IUDs: Increasing Women's Option

A Study to Provide the Basis for IUD Promotion

The Reproductive and Child Health Alliance (RACHA)

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IUDs: Increasing Women's Options
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Introduction

This report presents the results of investigating the knowledge, attitudes, beliefs and practices (KABP) related to IUDs. The study forms part of an activity to develop “Accredited Centres of Excellence” (ACE) in birth spacing services; it forms the basis of a marketing strategy to promote IUDs as a birth spacing option.

Research results will be used to identify messages and specific target audiences and to select the most appropriate channels to achieve communication and programme objectives.

The study was conducted by the Reproductive and Child Health Alliance (RACHA) in four health centre catchment areas - Trapeang Sala HC in Angkor Chey OD and Krang Ampil HC in Kampot OD, Kampot province; Kravangh HC in Sampouv Meas OD, Pursat province; and Pourk HC, Siem Reap OD, Siem Reap province.

Research Objectives

In order to design a client-oriented marketing and promotion focused program, the prime objective was to identify and describe the knowledge, attitudes, behaviour and motivations relating to IUDs, of women of reproductive age in the three areas identified (above) for intervention. In addition, the study investigated the key factors affecting acceptance and use of IUDs as a longer-term method; and it attempted to explore obstacles and anticipate factors that may affect the decision to adopt the IUD as a birth spacing method.

In order to identify the factors that influence satisfaction with a new service and method, it was decided that the study should not only investigate potential clients, but also current IUD users. Including current users in the study provides an insight into the motivation and decision-making process of successful users. This is important in communities where rumours and misinformation about methods are rife, and where dropout rates are high. How users coped with rumours and side effects, why they decided to continue despite side effects etc., offers important information that can be used to help convince others that IUDs are a viable, safe and effective method. The study, therefore, included a cross section of married women of reproductive age.

Lastly, the study aimed to form a relationship with satisfied IUD users. RACHA hopes to have them cooperate with promotional efforts to improve social acceptability and decrease social barriers to IUD use, making it easier for others to choose IUDs in the future.

Topics Under Investigation

In order to achieve the above research objectives, the study examined the following:
Focus Group Discussions (non-IUD users)

- Knowledge of birth spacing and modern Birth Spacing methods;
- Motivation and intention to practice birth spacing;
- Experience of Birth Spacing method use (including IUD);
- Knowledge about the IUD, and possibility/likelihood of adoption;
- Attitudes to service provision;
- Sources of information/channels of communication.

Interviews (IUD users)

- Motivation for IUD use;
- Experience and satisfaction with IUDs;
- Community beliefs about IUDs;
- Location of IUD insertion sites.

Methodology

Focus group discussions and in-depth interviews were used to collect qualitative information about the above issues. In order to capture a cross section of rural women, a total of 18 FGDs were conducted with three different groups of women in Trapeang Sala, Kravangh and Pourk HC catchment areas, as follows:

- **Group 1** - younger married women who have not yet had their desired number of children (who may or may not be using a Birth Spacing method);
- **Group 2** - married women who don't want more children and are using a Birth Spacing method;
- **Group 3** - married women who don't want more children and are not using a Birth Spacing method

In-depth interviews were also conducted with a total of 16 IUD users in Krang Ampil, Kravangh and Pourk health centre catchment areas, as follows:

<table>
<thead>
<tr>
<th>HC Catchment Area</th>
<th>Number of Focus Group Discussions</th>
<th>In-depth Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1 (Number of women)</td>
<td>Group 2 (Number of women)</td>
</tr>
<tr>
<td>Trapeang Sala, KPT</td>
<td>2 (22)</td>
<td>2 (18)</td>
</tr>
<tr>
<td>Krang Ampil, KPT</td>
<td>2 (19)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Kravangh, PST</td>
<td>2 (18)</td>
<td>2 (21)</td>
</tr>
<tr>
<td>Pourk, SR</td>
<td>6 (59)</td>
<td>6 (59)</td>
</tr>
<tr>
<td>Total Groups</td>
<td>6 (59)</td>
<td>6 (59)</td>
</tr>
</tbody>
</table>
**Respondent Recruitment**

Initial meetings were held with chiefs of the 3 selected health centers to determine the population of villages, and information about Birth Spacing method use in the catchment area. The research team then selected and visited 6 villages within each catchment area, based on population size and distance from each other, to ensure a cross section of women.

The chief of each village was asked to make a list of women in the village who met certain criteria (age, education, number of children, BSM use). Between 8-12 participants (of similar age and background) were then chosen from each list. The women were visited and invited to join a Focus Group Discussion in the village.

After obtaining information about IUD users from the Health Centre, those women were located and asked to participate in the study.

**Data collection**

A FGD semi-structured guide and an in-depth interview guide defining the areas to be explored were developed and field-tested to check for appropriateness and to ensure that the desired information was obtained. The guides consisted mainly of open-ended questions, from which the facilitator could diverge to pursue an area in more detail. Questions were designed to be as open-ended and non-leading as possible, although in some cases structured and closed questions were used to investigate particular behaviors.

Data collection took place between December 4th, 2000 and January 19th, 2001. Each FGD consisted of a facilitator, a note-taker and between 8-12 participants. Each interview consisted of an interviewer and the interviewee. All FGDs and interviews were fully recorded on tape as well as on paper.
Results and Discussion

A. Data Collected from Focus Group Discussions with non-IUD users

The findings in this section are presented as summaries of statements regarding knowledge, practice, and belief from individuals and group discussions. Findings are presented by group:

- Young women who have not yet had their desired number of children (they are referred to as “Spacers”);
- Women who don’t want more children and are not using a Birth Spacing method (referred to as “Stoppers not using a method”);
- Women who don’t want more children and are using a Birth Spacing method (referred to as “Stoppers using a method”).

I. Understanding and Knowledge of Birth Spacing and modern Birth Spacing methods

The majority of participants from all groups understood that birth spacing helps prevent having children too close together, and that BSMs can help a family space their children. Nearly all respondents had heard about Oral Contraceptives (OCs), injectables, and condoms. Some Stoppers who were not currently using a method had also heard about voluntary surgical sterilization (VSC). Predictably, some Stoppers who are currently using a Birth Spacing method, had also heard of other methods, namely the IUD and Tubal Ligation, and few had also heard of Vasectomy, Norplant and the calendar method.

The most common source of information on these methods was from health workers, followed by radio, TV, neighbours and word of mouth.

Motivations and intentions to practice Birth Spacing

Most of the spacers, who were aged between 25 and 35 and had between 1-4 children, planned to have more children in the future, and were not sure when they would want to stop having children. The majority of these women realized that having children meant they would be kept busy looking after them, less time to focus on business and work, and increasing family costs. Others, however, said that having children was an investment for the future, as older children can help and look after their parents and family.

Among all the spacers (61), only 2 were using a modern Birth Spacing method, both OCs. Among spacers, previous method use was only slightly higher with 5 women having used the injectable, and 7 women having used OCs.

The Stoppers (both groups) in the study were aged between 30 and 40 years and had between 2 to 6 children. Reasons given for not wanting any more children included that looking after children kept them busy, affected their incomes, living standard, family and health. All Stoppers using a method were using either OCs or injectables, (and more women were using OCs than the injectable). Many of these women had previously used a method,
the majority of which had used injectables. In addition, two women had previously used an IUD, however had switched once OCs and injectables were available, because of a contraindication to the method. Nevertheless, both that had good experiences with IUDs, were still in good health and were able to work as normal, e.g. growing rice.

Among Stoppers not currently using a method, about a third had previously used a modern Birth Spacing method. Out of the total 59 women, 10 had previously used injectables, 6 were previous OC users, and one had used condoms.

Source of Birth Spacing Method

The Spacers, using a method, had obtained it from a private practice. Most Stoppers currently using a method had obtained it from a health center or market, and Stoppers who had previously used a method, had obtained it from a health centre and the private sector. Of the women who had, or were still using injectables, most had obtained the method at the health centre. The two previous IUD users had their IUDs fitted at the district hospital and private clinic for 30,000R.

Experience of Birth Spacing Method

The majority of OC and injectable users said they felt healthy and normal, although they had experienced side effects in the past. Most Dropouts complained of having experienced side effects during method use. Most injectable users said they had experienced vaginal bleeding, dizziness, palpitations, headache, weight gain or loss, and feeling hot. Similar side-effects were quoted for OCs, namely vaginal bleeding, headache, palpitations, hot urine, feeling hot, fatigue, irregular menstruation, weight loss or nausea. A few current users said they had never experienced any side effects whatsoever. Interestingly, the majority of current pill and injection users, who had received the service at the health center, said they now feel normal and are in good health.

In addition to the desire to have another child, real or perceived side effects were quoted by previous method users as being the reason for dropping out.

II. Knowledge about IUDs

A few questions were asked in order to assess knowledge about IUDs. The aim was to identify gaps in knowledge to ensure that women would be correctly informed about IUDs through ACE activities. The majority of Stoppers had heard about IUDs; only about half of the younger spacers had heard about IUDs. Most had heard about the IUD from health workers. However, some had heard from radio, television, word of mouth, other users, printed materials and from a village volunteer (Feedback Committee members or Birth Spacing volunteers). The vast majority of women knew the IUD was a long-term method. Most thought it could prevent a pregnancy for three years, while others said its effectiveness ranged from between one to eight years. The most widely used IUD in Cambodia (the TCu-380A, also known as the Copper-T) lasts for 10 years. Only 6 women were aware of this fact.
Side effects and Misconceptions about the IUD

Several studies in Cambodia have shown that satisfaction with a method is balanced with effectiveness, 'suitability' to a woman, and real and perceived side effects. When respondents were asked what they had heard about the health affects of the IUD, most women said they rarely heard rumours about IUDs. OCs and injectables were more popular and, therefore, more talked about nowadays. Nevertheless, those that had heard rumours about IUDs cited the following side effects, rumours, and perceptions (in order of frequency):

- Inability to work hard. This also implies the IUD is a 'rich woman's method' because rich women do not need to work hard and they have sufficient money to overcome side effects. In any case, IUD insertion is considered to be expensive;
- Inflammation, tumours or cancer of the uterus;
- Vaginal discharge;
- Vaginal bleeding;
- Chronic illness;
- Weight gain or loss;
- Fatigue;
- Hot in the body;
- Movement of the IUD around the body;
- IUD can rust in the body;
- Difficulty with next delivery or inability to have children after IUD removal.

Although the rumours cited above are very prevalent in Cambodia, the extent to which a woman believes these rumours will influence whether or not she will consider using an IUD. Therefore, in order to examine the perceived importance attached to these rumours, women were asked whether they believed what they had heard. The findings illustrate that the extent to which women did believe such rumours was directly linked to whether they had seen or heard of such experiences from IUD users, or from their own experiences. Most spacers and Stoppers said they did believe these rumours because they had seen or heard about such experiences from other users. Others did not believe them because they had not seen or heard of such experiences from users. Predictably, most of the women less inclined to believe the rumours were Stoppers currently using a method. Their disbelief was explained by their never having used an IUD and, therefore, not being able to see for themselves. Some even said they thought using an IUD would not affect a woman's health, and instead would keep her in good health.

Availability and Cost of IUD

The majority of women said they thought IUD services were available at public health facilities - the health centre, district hospital, or provincial hospital. A minority knew of service availability in the private sector. Though most women who knew IUD users did not know where they had obtained the service, the few that did said those women had had the IUD fitted at the district hospital, provincial hospital, in the private sector or in Phnom Penh.
IUD services are not currently available in the health centres where the study was conducted. While it is not clear what private providers are currently charging for IUD insertion (although IUD users in this study paid between 35,000 and 60,000R - see later section) current IUD fitting costs in other facilities in the areas are as follows:

Table 2: IUD insertion costs by location

<table>
<thead>
<tr>
<th>Location</th>
<th>IUD Fitting cost (Riel)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Sector</td>
<td>Private Practice*</td>
</tr>
<tr>
<td>Angkor Chey OD &amp; Kampot OD</td>
<td>6000</td>
</tr>
<tr>
<td>Kravangh, Sampouv Meas OD, Pursat</td>
<td>5000</td>
</tr>
<tr>
<td>Zone C, Siem Reap (in which Pourk is situated)</td>
<td>10,000</td>
</tr>
</tbody>
</table>

* Actual prices quoted by IUD users in this study

(Note: The figures quoted above for public sector facilities are supposedly standard prices, however in reality clients are paying more for the service - see section B on IUD users).

When asked how much they thought IUD insertion charges were, all were unsure of the exact costs and only a few women estimated costs. Of those who estimated, most perceived costs far off actual costs in public facilities. Most estimates tended to be fairly high, possibly reflecting what women had heard about private practice costs, and explaining why IUDs are perceived to be a method for the 'rich'.

A few Spacers and Stoppers, not using a method, estimated prices in private clinics ranging anywhere between 5000R and 351,000R ($1.28 - $90). Stoppers who are currently using a method (and are therefore more likely to know about service availability), estimated costs nearer to actual costs (between 5000R to 58,500R ($1.42 - $15).

All Stoppers currently using a method knew the correct cost of IUD insertion at a public health facility. (See also prices paid by IUD users in results of in-depth interviews, section B).

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1 IUD insertion prices differ within an OD, depending on how rural or urban a place is. In the provincial capital of Pursat (in Sampouv Meas OD) for example, IUD services cost 10,000R and approx. 50,000R in the public and private sectors respectively. OD, prices in both sectors are cheaper than those in the town (half price in the public sector).
III. Attitudes toward IUDs

Reasons for Non-IUD Use and Likelihood of Future Adoption

In an attempt to assess motivation for IUD use, women were asked why they were not using an IUD, and about the likelihood of considering the IUD in the future. Younger spacers most commonly replied they still planned to have more children in the future, and that they perceived no need for an IUD. Some thought they would not be able to afford an IUD, others feared affects on health, and were too embarrassed to get an IUD fitted. Only a minority of younger spacers said they would consider an IUD once they had had all the children they desired.

Stoppers (both users and non-users) mostly cited the perceived high cost of having an IUD fitted as a reason for not using the IUD, followed by feelings that an IUD would not suit them, a preference for other methods because of the embarrassment of having an IUD fitted, a perceived inability to do hard work, and a lack of knowledge about the method and its availability.

When asked whether they would consider using an IUD in the future, there were differences between the groups. Nearly all younger spacers, and about half of the Stoppers not currently using a method, said they would not consider using an IUD, (for the same reasons as quoted above.

Understandably, half of the Stoppers using a method, felt comfortable with the method. They were currently using (OCs and injectable) and, therefore, would not consider changing to an IUD. However, the remaining half of Stoppers using and not using a method said they would consider trying the IUD in the future because it is a long-term method, is cheap, and is an alternative choice to other methods. A few Stoppers using a method also said they would consider the IUD, because of a perceived lack of side-effects. Most women who said they would consider an IUD felt their husbands would approve of the method, while few said they would have to discuss it with them first.

Interestingly, and very important, in spite of the findings in the above two paragraphs, nearly all women then went on to say (unprompted) that if they saw or knew of more women using the IUD successfully and without bad experiences, they would be convinced and would do the same as those women. As 'method-clustering' is very common in rural Cambodia, this finding has important implications for the use of satisfied clients as a channel to spread the word about IUDs.

2 It is unclear whether this also included other Birth Spacing methods, although anecdotal feedback from the field suggests that women who have not yet had their desired number of children perceive no need for a Birth Spacing method until they want to stop having children, as opposed to using a method to space their children.
It is important to note here that an expressed consideration to use a method does not imply, and indeed should not be interpreted as, an actual intention to use the method. It is possible that respondents expressed a positive attitude in order to 'please' the facilitator. However it is also very likely that a particular group of women (Stoppers) would genuinely contemplate using an IUD.

**Perceptions about IUD-Users and Appropriateness of Method for Rural Women**

Bearing in mind that clustering of method-specific contraceptive use is common, the potential impact of involving and engaging satisfied users to advocate and promote a method is great. Women were asked what they thought about IUD users to establish how socially 'acceptable' the method was for other rural women like themselves. The majority of respondents knew of someone who had, or was using an IUD. Some knew of users who were healthy and still able to work as normal, while a few said the IUD users they knew experienced some of the symptoms mentioned above (section II).

When asked whether the IUD would be an appropriate option for other rural Cambodian women, most said 'yes', and there appeared to be a common attitude that 'it's alright for them, but not necessarily for me'. Reasons given for their perceived appropriateness of the method were similar to those given for why they themselves would consider the IUD - it is a long term method, an additional choice to other methods, and you don't have to remember to use it. It was reportedly also appropriate because the users they knew were still in good health, and some reported they would follow these IUD users only, and as long as, those users' health was in good condition. Another very common reason given for the appropriateness of the method was that it is cheap - this however contradicts previously mentioned perceptions that the IUD is for rich women. It is possible that the question was somewhat leading, and indicates once again the confusion about the costs of IUD insertion.

A few women felt IUDs were not an appropriate option because of real and perceived side-effects. Others were not sure whether they thought it was a good method for other women to use or not.

**IV. Preferred IUD Service Site**

The ACE programme will concentrate on improving IUD services at the health centre level, where service utilization rates are currently very low. Consequently, women were asked where they would go for IUD insertion should they decide to use the method. Surprisingly, the majority of participants said they would go to the public sector. Spacers would prefer to get such a service from the district hospital because it was close to home, cheap and they trusted the health workers. However, they would go to a health centre if such a service existed. A minority felt the provincial hospital would be safer, and there was the possibility of getting financial support/reduced costs. Most Stoppers said they would be happy going to the health centre if the service was available, or the district hospital for the same reasons.
V. Preferred Channels of Communication about IUD

Participants were asked what type of information they desired about birth spacing and IUDs, and where they would like to hear such information. Nearly all said they wanted the following information about IUDs:

- Advantages;
- Correct information on rumours and side-effects;
- Length of use (as women have heard an IUD needs to be replaced often);
- Service availability and cost.

Health workers were the most preferred source of such information and explanation, followed by a combination of printed materials, radio, television and satisfied IUD users. The findings from the study as a whole, however, make it apparent that health workers and satisfied clients are clearly preferred to the above mentioned mass media and printed materials.

B. Data Collected from In-depth Interviews with IUD users

The IUD users interviewed in this study were using IUDs at different stages of their child bearing years and so were using the method both to space and stop:

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Frequency of women</th>
<th>Number of women using IUDs and why</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 child</td>
<td>1</td>
<td>Space</td>
</tr>
<tr>
<td>2 children</td>
<td>3</td>
<td>1 Space, 1 Stop, 1 Don't know</td>
</tr>
<tr>
<td>3 children</td>
<td>6</td>
<td>4 Stop, 2 Space</td>
</tr>
<tr>
<td>4 children</td>
<td>4</td>
<td>4 Stop</td>
</tr>
<tr>
<td>5 children</td>
<td>2</td>
<td>2 Stop</td>
</tr>
</tbody>
</table>

As shown in the table above, the majority of IUD users interviewed (eleven of the sixteen) were using the IUD to prevent further pregnancies. Four women still wanted more children and so were using the IUD to space. The remaining user did not know whether she wanted to have another child or not.

Those women with most (four or five) children were using the method to stop, whereas those with between fewer children were both Spacers and Stoppers. It appears thus, that while there is common perception among some women that Birth Spacing methods -- and especially IUDs -- should be used once a woman has had all the children she wants, there

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3 The reader is reminded that all IUD users in Kampot were from Krang Ampil health centre, as no IUD users were found in Trapeang Sala.
is also an understanding among users that the IUD can be used by spacers (not only by stoppers). In addition, contrary to the common rumour that even after IUD removal you will no longer be able to have another child, it appears that there is awareness and acceptance among some IUD users that they still have the option of having another child.

As shown in table 4 below, length of time of IUD use differed slightly by district - IUD users in Pourk tended to have used the method longer than women in the other 2 provinces. This is probably because Pourk was previously a district hospital where IUD services have been available for some time.

Table 4: Length of IUD use among users, by province

<table>
<thead>
<tr>
<th>Length of IUD Use</th>
<th>Number of Users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Krang Ampil</td>
</tr>
<tr>
<td>2 months</td>
<td>1* (2\textsuperscript{nd} IUD)</td>
</tr>
<tr>
<td>5 months</td>
<td>1</td>
</tr>
<tr>
<td>6 months</td>
<td>1</td>
</tr>
<tr>
<td>7 months</td>
<td>1</td>
</tr>
<tr>
<td>1 year</td>
<td>1</td>
</tr>
<tr>
<td>2 years</td>
<td>1</td>
</tr>
<tr>
<td>3 years</td>
<td>1</td>
</tr>
<tr>
<td>5 years</td>
<td>1</td>
</tr>
<tr>
<td>8 years</td>
<td>1</td>
</tr>
<tr>
<td>9 years</td>
<td>1</td>
</tr>
<tr>
<td>12 years</td>
<td>1</td>
</tr>
</tbody>
</table>

* Length of use of second IUD only
** Length of use of first and second IUD combined.

All but two women were first time IUD users. These two women (in Krang Ampil and in Pourk) were currently on their second IUD after previous use of 3 years and 2 months respectively. It is not known why the IUDs were replaced after such a short time, although it is likely that these women had either wanted another child, or the private provider had recommended she get her IUD replaced. Anecdotal evidence suggests that private practitioners often replace IUDs before their limit of use is up.

Knowledge about IUDs

Before using the IUD, users had heard about the method from various sources. The most frequently cited sources of information about IUDs were health workers (7 women) and neighbours (6 women), followed by relatives (3), radio (2), other IUD users (2), and the district authority office (1). These sources of information are very similar to those reported as preferred channels of information by non-IUD users.

There were varying answers to the length of time an IUD can be used. The most frequently cited length of time was three years (9 women, most in Pourk, where many women had gone to a private practice), followed by 3-10 years (5 women), and four years (2 women). It appears that there is a lack of correct information, even among users, about the maximum length of use of an IUD.
Motivations for IUD Use

Before making the decision to have an IUD fitted, the majority of women had heard a number of rumours about the method: vaginal discharge, uterus tumours, ulcers and cancers, palpitations, ectopic pregnancy, weight gain, feeling hot, movement of the IUD around the body, bleeding and abdominal pain. These are common rumours about IUDs in Cambodia. Nearly all women who had heard these rumours believed them because they had seen and they heard about them from others, (and because they had never used an IUD had no experience).

However, women appear to distinguish between 'believing' what other IUD users say about their experiences, and 'believing' whether they will experience the rumours or not. In other words, the belief does not appear to center on whether the rumour is true or not. Thus, when asked why they had chosen the IUD, even though they had heard rumours, 13 said they chose it because they did not want to use other methods or because other methods did not suit them. The remaining three did so because they felt the IUD was a good long-term method for them to use.

Experiences of Use and Satisfaction with IUD

In order to assess clients' satisfaction with the IUD, users were asked if they were 'happy' with their method. The majority of respondents (13) were satisfied with, and had a good feeling about the IUD because it is a long-term method; they don't have to remember to use it as with other birth spacing methods; they can still work as normal; and it does not interfere with their sex life. A few respondents (3) still had concerns that the IUD could cause uterine tumours, ectopic pregnancy and/or it could move around the body, even though they had had good experiences with the method.

Overall, women attached great importance to their IUD. Most women responded very positively when asked how important the IUD was to their lives, mainly because it was effective in preventing a pregnancy, but also because it is a long-term birth spacing method. One woman liked it because it kept her menstruation regular. Meanwhile, five of the newer IUD users complained of the IUD causing lower back pain during menstruation, discomfort and weight gain. They saw these as troublesome rather than something to be worried about.

Perceived Community Attitudes toward IUD Users

All respondents said they knew other IUD users, most of whom were also happy with their IUD because they felt healthy and were still able to work as normal. Some of these other users, however, were said not to be too satisfied with their IUD because it had caused them bleeding, vaginal discharge, and dizziness; and they feared uterine tumours and ectopic pregnancies.

Nearly all IUD users said they rarely heard people talking about rumours regarding IUDs these days. In fact only three women in Pourk had heard women talking about the usual misconceptions and rumours already quoted in these findings. No women in Krang Ampil or Kravangh had heard others mentioning rumours about the IUD. Of these three women who had heard rumours, two did not believe what they heard because they had not experienced what they had heard. The other woman did believe what she had heard and was worried that her IUD may travel around her body.
IUD users were also asked what they believed their friends thought about their IUD use, in order to attempt an understanding of the importance attached to others' perceptions. Most perceptions were fairly positive. Four women said their friends were worried about their (respondents') health. Four other respondents had no idea what their friends thought. The remaining half said their friends either thought they (respondents) looked normal or in good health. What their friends thought did not appear to bother those IUD users because they knew, and had seen with their own eyes, its advantages and effectiveness. Regarding approval and support from husbands, virtually all respondents (15) said their husbands agreed and supported them in their IUD use. Only one woman reported using the IUD without her husband knowing.

Asked whether the IUD would be a good method for other rural women like themselves, nearly all agreed. This was due to its effectiveness in spacing pregnancies, and allowing more time for business. It is also a long term method, is cheap, healthy, easier to use than other methods, and it does not affect your ability to work. Based on their own experience, respondents felt that to consider the method, other rural women would need correct information on the advantages, side-effects, duration and cost of the method. And very importantly, they would need to have rumours about the method dispelled.

The women interviewed appeared to be strong advocates of the method, and all users said they would like to recommend the IUD and dispel rumours about the IUD to other women. In particular, they wanted to promote the fact that IUD users still can work as normal, are healthy, the method is effective, comfortable, spaces births, and there are no associated health problems. However, while satisfied clients are a highly effective and credible channel for spreading the word, when asked if they would collaborate with us to promote the method in the ACE programme, only six women (3 in Pourk and 3 in Kravangh) said they would. Others said they were too shy.

IUD Service Provision

Ten of the sixteen IUD users interviewed had their IUD fitted in the private sector; the remaining six had gone to the public sector. Over half of these women learned where to get an IUD inserted from a health worker, five had found out from neighbours and relatives, and the remaining two learned from IUD users and the radio.

Prices varied greatly across the board by area and source of insertion, with the most expensive services overall being in Pourk district. The most frequently paid price was between 50,000 to 60,000R (seven women), followed by four women spending 30,000-40,000R. Three women spent 5000 Riels in the public sector, and the remaining two women spent 15,000 and 10,000R at public facilities, as follows:
Table 5: Price paid for IUD insertion by Number of Women per Province

<table>
<thead>
<tr>
<th>Price Paid (Riels)</th>
<th>Number of Women</th>
<th>Krang</th>
<th>Ampil</th>
<th>Kravangh</th>
<th>Pourk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5000R</td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>10,000R</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>15,000R</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>30,000R</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>35,000R</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>40,000R</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>50,000R</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>60,000R</td>
<td></td>
<td>1</td>
<td></td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Table summary of the Findings

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Women not wanting to stop bearing children (spacers)</th>
<th>Women wanting to stop bearing children and currently using BS</th>
<th>Women wanting to stop bearing children and not currently using BS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledge</td>
<td>Attitudes &amp; Beliefs</td>
<td>Service Provision</td>
</tr>
<tr>
<td>KNOWLEDGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge about IUD</td>
<td>low</td>
<td>medium</td>
<td>medium</td>
</tr>
<tr>
<td>Know IUD is a long-term method</td>
<td>medium</td>
<td>most</td>
<td>most</td>
</tr>
<tr>
<td>Know approximate price</td>
<td>few</td>
<td>medium</td>
<td>few</td>
</tr>
<tr>
<td>Know where to get an IUD</td>
<td>most</td>
<td>most</td>
<td>most</td>
</tr>
<tr>
<td>ATTITUDES &amp; BELIEFS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for not using IUD:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Want another child</td>
<td>most</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>- Perceived cost</td>
<td>most</td>
<td></td>
<td>most</td>
</tr>
<tr>
<td>- Effects on health (especially inability to work)</td>
<td>most</td>
<td></td>
<td>medium</td>
</tr>
<tr>
<td>- Embarrassed</td>
<td>most</td>
<td></td>
<td>most</td>
</tr>
<tr>
<td>Would use in future</td>
<td>few</td>
<td>medium</td>
<td>medium</td>
</tr>
<tr>
<td>Would listen to &amp; possibly follow other IUD users</td>
<td>most</td>
<td>most</td>
<td>most</td>
</tr>
<tr>
<td>Believe rumours about IUD</td>
<td>most</td>
<td>medium</td>
<td>most</td>
</tr>
<tr>
<td>SERVICE PROVISION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would go to public health sector for IUD</td>
<td>most</td>
<td>most</td>
<td>most</td>
</tr>
<tr>
<td>Would go to Health Centre</td>
<td>few</td>
<td>most</td>
<td>most</td>
</tr>
<tr>
<td>Would go to Hospital</td>
<td>most</td>
<td>most</td>
<td>most</td>
</tr>
</tbody>
</table>
Implications of Findings for Action

The study findings provide us with an understanding of current knowledge, attitudes and practices of a select group of women. Further, they illustrate the interaction of belief and motivational factors that influence decisions to use a Birth Spacing method. The findings also identify areas that would need to be addressed in a promotional strategy to change behaviour and encourage IUD use. The implications of these findings are discussed using the 'Stages of Change' Model (Prochaska, DiClemente & Norcross 1992) as a framework for understanding how individuals may undertake such behaviour change (see appendix 3 for a description of the model). The implications for action of facilitating this behaviour change are then examined.

Current Stages of IUD Behaviour Change

Identifying possible communication strategies requires an understanding of where the audience currently is along the behaviour change continuum. The study findings suggest that the majority of the women interviewed, in all three groups, are clearly not currently contemplating using an IUD for various reasons - some have not yet had their desired number of children and perceive no need for a Birth Spacing method, some are already using another Birth Spacing method, and many have attitudes and beliefs that act as barriers to their contemplating the method. These women are most likely in the 'Precontemplation' stage of behaviour change.

There is a group of women, however, some stoppers and spacers, both not using a method (some of whom are also the same women described in the previous paragraph) - who expressed an interest in adoption of the method in future. This, they said, was on the condition that certain informational needs are met and their fears about the method's affect on health are allayed. Of these women, some have gathered information from other IUD users and some have previously used another birth spacing method, and thus have been through some birth spacing counselling. These women are either currently in the 'Precontemplation' stage, or they fall somewhere between the first three stages, 'Precontemplation', 'Contemplation', and 'Preparation'. It is these women who are likely to pass through the stages of behaviour change to IUD use more quickly. These women are likely to be more responsive to IUD/ACE demand creation, and should be the focus of efforts to create a core of satisfied IUD users.

Influencing Behaviour Change

The findings suggest that while only a few women have not heard about the method, most have some basic knowledge about the method. Women know the IUD is a long-term contraceptive method that is inserted into the 'womb', it is available at some public or private health facilities, and it has side-effects. A few women also know the cost of IUD insertion. At the same time, however, there are larger knowledge gaps that are influencing a woman's decision not to consider an IUD - the method is considered expensive and for rich women; there are several rumours about the IUD's affect on health; and women are not entirely clear how long it can or should remain in the body. Providing sufficient correct information about the method clearly needs to be one of the first steps of any effort to encourage women to
consider using the IUD. Specifically, communications should focus on: information about the method, its advantages, method of use, the correct price, affordability, and availability of the method. Also a strong focus should be put on explaining and reassuring women about side-effects, and dispelling misperceptions and rumours. It will be important to continue to provide information during all stages of behaviour change, and as and when people need it.

Providing correct information alone will be insufficient to influence behaviour change. Before behaviour can change, it is vital that women believe correct information and form a favourable attitude toward IUDs. Women need to be convinced of the safety, effectiveness and suitability of IUDs before they consider using the method themselves. To do this, the source of information has to be credible and trustworthy. Other studies have repeatedly shown that decisions concerning birth spacing are often based on what women hear from others about methods. In this study women indicated that they trusted health workers, and the findings clearly show that women base their beliefs on the experiences of other IUD users. Efforts to promote IUDs must include these two social change agents to increase acceptability of the method and encourage other women to consider the IUD as a contraceptive option. The involvement of these two players is particularly important for dispelling misperceptions about IUDs.

According to many respondents, while rumours about IUDs do exist in their communities, the method was not talked about much these days, as IUD use is less common than previously. Instead, with more women using OCs and injectables, rumours about the latter two methods tend to be more prevalent. Gaining acceptance of a method among rural women is not going to come about quickly or easily; this creates a good opportunity for ACE activities to almost start afresh with correct information to influence social acceptability from the onset of the programme.

In addition to providing information and influencing attitudes towards IUDs, moving women through the stages of behaviour change will require creating a demand for the method. As discussed above, the women most likely to benefit from the intervention are not currently very motivated to use IUDs, and in many cases are not even using another method; they may not even be motivated to practice Birth Spacing full stop. The challenge of IEC efforts will be to create a perceived need to use an IUD. It should focus on marketing the IUD in terms of the advantages it can bring to a woman's life, while appealing to her current situation, concerns and values.

**Behaviour Change**

Moving clients from considering IUD use to actual use also depends on the counseling and health care a woman receives. Counseling has a very important role to play in promoting the method, helping clients to make informed choices, and ensuring that women benefit from, and continue to be satisfied with their IUD. As the women in this study indicated, they trusted health workers and wanted to hear accurate information from them; the implications for birth spacing providers to provide quality services are great.
Currently, counseling in health centres and during outreach is typically inadequate, and often does not even occur. There is a great need for counseling skills to be upgraded before women can obtain a quality service and be motivated to continue method use. If health workers are to be expected to promote the method and provide the support outlined above, they, too, must be convinced that IUDs represent a safe, effective and valid option for rural women. Only then can they provide accurate information on the method’s advantages, dispel misconceptions, rumours and myths, and provide the support and encouragement a woman requires to be satisfied with her method. To ensure the process is client-oriented, the findings of this study should be incorporated into counseling training so that providers can respond to the specific knowledge gaps and typical concerns of women in their catchment areas.

Ensuring sustained use of the method requires continued support, reassurance and encouragement to new clients by continuing to emphasise the benefits of IUDs and guiding women through any side-effects they may be experiencing. Clearly, health providers continue to play a vital role during this stage, by encouraging women to continue the counseling process through subsequent visits to the provider, and during outreach visits. Other satisfied clients can also influence this process by continuing to share their experiences and to encourage women to continue their method use. Based on the 'satisfied user' approach, new IUD/ACE clients should then be incorporated into ongoing IEC activities to augment informal, word-of-mouth dissemination of information and to 'spread the word'.

Conclusion

Successful communication programmes do more than just provide information. Creating a 'first generation' of satisfied IUD users will require a comprehensive approach that supports women through the processes and stages of behaviour change. To be effective, the program requires an approach that will encourage and build discussion among couples and communities to increase acceptability of the method and generate demand by increasing knowledge, reflection, and providing encouragement, support and reassurance. To do this, a multi-channel approach is required, involving all the relevant people - those who will be affected by the programme and those most likely to have an influence in making changes (the opinion leaders, e.g. village leaders, health workers etc.). Based on RACHA's experience with community programmes, it will also be essential to bring information about birth spacing and IUDS, and support to users as close to the village level as possible to make such services accessible to clients.

PROMOTIONAL STRATEGIES For IUD/ACE

The overall goal of the communications effort is to increase demand for and use of IUD services. Specific objectives are to:

? Increase awareness and knowledge about IUDs.
? Increase awareness of the availability of IUD/ACE services.
? Increase the number of clients seeking information about IUDs, and
? Increase the number of clients who choose IUDs
Four key strategies will be used to achieve these objectives. Using a 'satisfied IUD user' approach, the overall strategy will be based on a theme, similar to “you no longer need to worry about preventing a pregnancy.”

**Strategy 1: Promote the key benefits of IUDs.**

Provide sufficient accurate information on IUDs (their advantages, method of use, price etc.), highlighting the comparative advantages of IUDs over other birth spacing methods (and non-use of any method). This will be done through method-specific materials targeting both literate and low-literate audiences; and through activities conducted by credible players, such as satisfied clients and health workers. IUDs will also be promoted through community health promotion activities, such as Community-Based birth spacing Services (CBS) and through Feedback Committee members.

**Strategy 2: Use satisfied clients and health workers to improve social acceptability and reduce fears about IUDs.**

Satisfied clients and health workers can be used to share their experiences, dispel rumours, myths and other fears about IUDs. In addition they can provide encouragement, support and reassurance to women contemplating and trying the method. Both will be involved in education/counseling activities, and their words will be used in print materials.

**Strategy 3: Advertise IUD/ACE service sites.**

Given the fairly limited availability of IUD services in rural areas, accredited providers recently trained by RACHA/RHAC represent a special local resource that will increase prospective clients' confidence in the service. This comparative advantage can be promoted through a mini-launch, posters and/or banners, flyers, 'free IUD days', and through other IUD health education activities.

**Strategy 4: Provide specialised counseling for prospective clients.**

IUD/ACE providers will be trained to identify potential clients and to provide specialised counseling allowing clients to make informed choices. Training should emphasise counseling on the health benefits of using an IUD; how to dispel fears and concerns about rumours, myths and side-effects; to support and guide clients through their decision to use, and eventual use, of an IUD; and to continue the counseling process through adequate and timely follow-up during outreach. Providers will be encouraged to follow the same practices in their private practice.
Target Audiences

Because IUD use is currently low, the task for ACE will be to generate a 'critical mass' of IUD users who have obtained services from an ACE provider and can inform others about their experience. From a diffusion of innovations perspective, it will be more efficient to first target the easy-to-reach audiences who are most likely to adopt the innovation than to target a highly resistant, difficult-to-reach audience. After this critical mass has developed, the focus of promotional efforts can shift to a broader audience.

To do this, it is important to identify the 'innovators' in rural communities and assist them in obtaining the birth spacing or IUD methods of their choice. When women have had a good experience with a method, others will follow.

Women who are most likely to choose IUDs are:

(a) Women who have had their desired number of children and wish to prevent further pregnancies, who may, or may not be currently using a method, and have easy access to health care and information, and

(b) Those who know and trust someone who is using an IUD and who is satisfied with her experience.

Thus the target audiences will be:

Primary 1: Women who do not want any more children, may or may not currently be using a method, and who live within a 5km radius of the IUD/ACE health centres.

Primary 2: As above, but who live beyond a 5km radius of IUD/ACE health centres.

Secondary audiences: Spouses and service providers/birth spacing counsellors.

Proposed communication activities and materials

The results of this research will be used to identify messages. A multi-media approach will be used to ensure these messages reach potential clients through a number of channels:

1. **Community birth spacing education meetings.** Led by health workers and satisfied IUD users, these meetings will provide a forum for information dissemination, answering questions and concerns about the method, allaying fears and advocating the method. Satisfied IUD users will take part to share their experiences and present a 'role model' for potential clients. Through this channel, women will get to know their local providers, thereby increasing the likelihood she will visit her.
2. **Motivational leaflet for low-literate clients.** Containing a summary of the information obtained in the above meetings, this take-home pictorial leaflet with basic messages will encourage potential clients to think about the IUD and visit their local birth spacing provider for counselling.

3. **Poster/banners advertising IUD/ACE.** Informational message to inform clients of the new affordable IUD/ACE, where providers have recently been trained by an NGO, and to encourage women to visit their health center to learn more. Using a photo of a true happy IUD user either working hard (in the fields or carrying something heavy), or with her happy-spaced family will increase the impact of this poster. These will be put up around the village, and the banner would be placed near the hospital.

4. **Flyer.** A mini-version of the poster will be produced as a flyer, for mass distribution.

5. **Post-insertion instruction sheet.** A simple list of instructions of what-to-do after IUD insertion, that will advise clients to return to the health center if there are problems. This will double as a counseling aide.

6. **CBS Promotion** Train FBC members, MOWA BS volunteers and any other community volunteers to inform potential clients about IUDs, and how to refer clients to the health center.
IUD Focus Group Discussion Guide
(Non-IUD Users)

Introduction
- Greeting
- Introduce yourself as a moderator
- Explain the purpose of the focus group discussion
- Ask for participants' permission to record
- Stress confidentiality

Warm up
- How long have you been married?
- How many children do you have?
  - What about you?
  - How many children have you planned for? What about you?
  - Do you want to have more children?
- Tell me, how does having children affect your life?

Birth Spacing/Family planning
- Let's take a little time to discuss the different ways women and families can plan when to have children...
  - Have you heard about birth spacing? What does it mean?
- What methods have you heard of? (What else?)
  - Where did you hear about these methods?
- Has anyone in the group used any of these methods? (What method?)
  - What were your experiences with the method?
  - Where did you get the method?

Awareness / Knowledge on IUD method
- Have any of you heard about IUDs?
- Where did you hear about this method?
- Can you tell us about what you have heard about IUDs?
  - Effectiveness
  - Length of use/permanent?
  - Where available and cost
- Have you heard other people mentioning any bad things about IUDs?
- What are the good and bad things you've heard about IUDs?
- Do you believe these things you have heard? Why/not? (Ask for each cited misconception)
Attitude / feeling towards IUD
- Has anyone here ever used an IUD?

If NO:
- Why not?
- Do you think you would ever consider using this method? Why/not?
- How would your husband feel if you decided to use this method?
- Do you know anyone who uses or has used this method?
  - How does she feel about this method?
  - Where did she get it?
- Have any of you ever thought about using this method? Why?

If YES:
- What made you consider this method?
  - Why IUD as opposed to another method?
- Can you tell me about your experience of using the IUD?
  - How did you feel about this method?
- How did your husband feel about you using this method?
- Where did you get it?
- What do you think about women who use this method?
- Do you think it's a viable option for women in villages like yours to use? why/not?

Attitudes to Service Provision
- If you were interested in getting an IUD, where would you go to get it (inserted)?
  - Why?
- If the service were available at your health centre, would you get an IUD there?
  - Why? Why not?
  - Staff
  - Perceived quality of services/costs...

Channel of communication
- If you were interested in using such a method but did not have enough information, how do you like getting information like this? (friends, radio, Health Worker....)
- If any of were to consider having an IUD but are reluctant, what information do you think you would need to be able to make the right decision?
IUD Users Interview Guide

1. How many children do you have?
2. How many more would you like to have?

Motivations

Can you tell me about your experience of using the IUD?

? How long have you been using the IUD?
? How did you first hear about IUDs?
? Why did you decide to use this method?
? Why did you choose the IUD rather than another method?
? What had you heard about IUDs before you decided to get one?
   ? Effectiveness
   ? Length of use
   ? Side-effects
   ? Rumours
? Did you believe what you heard before you decided to use the IUD? and Why?
? How do you feel about the IUD?
? What do you like about the IUD? / How easy is it to use?
? How important is your IUD to you?
? What don't you like about the IUD? Why?

Normative Beliefs/external attitudes towards IUD

? Do you know any other women using an IUD?
? How do they feel about using an IUD?
? What do your friends think about you using an IUD?
? What does your husband think about IUDs as a method?
? Do you think there are other rural women who could benefit from using IUDs? Why/not?
? What do you think they would need to be convinced?

Beliefs/Misconceptions

? What rumours about IUDs do you hear people talking about these days?
? Do you believe them?
? Why do/don't you believe them?

Service Provision

? Where did you get the IUD inserted?
? How did you know IUD services were available there?
? How much did it cost?
? What advice do you have for other women about IUDs?
? Would you be willing to cooperate with us in educational/promotional activities?
'Stages of Change' Model

Behavior change is a process that takes place over time, and people go through stages that are influenced by different processes, before final changes are made. The 'Stages of Change' model (Prachaska, DiClemente & Norcross, ’92) suggests an individual goes through, and moves back and forth between, five main stages of behavior change - Precontemplation, Contemplation, Preparation, Action and Maintenance, as follows:

Precontemplation stage
A person might not realise that change is possible, desirable or even relevant, and has not begun to contemplate change or the need for change. E.g. a woman may not yet have her desired number of children and therefore perceive no need to use a birth spacing method.

Contemplation stage
Later, something happens to prompt a person to start thinking about change, and the person becomes aware, more knowledgeable and concerned about the problem and the impact on themselves (perhaps by hearing someone else has made a change, for example). At this stage the person has started the process of contemplating change. E.g. a woman may have started considering the IUD after hearing a woman in her village talking about her new IUD and the benefits it has brought to her life.

Preparation stage
The person becomes motivated to do something about the problem and prepares to undertake change. This requires gathering of information, finding out how to achieve change, learning what skills are necessary and deciding when change will take place. It may include talking with others to assess how they feel about the change, there may be strong feelings associated with the change, and the person might need time to reflect on those feelings. This stage may occur quickly and easily or it may take time. E.g. a woman goes to see her local birth spacing provider to find out more about the IUD.

Action stage
Eventually the person changes their behavior, based on previous decisions, experience, information, skills and motivations for making the change. E.g. a woman has an IUD fitted.

Maintenance stage
Once a new behavior has been adopted, practice is required for the behavior to be consistently maintained or sustained. Maintenance occurs when the behavior is familiar, has been incorporated into the rest of the person's life, and occurs without requiring active thinking. A person may have to go through some of the stages more than once before maintaining behavior. E.g. a woman has been using for years and is comfortable with it.

Change is rarely straightforward, and it is affected by influences such as a person's beliefs, expected benefits, other people's expectations, normative beliefs etc. Therefore, not all people need to go through the same processes for every change they make, nor can people always be clearly categorised as being in a particular stage.
Many factors can influence behavior change, and for all sorts of reasons and influences people may move back to the earlier stages of behavior change (a 'relapse'), and work through the stages again. In the case of the IUD for example, a woman may have contemplated trying the method in a desperate attempt to avoid a pregnancy, but on gathering more information heard some rumour about it and decided against it (i.e. relapsing from 'Preparation' back to 'Contemplation'); or a woman may have gone through all the stages and tried the IUD, but then discontinued the method due to its side-effects (relapsing from 'Action' to 'Contemplation' or 'Preparation'). Eventually people will continue to act in ways that make sense to them.