI_IUCD User_TT)

Side-effects: Participants (women) regard heavy bleeding during menstrual cycle, cramps post-IUCD insertion, and vaginal thrush as serious reasons they prefer not using IUCD. Some of the respondents stated that IUCD caused weight gain and continuous bleeding while others felt that “a surgical procedure was required to insert the IUCD in the womb”. Vaginal thrush, vaginal infections and cramps for a day up to few weeks' post-IUCD insertion. **Lived experiences of current and past IUCD users:** Past IUCD users cited that their husbands complained about IUCD strings pricking them or coiling their penis, partners disapproved the contraceptive method, and had conflicts with partners over IUCD insertion as it caused pelvic inflammatory diseases. Peers, community leaders, relatives, and in-laws were the informal, often inaccurate information networks who misinformed the participants, and their perceptions regarding IUCD.

Community influences, values and social norms: Traditional and Apostolic religious leaders interviewed in this study labeled women who use IUCDs and modern family planning methods as witches, murderers and “women of loose morals”.

Body politics, Reproductive system and Contraception: Both traditional and religious leaders highlighted that the IUCD “disrespects” the

Table 2: Socio-demographic characteristics of women and men (community members)

Variable	Female participants age 15-49yrs N=169		Male participants age 15-49 years N=22	
	%	Number of women	%	Number of men
Age category				
15-19	4.7	8	-	-
20-24	22.5	38	9.1	2
25-29	29.0	49	31.8	7
30-34	18.9	32	27.3	6
35-39	18.3	31	18.2	4
40-44	4.1	7	13.6	3
45-49	2.4	4	-	-
Marital Status				
Single (Never married)	6.5	11	9.1	2
Married	84.0	142	86.4	19
Divorced	5.3	9	-	-
Widowed	.6	1	-	-
Separated	3.6	6	4.5	1
Place of residence				
Urban	41.4	70	36.4	8
Rural	58.6	99	63.6	14
Highest level of education				
No education	-	-	4.5	1
Primary	21.9	37	22.7	5
Secondary	64.7	108	45.5	10
Higher	5.4	9	4.5	1
Tertiary	7.8	13	22.7	5
Religion				
Traditional	1.8	3	13.6	3
Catholic	6.5	11	4.5	1
Pentecostal	29.8	50	13.6	3
Protestant	17.3	29	18.2	4
Apostolic sect	40.5	68	50.0	11
Muslim	.6	1	-	-
None (No religion)	3.6	6	-	-
Number of children				
None	7.1	12	13.6	3
1-2	53.6	90	59.1	13
3-4	32.7	55	18.2	4
5+	6.5	11	9.1	2

woman's reproductive system through the insertion of a "foreign object". Due to their objections to IUCD, the religious and traditional leaders strongly recommended the use of withdrawal method, Lactational amenorrhea and abstinence **Culture and Religion:** In both Shona and Ndebele culture / traditions, the use of contraceptives, especially LARCs is shunned since it is perceived as a cause of infertility, cancers, pregnancy complications and birth defects. Young women and those without children are also forbidden from using IUCD, and the 5-10 years of LARCs' potency are viewed as undermining a women's capacity to naturally bear as many children as possible. **IUCD use and sexual relations:** Current and former IUCD users who participated in the study expressed concerns that

their partners / husbands complained about the strings interfering with sex, and that the side-effects related to IUCD also affected their sexual relations hence partners / husbands disapproved the use of IUCD. **Views on women's' fertility behaviour and reproductive relationships:** The community fertility norm as highlighted by traditional leaders reflected that a woman was not expected to use contraceptives before she got married and had had at least one child to prove her fertility upon marriage. **Male decision-making and contraceptive use:** The findings demonstrated gender norms in fertility behavior, reproductive decision-making and contraceptive use. The role of men in family planning decision-making was embedded in culture (tradition) and religion, which

Table 3: Four main themes and barriers to IUCD uptake in Zimbabwe

Theme	Categories
Fears, myths, rumors and misconceptions	<ul style="list-style-type: none"> • Fears, myths and rumours • Side-effects • Lived experiences of current and past IUCD users • Misconceptions and sources of misconceptions
Community influences, values and social norms	<ul style="list-style-type: none"> • Culture and religion • Views on women's fertility behaviour and reproductive responsibilities • IUCD use and sexual relations • Body Politics, Reproductive System and Contraception • Male decision-making and contraceptive use • IUCD and Gender-based violence • Access to health care and family planning services
Women's empowerment, agency and contraceptive choices	<ul style="list-style-type: none"> • Decision making around family planning and contraception • Women's ability to act (women's' agency) • The burden to take care of children in the context of economic hardships.
Health care providers (HCP)-level factors	<ul style="list-style-type: none"> • Inadequate client counselling IUCD (Loop) by service providers / health professionals • Skills gaps related to IUCD insertion and removal among HCPs • Supplies, logistical and human resource challenges in IUCD provision • User fees and service-related expenses • Institutional configuration of IUCD service delivery

asserted a husband as the head of the household and subjugated to their decisions and authority. Therefore, male dominance in decisions related to family planning and contraceptive use was identified by both women and men in the study communities. **Access to health care and family planning services:** In rural study communities, the majority of the health facilities were not providing IUCD insertion and removal, and did not have qualified and trained staff for IUCD-related services. The urban centers (Bulawayo, Harare, Masvingo, and Mutare) sampled in this study had facilities and service providers offering IUCD-related services, which enabled access to IUCD services.

Women's empowerment, agency and contraceptive choices: In strong patriarchal societies, women are often not included or marginally included in decision-making around family planning and contraception. The women have to consult with their husband before deciding to use family planning, which contraceptive method to use, when to start and stop as well as the number of children to have. Women's agency in contraceptive use has also been driven by a growing realization of the burden to take care of children falling squarely on the woman especially in the context of economic hardships. Hence, they act to space and limit the number of children by utilizing LARCs secretly.

"However, as a woman who can reason, you will realize that children are not getting enough food to satisfy them. You are impoverished, you are failing to meet the needs of your children. You can go and get it secretly. It is not visible that one has a Loop. You just tell your husband that you are taking Pills whilst you are throwing them away. When you try, and fail to get pregnant, you just tell him that I have failed to get pregnant, the womb is not being receptive..." (MTD_Chitonho Village_FGD Women_TT_JJ)

"Just go and have a Loop inserted secretly. Most of us here have Jadelle and most of the men don't even know about this. The husband doesn't have time to scrutinize you in order to see how things are. You just realize that we now have many children" (MTD_Chitonho Village_FGD Women_TT_JJ)

Health care providers (HCP)-level factors: Inadequate client counselling on IUCD (Loop) by service providers / health professionals: This was highlighted by female participants who revealed weaknesses in family planning counseling and IUCD-related services since most health facilities do not offer IUCD insertions. Some HCPs discouraged women to use the method. **Skills gaps related to IUCD insertion and removal:** HCPs and family planning staff at health centers were not trained in IUCD insertion and removal while others

lacked the experience in these services. Even some HCPs commented that while they had received IUCD-related training, they lacked practical experience to confidently insert IUCD. In all the rural study sites, not a single health facility offered IUCD services as part of their care package except when there was an outreach by mobile team from other service providers. ***Institutional configuration for IUCD services:*** The health facilities do not have a dedicated room that has all the necessary equipment.

Discussion

The evidence revealed that barriers and facilitators of IUCD are situated at the various socio-ecological levels, and therefore it is imperative to address the challenges in these multiple layers. In applying the Socio-Ecological Model (SEM)¹¹, the study was able to examine the multi-dimensional aspects of reproductive health seeking and contraceptive behavior regarding IUCD, and placing action within a social context. IUCD use among women is “shaped less by individual behavior and more by the wider environment in which people live and make choices, influenced by family, peers, local beliefs and values, cultural norms and practices and political and economic circumstance”¹¹. In addition, policy / legal frameworks and institutional structures (health systems and infrastructure, supplies among others) affect the use of IUCD.

IUCD services are relatively more accessible to women in urban areas than in rural areas as most rural health facilities are not well equipped with the suitable infrastructure. Similarly, a study by PSI Zimbabwe shows that “rural women are comparatively more disadvantaged than urban women” and they are often the “most vulnerable to unwanted and unplanned pregnancies”⁹. The 10 years potency / efficacy of IUCD demonstrates that once it is inserted one should not expect to be fertile during that period.

IUCD is often treated with suspicion and feared by non-IUCD users as short-term methods and traditional methods such as withdrawal, rhythm and use of herbal medicines are regarded as safer family planning methods in the communities. In general, fears, myths and misconceptions about LARCs including IUCD seemed to influence rural women’s preference of the Pill and traditional family planning methods. In African patriarchal

communities, the cultural reproductive duty of a woman is to bear as many children as possible to enlarge the family and clan. Therefore, modern contraceptives including IUCD were discovered to be contrary to the reproductive duty of women in marriage. Early use of modern family planning methods was viewed as a taboo and the cause of barrenness, hence nulliparous women were discouraged from using modern contraceptives, and women are supposed to prove their fertility potential as soon as they get married¹⁰. The views of religious values and beliefs from religious and traditional leaders do oppose the use of IUCD as this is regarded as murder, sin and an act against God’s will. These results concur with other studies that revealed religious objections to modern family planning methods among the Apostolic religious sect¹²⁻¹⁴. ‘African’ culture emphasizes giving birth to as many children as possible and the apostolic sect doctrine and beliefs state that women should give birth to as many children as “divinely possible”¹⁵, and they use biblical texts and traditional folklores to substantiate these fertility norms. This results in women from religious sectors and traditional religion shunning the use of IUCD as a method of contraception. Others also argued that contraceptive use is limited by the “cultural belief of most of these women that God has placed Children in the womb of a woman and until they are given birth to, you do not stop”¹⁶. Such pro-natalist religious and cultural beliefs and values discourage the use of IUCD, and largely promote natural contraceptive methods in an effort to manage fertility¹⁷⁻¹⁸. The influence of culture on contraceptive use and reproductive health is well documented by^{8,10,16,18-19}. The broader fears have to be understood in the social context within which African women are raised and the strong socialization that their reproductive system is sacred and belongs to a man upon marriage. Most myths, misconceptions and fears are being driven by lack of knowledge and misinformation from service providers who lack knowledge about IUCD. Health care providers (HCPs) fail to increase uptake of IUCD among women of reproductive age, they do not emphasize the advantages - safety, efficacy and reversibility - of IUCD, through comprehensive counseling and dispelling fears, myths and misconceptions related to the contraceptive method. Concerns regarding the effects of IUCD on sexual relations have to be addressed in context

recognizing the social consequences of poor sexual relations on women or IUCD users. These results also concur with other findings⁶. When men complain about their sexual relations being affected due to the perceived effects and women's experience with side effects, then IUCD discontinuation and lack of uptake of IUCD are likely. Consequently, social norms on fertility behavior and the social construction of gender identities of manhood / masculinity as well as womanhood / femininity are critical to the understanding of the impact of these fears, myths and misconceptions on use of IUCD.

Social and male disapproval of the contraceptive method in determining the choice and use of modern contraceptives contribute to low use of IUCD unless when women decide to use the contraceptives secretly⁹. Threats of violence, gender-based violence, harassment by in-laws, disruptions of sexual relations, social labeling, coercive removal of IUCD and implants, and abandonment may discourage use of IUCD. In contrast, evidence highlighted that male who had adequate information on IUCD as well as good interpersonal communication with their female partners were more receptive to IUCD.

Despite social disapproval and objection of the use of IUCD, some women use these methods secretly. Women who use IUCDs empowered themselves to deal with the demands of child bearing, limited socio-economic opportunities, and effectively spacing their children in ways that enable them to pursue their life goals and household security as well as have improved sexual relations with their partners and they have become facilitators of IUCD use. Women recognized that the burden of caring for children rested squarely on them, and IUCD enables them to mediate the impact of economic hardship, and hence the need to exercise control over fertility through safe, effective long-term reversible contraceptive methods. It is therefore not surprising that some of the women choose to use IUCDs secretly as an act of personal/women's empowerment in a context of social disapproval²⁰.

Conclusion

It is therefore imperative that low cost innovations and strategies to increase access to contraception especially IUCD among women of reproductive

age should be strengthened, and access to SRHR information be improved as well to clarify misconceptions on contraception issues. This will have a positive impact on reducing unwanted pregnancies, unsafe abortions, child mothers, child and teenage marriages, and maternal morbidities and mortality. The gaps in family planning counseling, lack of comprehensive counseling on IUCD, and scarcity of trained, skilled and experienced HCPs, in IUCD services, and negative attitudes of HCPs towards IUCD should be addressed. When HCPs do not prioritize IUCD as a viable contraceptive option, the uptake of the method will remain low. It is imperative that knowledge, attitudes and practices (KAP) of HCPs be examined, and examine the extent to which these depart from the Family Planning Guidelines for Zimbabwe. There is need to strengthen HCPs capacity for IUCD service provision in the country. Evidence-based strategies on demand generation, supply-side interventions, programming, advocacy and communication for development (C4D) strategies are crucial in improving uptake and provision of IUCD in Zimbabwe. Generally, uptake of modern contraceptives is socially and culturally nested, and largely influenced by myriad of individual, socio-cultural and religious, community, and institutional factors. Hence, there is need to understand the socio-ecological context of family planning, modern contraceptive use and reproductive health behavior in order to fully appreciate uptake of IUCD in the country.

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Authors contribution

Authors in this study contributed immensely from research design up to the analysis and report

writing. The authors were all members of the technical advisory team providing technical guidance on the study processes. The first author (Mercy Marimirofa) is the writer of this paper. Dr Munyaradzi Murwira was the principal investigator to the study.

References

1. Ngome, Enock and Odimegwu C. The social context of adolescent women's use of modern contraceptives in Zimbabwe: A multilevel analysis. *Reprod Health*. 2014;11(1):1-14. doi:10.1186/1742-4755-11-64
2. Sharan M, Soucat A, May, John and Ahmed S. Family Planning Trends in Sub - Saharan Africa: Progress, Prospects, and Lessons Learned. *World Bank*. Published online 2009:445-469.
3. Indicators K. Zimbabwe Demographic and Health Survey. 2016;(May).
4. Van Zijl S, Morroni, Chelsea and Van Der Spuy ZM. A survey to assess knowledge and acceptability of the intrauterine device in the Family Planning Services in Cape Town, South Africa. *J Fam Plan Reprod Heal Care*. 2010;36(2):73-78. doi:10.1783/147118910791069367
5. Khan, Amna and Shaikh BT. An all time low utilization of intrauterine contraceptive device as a birth spacing method- A qualitative descriptive study in district Rawalpindi, Pakistan. *Reprod Health*. 2013;10(1):1. doi:10.1186/1742-4755-10-10
6. Katz KR, Johnson LM, Janowitz, Barbara and Carranza JM. Reasons for the low level of IUD use in El Salvador. *Int Fam Plan Perspect*. 2002;28(1):26-31. doi:10.2307/3088272
7. Brunie A, Tolley EE, Ngabo F, Wesson, Jennifer and Chen M. Getting to 70%: Barriers to modern contraceptive use for women in Rwanda. *Int J Gynecol Obstet*. 2013;123(SUPPL.1):e11-e15. doi:10.1016/j.ijgo.2013.07.005
8. Stephenson R, Baschieri A, Clements S, Hennink, Monique and Madise N. Contextual influences on modern contraceptive use in sub-Saharan Africa. *Am J Public Health*. 2007;97(7):1233-1240. doi:10.2105/AJPH.2005.071522
9. Prevention M, Under C, Five A. TRaC Summary Report The PSI Dashboard. Published online 2008:1-18.
10. Herbert S. Social norms, contraception and family planning. *GSDRC Help Res Rep*. Published online 2015:1-15.
11. Joanna Busza, Damilola Walker, Alana Hairston, Alicia Gable, Christian Pitter, Stephen Lee, Leila Katirayi, Rogers Simiyu and Daphne M. Community-based approaches for prevention of mother to child transmission in resource-poor settings: A social ecological review. *J Int AIDS Soc*. 2012;15(Suppl 2):1-11. doi:10.7448/IAS.15.4.17373
12. Maguranyanga B. Apostolic Religion , Health and Utilization of Maternal and Child Health Services in Zimbabwe. *Unicef*. Published online 2011:1-74. http://www.unicef.org/zimbabwe/ZIM_resources_apostolicreligion.pdf
13. UNICEF. The Apostolic Maternal Empowerment and Newborn Intervention (AMENI) Model: Improving Maternal and Newborn Child Health Outcomes among. 2011;(13).
14. Machingura, Francis and Nyakuhwa P. Sexism: A Hermetical Interrogation of Galatians 3: 28 and Women in the Church of Christ in Zimbabwe. *J Pan African Stud*. 2015;8(2):92-113. <https://ezproxy.southern.edu/login?qurl=http%3A%2F%2Fsearch.ebscohost.com%2Flogin.aspx%3Fdirect%3Dtrue%26db%3Da9h%26AN%3D108372599%26site%3Dehost-live%26scope%3Dsite>
15. Nyongesa, Paul and Odunga J. 'Contraceptive Use in Sub-Saharan Africa: The Sociocultural Context',. *Int J Public Heal Res*. 2015;3:336-339.
16. Obasohan PE. Ijma-3-63. *Int J Matern child Heal AIDS*. 2015;3(1):63-73.
17. Williamson LM, Parkes A, Wight D, Petticrew, Mark and Hart GJ. Limits to modern contraceptive use among young women in developing countries: A systematic review of qualitative research. *Reprod Health*. 2009;6(1):1-12. doi:10.1186/1742-4755-6-3
18. Ejembi CL, Dahiru, Tukur and Aliyu A. Contextual Factors Influencing Modern Contraceptive Use in Nigeria. *DHS Work Pap*. 2015;120(September):44. doi:10.13140/RG.2.1.1719.5923
19. Makinwa-Adebusoye P. 'UN / POP / PFD / 2001 / 2 ENGLISH: ONLY , 9-11 July 2001 SOCIOCULTURAL FACTORS AFFEC',. *Work Prospect Fertil DECLINE HIGH Fertil Ctries Popul Div Dep Econ Soc Aff United Nations Secr New York*. 2001;2:2-16.
20. Lwelamira J, Mnyamagola, G and Msaki MM. Knowledge, Attitude and Practice (KAP) Towards Modern Contraceptives Among Married Women of Reproductive Age in Mpwapwa District, Central Tanzania. *Curr Res J Soc Sci*. 2012;4(3):235-245.