



Original Research Article

Contraceptive Confusion: A Retrospective Analysis of IUCD Misbeliefs in Primary Care

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Abstract: **Background:** Despite national efforts to promote modern contraceptive methods, the uptake of intrauterine contraceptive devices (IUCDs), particularly the Copper T, remains suboptimal in India. Myths and misconceptions contribute significantly to this underutilization, especially in primary health settings where formal education and contraceptive exposure are limited. **Methods:** A retrospective cross-sectional study was conducted from July to September 2025 at a PHC outpatient department. Data were collected from 112 women aged 18–35 years through record review and direct observation during counselling. A semi-structured proforma was used to document myths, sources of misinformation, and post-counselling decisions. **Results:** A significant proportion (63.4%) believed that IUCDs cause permanent infertility, with bleeding (73.2%) and pain (67.0%) being major deterrents. Device migration fears were reported by 59.8%. Myths were primarily propagated through peers (60.7%) and family (50.9%). The infertility myth was significantly more common among younger women, those with lower education, and low parity ($p < 0.05$). Post-counselling, 57.7% of new candidates and 82.4% of initial removers opted to retain or initiate Copper T use. **Conclusion:** Widespread misconceptions about IUCDs remain prevalent among women in PHC settings. Structured counselling addressing these fears significantly improved acceptance. Targeted myth-debunking strategies are essential for improving IUCD uptake in community healthcare.

Keywords: Intrauterine Contraceptive Device (IUCD), Copper T, Myths and Misconceptions, Primary Health Centre, Family Planning, Counselling

INTRODUCTION

India launched the National Family Welfare

Programme in 1951, with the central goal of stabilizing population growth by promoting small

family norms and increasing access to contraception. However, despite decades of policy efforts, India continues to face significant challenges in achieving effective contraceptive uptake and lowering its fertility rate. A key impediment has been the limited awareness and pervasive myths surrounding modern contraceptive methods—especially intrauterine contraceptive devices (IUCDs), such as the Copper T (Cu T).

The IUCD is a safe, long-acting, reversible, coitus independent contraceptive method with strong efficacy and cost effectiveness. Yet, its utilization in India remains relatively low compared to its theoretical potential. A national survey revealed that despite free availability of IUCD services under government programmes, uptake remains minimal, largely due to lack of accurate information and exaggerated perceptions of side effects.[1]The advantages of IUCDs are often understated, while the disadvantages are overemphasized; myths and misconceptions among users and providers contribute to low acceptance and high discontinuation rates. [2]

Globally, barriers related to myths and misconceptions are well documented. The misperceptions surrounding IUCDs—including concerns about device migration, infertility, infection, and pain—and how these deter both users and health providers from recommending the method. [1] Moreover, among women considering IUCD insertion, the most commonly endorsed negative beliefs included that insertion is painful and that the device might “move around” within the body. [3] These misconceptions persist despite extensive evidence affirming the safety and reliability of modern IUCDs such as Cu T 380A.

In India’s context, several qualitative and mixed-methods studies have highlighted local beliefs and cultural factors that obstruct IUCD uptake. The barriers in rural Odisha were explored, finding that fear, privacy concerns, and lack of quality counselling discouraged women from considering IUCDs. [4]Only about 21% of eligible women actually used IUCDs, while common reasons for refusal included fear of adverse effects, disagreements within the family, and lack of awareness about benefits.[5] In urban women who had heard of Cu T, many could articulate little beyond the name—suggesting superficial awareness and minimal in-depth knowledge. [6]

Given this backdrop, postpartum insertion of IUCDs (PPIUCD) represents a strategic opportunity to increase contraceptive coverage. The immediate postpartum period provides a “captive” moment when women are in contact with health services and may be more motivated to space births. Nonetheless,

myths and misconceptions may still deter acceptance even in this favorable period. [7] Insertion errors and malposition may also feed into negative perceptions: a high rate of malpositioning of IUCDs in the immediate postpartum period, which was significantly associated with increased complications such as pain, menstrual irregularities, and expulsions. [8] Such associations may reinforce negative beliefs in the community and further discourage uptake.

In a primary health care (PHC) setting, where women often receive family planning counselling and services, misunderstandings may persist unchallenged, particularly in rural and semi urban areas. Identifying the specific myths and misconceptions that influence refusal or discontinuation is essential to strengthen counselling strategies, design targeted educational interventions, and improve IUCD acceptance.

Therefore, the present retrospective observational study aims to systematically examine the myths and misconceptions surrounding Cu T insertion among women attending an OPD at a PHC, and to relate these to demographic, socio cultural, and service delivery factors. By focusing on both retrospective records and real time counselling interactions, this study seeks to provide actionable insights into gaps in knowledge and counselling, with the ultimate goal of enhancing IUCD uptake in primary care settings.

Aim of the Study

To identify and analyze the myths and misconceptions associated with Copper T (Cu-T) insertion among women attending the outpatient department of a primary health centre in Southern India and to evaluate the socio-demographic and cultural factors influencing these beliefs..

MATERIALS AND METHODS

Study Design

This study was designed as a retrospective cross-sectional observational analysis to assess the myths and misconceptions surrounding intrauterine contraceptive device (IUCD), specifically Copper T (Cu-T), among women attending the outpatient department of a primary health centre (PHC) in Southern India.

Study Setting

The study was conducted in the Outpatient Department of a government primary health centre located in a semi-urban area of Chennai, Tamil Nadu. The PHC catered to a predominantly rural and low-to-middle income population and provided maternal and child health services, including family planning and postpartum contraception.

Study Duration

The study was carried out over a three-month period from 1st July 2025 to 30th September 2025.

Study Population

The study population consisted of women aged 18 to 35 years who visited the OPD for postpartum care, contraception counselling, or for IUCD-related concerns. These included:

- Postpartum women eligible for postpartum IUCD (PPIUCD) insertion,
- Women seeking contraceptive counselling,
- Women who had previously refused Cu-T insertion,
- Women requesting Cu-T removal due to discomfort, fear, or misconceptions.

Inclusion Criteria

- Women aged between 18 and 35 years,
- Women who were eligible for or had been counselled for Cu-T insertion,
- Women who expressed myths, doubts, or fears about Cu-T during counselling,
- Women who requested removal of Cu-T due to personal or perception-related concerns.

Exclusion Criteria

- Women below 18 or above 35 years of age,
- Women using other contraceptive methods without concerns related to Cu-T,
- Women with medical contraindications to IUCD use (e.g., pelvic inflammatory disease),
- Patients with incomplete medical records or who did not consent to participate.

Sampling Technique

A convenient sampling method was used. All eligible women who attended the OPD during the study period and met the inclusion criteria were included. Based on OPD attendance and service records, approximately 100–120 participants were enrolled in the study.

Data Collection Methods

1. Retrospective Record Review:
 - o OPD and family planning registers from the previous 12–24 months were reviewed.
 - o Cases of Cu-T refusal or removal were identified.
 - o Counselling notes and patient-reported

reasons for refusal or removal were extracted.

2. In-Person Observation and Documentation:
 - o During the study period, real-time observations were made during routine family planning counselling.
 - o Women were engaged during counselling sessions and their concerns were documented using a semi-structured proforma by the investigator or trained staff.
3. Health Worker Inputs:
 - o Informal discussions were conducted with Auxiliary Nurse Midwives (ANMs) and medical officers to record commonly encountered misconceptions during counselling. These were used to supplement data but not considered formal interviews.

Data Collection Tool

A semi-structured data collection proforma was used to record:

- Demographic details such as age, parity, and education,
- Reproductive history and contraceptive usage,
- Nature of counselling received,
- Specific myths or misconceptions stated (e.g., infertility, cancer, migration, menstrual irregularities),
- Source of misinformation (e.g., family, media, peer groups).

Ethical Considerations

Ethical approval was obtained from the Institutional Human Ethics Committee prior to initiating the study. Permission was also secured from the Medical Officer of the PHC. Verbal informed consent was obtained from all participants before data collection. All personal identifiers were removed and data confidentiality was strictly maintained throughout the study.

Data Analysis

Collected data were entered into Microsoft Excel and analyzed using descriptive statistical methods. Frequencies and percentages were calculated for demographic variables and responses. Thematic analysis was used to identify and categorize common myths and misconceptions. Where applicable, subgroup comparisons were made based on age, education, and parity.

RESULTS

A total of 112 women who met the inclusion criteria were enrolled in the study over the three-month period. The demographic and baseline characteristics of the participants are summarized in Table 1. The study population was predominantly young, with the majority (74.1%) being below 30 years of age. A significant proportion of women (83.8%) had some level of formal education, though 43.8% had only primary-level schooling or less. Nearly half of the participants (46.4%) had two living children, indicating a key demographic for spacing methods. A notable finding was that 42.9% of women had never used any modern contraceptive method prior to their counselling for IUCD, highlighting a potential gap in prior exposure to family planning information.

Table 1: Socio-Demographic and Reproductive Profile of Participants (N=112)

Characteristic	Category	Frequency (n)	Percentage (%)
Age Group (Years)	18 - 24	38	33.9
	25 - 29	45	40.2
	30 - 35	29	25.9
Education Level	No Formal Schooling	17	15.2
	Primary School (1-5)	32	28.6
	Secondary School (6-10)	44	39.3
	Higher Secondary (11-12) or above	19	17.0
Parity	1	41	36.6
	2	52	46.4
	3 or more	19	17.0
Contraceptive History	Never used any modern method	48	42.9
	Used Condoms	39	34.8
	Used Oral Pills	18	16.1
	Had undergone Female Sterilization	7	6.3

The primary aim of the study was to identify specific myths and misconceptions. The concerns expressed by the women were categorized and are presented in Table 2. The most prevalent concerns were related to health and side effects. The fear of heavy bleeding leading to weakness (73.2%) and chronic pain (67.0%) were the most common. A critically significant misconception was the belief that the IUCD causes permanent infertility (63.4%), which was a major deterrent for younger women wanting more children in the future. Device migration fears were also highly prevalent, with 59.8% of women fearing the device could travel to vital organs like the heart or brain. Concerns about the insertion process being unbearably painful were voiced by 56.3% of participants.

Understanding where women heard these myths is crucial for designing interventions. The reported sources of misinformation are detailed in Table 3. The data clearly shows that informal social networks are the primary vectors of misinformation. Friends and peers were the most frequently cited source (60.7%), closely followed by family members (50.9%). This indicates that myths are being perpetuated within the community itself. The influence of the husband or partner was also significant (36.6%). Only a small proportion attributed their beliefs to formal or media sources, suggesting that misinformation is largely interpersonally transmitted.

Table 2: Spectrum and Prevalence of Documented Myths and Misconceptions (N=112)

Category of Myth/Misconception	Specific Belief Expressed	Frequency (n)	Percentage (%)
Device-Related Concerns	"The Copper-T will move to the heart or brain"	67	59.8
	"It will get lost inside my body"	54	48.2
	"It can cause cancer"	29	25.9
Health & Side Effect Concerns	"It will cause permanent infertility"	71	63.4
	"It will cause heavy bleeding and weakness"	82	73.2
	"It will cause severe, chronic backache and stomach pain"	75	67.0
	"It will cause frequent infections"	58	51.8
Sexual & Marital Concerns	"My husband will feel the strings and it will cause discomfort during intercourse"	49	43.8
	"It is only for women who have had many children"	31	27.7
Procedural Concerns	"The insertion process is extremely painful and dangerous"	63	56.3
	"It requires a major surgery to put in or take out"	27	24.1

Table 3: Primary Sources of Misinformation about Copper-T (N=112)

Source of Misinformation	Frequency (n)	Percentage (%)
Friends & Peers	68	60.7
Family Members (Mother/Mother-in-law/Sister)	57	50.9
Husband/Partner	41	36.6
Local/Community Health Worker (e.g., unqualified practitioner)	22	19.6
Media (TV Serials, Social Media Forums)	18	16.1
Could not recall a specific source ("Heard it generally")	29	25.9

Note: Participants could cite more than one source, so the total percentage exceeds 100%.

A subgroup analysis was performed to explore if certain demographics were associated with specific, high-impact misconceptions. The results for the myth of "Permanent Infertility" are shown in Table 4. The fear of permanent infertility was significantly more common among younger women (78.9% in the 18-24 group), women with lower educational attainment (83.7% in those with primary schooling or less), and women with only one child (80.5%). The P-values indicate that these associations are statistically significant. This suggests that nulliparous or low-parity women, who are precisely the target for a spacing method like IUCD, are the most deterred by this particular misconception.

Table 4: Association Between Selected Characteristics and the Belief that IUCD Causes Permanent Infertility

Characteristic	Category	Believed in Infertility Myth (n=71)	Did Not Believe (n=41)	P-value
Age Group	18-24 (n=38)	30 (78.9%)	8 (21.1%)	0.02
	25-35 (n=74)	41 (55.4%)	33 (44.6%)	
Education	Up to Primary (n=49)	41 (83.7%)	8 (16.3%)	<0.001
	Secondary & Above (n=63)	30 (47.6%)	33 (52.4%)	
Parity	Parity 1 (n=41)	33 (80.5%)	8 (19.5%)	0.01
	Parity 2+ (n=71)	38 (53.5%)	33 (46.5%)	

After receiving structured counselling at the PHC that directly addressed the documented myths, the final decisions of the women were recorded.

- Of the 78 women who were new candidates for IUCD insertion (i.e., had refused earlier or were first-time counsellees), 45 (57.7%) agreed to proceed with Copper-T insertion after the myth-busting session.
- Among the 34 women who had initially requested removal, 28 (82.4%) decided to continue using the method after their concerns were addressed.
- The remaining women either opted for an alternative method (e.g., condoms, oral pills) or requested more time to discuss with their families.

Figure 1: Top 5 Most Prevalent Myths about Copper-T

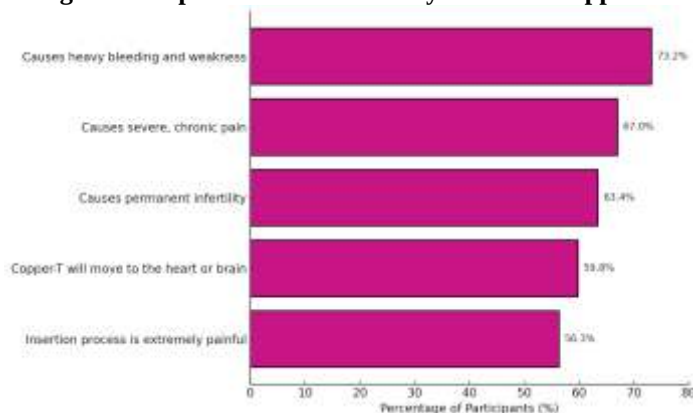


Figure 2: Primary Sources of Misinformation



Figure 3: Association Between Education Level and Key Myths

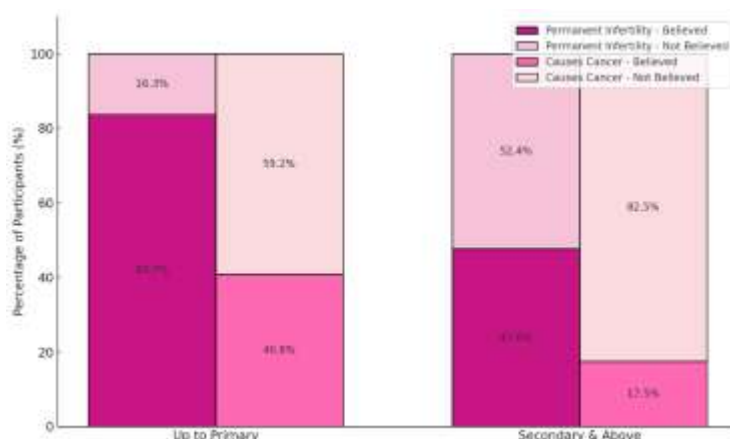


Figure 4: Impact of Targeted Counselling on Participant Decisions

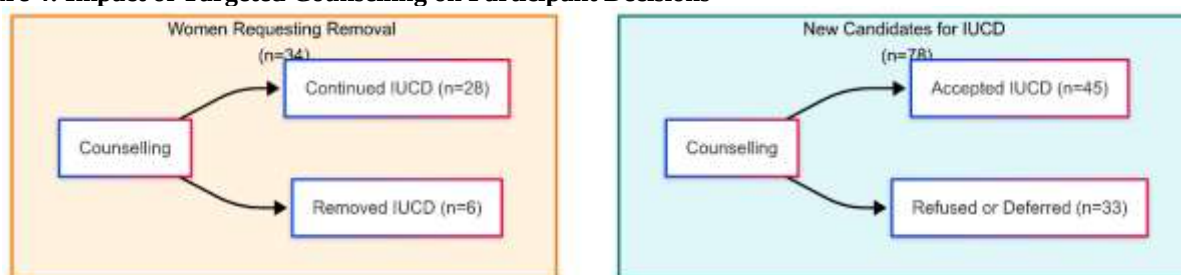
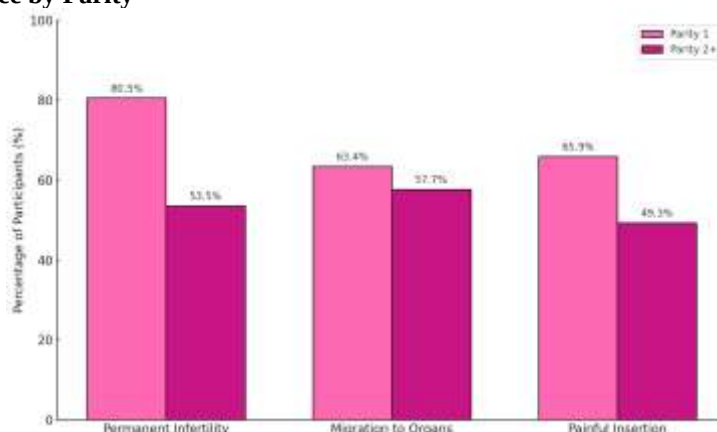


Figure 5: Myth Prevalence by Parity



DISCUSSION

In this retrospective observational study of 112 women attending a primary health-care outpatient setting, a spectrum of myths and misconceptions regarding Copper T (Cu T) insertion was documented, and the potential for myth addressing counselling to modify decisions was assessed. The findings highlight important attitudinal barriers to IUCD uptake, particularly among younger, less-educated, and first-parity women. In this discussion, I contextualize these findings in light of existing literature, explore plausible explanations, examine implications for practice, and address strengths and limitations.

Our study sample was skewed toward younger women (74.1% < 30 years) and nearly half (46.4%)

were with parity 2, aligning with the demographic group for spacing contraception. Interestingly, 42.9% of participants had never used any modern contraceptive method. This proportion is comparable to other Indian settings. Mukherjee et al. in Odisha documented that a majority of potential users had never adopted IUCD, citing informational deficits and entrenched cultural beliefs as barriers. [9] The relatively high proportion of contraceptive-naïve women in our sample underscores the need for primary-level counseling and awareness-raising before myths become entrenched.

It is plausible that women who have never used any method may harbor more misconceptions, because they lack experiential knowledge or peer accounts of benefits and tolerability. In our subgroup analysis,

women with lower education (primary or less) had significantly greater belief in the infertility myth (83.7%) compared to those with secondary or above (47.6%), reinforcing the role of education in shaping receptivity to accurate information.

The preponderance of health and side-effect-related concerns in our cohort mirrors findings from other contexts. In our study, 73.2% of women feared heavy bleeding and weakness, 67.0% feared chronic pain, and 63.4% believed that Cu T may lead to permanent infertility. Device migration fears were common (59.8%), while procedural pain fears were endorsed by 56.3%. Sexual/discomfort concerns and notions that Cu T is only for high-parity women also appeared.

A similar pattern emerged in a study by Michie et al. among women seeking pregnancy termination; the most strongly agreed misconceptions were “painful to insert” (34%) and “can move around inside the body” (23.6%). [4] Our percentages are notably higher, perhaps reflecting lower baseline awareness in a rural or PHC-based population compared to an urban or hospital setting. Another Indian study in the post partum context in Delhi found fear of malignancy (38%) and fear of menorrhagia (36.4%) among Cu T non-acceptors, and spousal or mother-in-law influence as important factors. [10] The prominence of bleeding-related fear in both their and our study suggests that myths around menstrual disturbances are particularly entrenched and may supersede other fears in motivating refusal. In an Ethiopian mixed-methods evaluation of IUCD scale-up, Tilahun et al. noted that myths and low community awareness were barriers to acceptance, though many women expressed latent demand once counseling and access were available. [11] Our counselling component aligns with their observation that correcting misinformation can shift intention toward uptake.

Black et al., in their review of global barriers, highlighted that some health care providers hold misconceptions—such as that IUCs should not be used in nulliparous women or have greater expulsion risk—despite evidence refuting these beliefs. [1] These provider-side myths may reinforce community-level misconceptions. Thus, the myths we documented (infertility, migration, procedural pain) are not unique; they echo broader patterns found internationally. The study by Anant et al. also reported that about one-third (32.8%) of women believed IUCD causes heavy menstrual bleeding, and about 25% thought it might cause genital tract cancers — numbers considerably lower than ours but pointing to similar myth domains. [12] The higher frequencies in our study may reflect lower prior exposure to accurate counselling in PHC settings, or cultural amplification of fears in this context.

We found that friends and peers (60.7%) and family (50.9%) were the leading sources of misinformation, followed by husband/partner (36.6%), local unqualified practitioners (19.6%), and media (16.1%). This interpersonal diffusion of myths mirrors the findings of Anderson et al., who emphasized the role of women’s social networks in spreading negative narratives about IUDs and shaping attitudes toward usage. [13] Their qualitative work posits that stories about complications travel rapidly through peer groups and are more persuasive than sterilized health messaging, especially in low-trust settings. The relatively lower role of media or official sources may reflect gaps in targeted health communication at the community level, or skepticism toward institutional messaging. Madden et al. demonstrated that even online information about IUDs is highly variable in accuracy, further complicating reliance on media sources. [14]

In Indian studies, family dynamics—particularly the influence of husbands and mothers-in-law—are commonly cited as barriers. Khatri et al. observed that 23.8% of women aware of IUCDs declined use due to assumed spousal disapproval. [15] Similarly, in Delhi postpartum settings, the influence of the husband or mother-in-law was a recurring theme in decision-making about Cu T insertion. [10] While our study found media-level influence low, familial and peer influences were dominant, highlighting the need to engage these stakeholders in educational interventions.

Our subgroup analysis revealed statistically significant associations: the belief in permanent infertility was much more common among younger women (78.9% in 18–24), women with lower education (83.7%), and women with only one child (80.5%). These associations are particularly concerning, as the primary target for spacing methods is often women early in their reproductive trajectory. If these women hold the strongest myths, uptake efforts may face bias against the very group most in need. This aligns with findings from Dey et al. in an India-based modeling study, which identified fear of infertility as a prominent barrier to IUCD use, particularly in younger or less-educated populations. [16] It also corresponds with Sharma et al.’s determinants study which found that lower education was correlated with greater discontinuation and negative attitudes toward IUCDs. [17]

These results are imperative to design counseling strategies that are particularly attuned to younger, low education women, and to tailor messaging that addresses their specific fears in approachable language.

One of the most optimistic findings of our study was

that after structured counselling targeting identified misconceptions, 57.7% of new candidates agreed to Cu T insertion, and 82.4% of those who sought removal opted to continue. This suggests that misinformation is modifiable and that tailored counselling in the PHC environment can significantly shift behaviour.

Few studies provide comparable intervention outcomes in the same design, but Gudi et al. in a prospective multicentric study of IUCD acceptance reported that proper counselling and reassurance were key facilitators in boosting uptake and reducing early removals. [18] Similarly, in the Ethiopian context, Tilahun et al. observed that once myths were addressed and quality services assured, women began accepting IUCDs in greater numbers. [11] These findings support the notion that myth-addressing is not merely hypothetical but has real-world potency in increasing acceptance. However, even after counselling, a proportion declined or deferred decision, indicating that additional structural or psychosocial barriers remain.

The high prevalence of misconceptions related to bleeding, pain, infertility, and device movement in this PHC-based population indicates that knowledge gaps and fear-based beliefs remain entrenched in many communities. Because these myths concentrate among younger and lower-education women — those who stand to benefit most from long-acting reversible contraception — their persistence is especially problematic. Counseling and demand-generation efforts may be inadequate if they do not actively surface and address these myths. Educational interventions must therefore be multi-pronged: not limited to the individual woman, but encompassing her social network (husband, family, peers). Community-based interventions (group counselling, peer educators, myth-debunking campaigns) may help counter peer spread misinformation. Training health workers to proactively anticipate and address myths is essential, as provider beliefs or lack of confidence can reinforce misconceptions. Black et al. warn that provider-side myths, especially about nulliparous use or expulsion risk, must also be debunked to avoid undermining patient trust. [1]

Another implication is that counselling must be iterative and interactive, not merely didactic. Allowing women to voice fears, comparing myth vs evidence, and demonstrating technique or showing models may enhance trust. Innovative tools — for example, motion graphics or visual aids to counter myths — have been trialed elsewhere and shown promise in debiasing perceptions. [19] From a policy lens, integrating standardized myth addressing modules into national family planning protocols at PHCs could help ensure uniformity of messaging. Monitoring and evaluation of counselling quality

should include assessment of myth detection and response.

Strengths of this study include its integration of retrospective and contemporaneous data, its focus on the “on-the-ground” PHC setting, and its attempt to measure both myth prevalence and change in decision after targeted counselling. The sample size ($n = 112$) is modest but arguably adequate for exploratory subgroup analysis in this setting. However, limitations must be acknowledged. Social desirability bias may have led participants to underreport certain beliefs or shift responses after counselling. Because this was a convenience sample at one PHC, findings may not generalize to other regions or urban settings. Our “myth-busting” counselling was not standardized across all sessions in detail, and we did not follow up participants longitudinally to assess continuation. Associations such as P-values in subgroup analysis are exploratory; causality cannot be inferred.

Future studies should ideally use larger, multi-site samples and include longitudinal follow-up to assess whether decisions after counselling translate into sustained use. Randomized trials comparing standard vs myth-targeted counselling modules may help isolate the effect size of myth-busting. Qualitative studies exploring the narratives by which myths are transmitted in these communities (e.g., peer stories, family lore) could further refine intervention content. Given the strong influence of social networks found here, community-level interventions — perhaps via women’s groups or community health workers trained as myth “champions” — merit testing. Further, provider-focused training, including addressing provider misbeliefs about IUCDs in nulliparous or low-parity women, is critical to prevent health system reinforcement of myths.

CONCLUSION

This study highlights that myths and misconceptions about Copper T insertion remain potent barriers in a PHC outpatient population, particularly among younger, lower-education, and lower-parity women. The dominant concerns — heavy bleeding, infertility, pain, device migration — reflect patterns observed in other global and Indian settings. Encouragingly, structured counselling that explicitly addresses these myths led to significant uptake among new candidates and reversal among those considering removal. To expand IUCD acceptance, family planning programmes must systematically integrate myth detection and debunking into counselling, engage social networks, and empower providers to dispel misconceptions. Only by countering misinformation at multiple levels can the potential of IUCDs as a safe, long-acting, reversible contraceptive be fully realized in primary care

settings.

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