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A phenomenological study on factors influencing women of childbearing age in the use of intrauterine devices at Gumawang Community Health Center

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Abstract

Background: The Intrauterine Device (IUD) is one of the most effective long-acting reversible contraceptives, yet its utilization remains low in Indonesia, including at Gumawang Community Health Center, Ogan Komering Ulu Timur District. Predisposing factors such as knowledge, beliefs, and cultural perceptions are believed to contribute to the low uptake of IUDs.
Objective: This study aimed to analyze the factors influencing IUD use among women of reproductive age.
Methods: A qualitative study with a phenomenological approach was conducted to explore participants' experiences and perceptions. Data were collected through in-depth interviews and focus group discussions (FGDs) involving 17 informants, including IUD acceptors, non-IUD acceptors, unmet need groups, health workers, and family planning program officers. Data analysis employed reduction, data presentation, and conclusion drawing, supported by source triangulation to ensure trustworthiness.
Results: Three major themes emerged: (1) knowledge—variations in understanding IUD definition, duration, benefits, and side effects; (2) beliefs—dominated by fear, shame, and mixed religious views; and (3) culture—community myths and narratives surrounding IUD safety that shape perceptions negatively. These findings demonstrate that misinformation and limited exposure strongly influence decision-making regarding IUD adoption.
Conclusion: Knowledge, beliefs, and cultural perceptions significantly affect women's decisions to use IUDs. Strengthening health education, counseling, and partnerships with community and religious leaders is essential to counter misinformation and improve IUD acceptance.

Background

Family planning (FP) enables couples to achieve their desired number of children and determine the spacing of pregnancies through contraceptive methods. Beyond its reproductive role, FP contributes to broader development goals by promoting health, advancing gender equality, and supporting education and economic opportunities (WHO, 2025). Despite its benefits, the use of long-acting reversible contraceptives (LARCs) such as intrauterine devices (IUDs) and implants remains low in Indonesia, accounting for only 23.64%, compared to short-term methods such as injections, pills, and condoms at 76.36%. Injectable contraceptives dominate with 58.52%, followed by pills (13.19%), while IUD use is only 8.87%. A similar pattern is evident in South Sumatra Province, where LARC use is 21.41% and non-LARC methods 78.59%, reflecting a decline compared to previous years (BKKBN, 2023). In Ogan Komering Ulu Timur District, LARC prevalence was 21.73% in 2024, with implants being the most preferred method (20.1%), while IUDs accounted for only 1.01%. At Gumawang Community Health Center, IUD coverage was 8.55% among 5,912 women of reproductive age, with only eight IUD insertions recorded by the end of 2024, far below the annual target of 1,152 acceptors (DPPKB OKU Timur, 2024).

Although IUDs demonstrate high effectiveness, with a success rate of 0.867%, minimal side effects (0.133%), and no reported failures (Yanti et al., 2022), their uptake remains limited. IUDs are suitable for women with chronic conditions such as hypertension, cardiac disease, coagulation disorders, or diabetes because they are hormone-free (Kemenkes, 2021). However, unmet need persists due to side effects of other hormonal methods and medical contraindications, leading to unintended pregnancies that may result in maternal psychological distress, including postpartum depression and unsafe abortion (Siregar et al., 2021).

The low acceptance of IUDs is influenced by multifaceted factors. Previous studies indicate that barriers include negative community perceptions, lack of resources and skilled providers, limited spousal support, and weak partnerships with religious and community leaders. Conversely, enabling factors include the safety, effectiveness, and availability of IUD services (Nor Aperiani & Hasbiyah, 2024). According to Green's theory, health behavior is shaped by predisposing factors (knowledge, attitudes, beliefs), enabling factors (facilities, resources, cultural context), and reinforcing factors (support from family, health workers, and community leaders) (Wawo et al., 2022; Erviana & Azinar, 2022).

Preliminary findings at Gumawang revealed that non-IUD users often cited fear, shame, concerns about IUD displacement, and the belief that IUDs interfere with sexual activity. Moreover, many women demonstrated poor knowledge about IUD effectiveness, despite evidence that it prevents pregnancy up to 99%. These observations suggest that knowledge gaps, personal beliefs, and cultural perceptions play a critical role in IUD decision-making.

While numerous studies have examined IUD utilization in Indonesia, little is known about women's lived experiences in rural health centers such as Gumawang. Given the persistent low coverage and unmet need, qualitative inquiry is essential to capture the underlying meanings, perceptions, and cultural contexts influencing contraceptive choice. A phenomenological approach is particularly valuable to explore how women and stakeholders perceive, interpret, and experience IUD use in everyday life. Such exploration will provide deeper insights beyond numerical prevalence, allowing health providers and policymakers to design more culturally responsive interventions.

Therefore, this study aims to analyze the factors of knowledge, beliefs, and cultural perceptions influencing IUD use among women of reproductive age at Gumawang Community Health Center, Ogan Komering Ulu Timur District, using a qualitative phenomenological approach.

Methods

Study Design

This study employed a qualitative research design using a phenomenological approach. The phenomenological method was chosen because it allows researchers to deeply explore and understand the lived experiences of individuals regarding a phenomenon—in this case, the low utilization of intrauterine devices (IUDs). Phenomenology provides an in-depth framework to capture personal meanings, perceptions, and interpretations, enabling the researcher to uncover the essence of participants' experiences beyond quantitative indicators.

Participants

Participants were selected purposively and expanded using a snowball sampling technique until data saturation was achieved. The study involved a total of 17 informants, consisting of one key informant and 16 supporting informants. The key informant was the Head of the Family Planning Division at the District Office of Population Control and Family Planning (DPPKB) of Ogan Komering Ulu Timur, who had extensive experience and involvement in family planning programs, particularly IUD services. Supporting informants included four IUD acceptors, six non-IUD acceptors, two women with unmet need, one Head of Family Planning Service Assurance Section, one midwife coordinator at Gumawang Community Health Center, and one family planning field officer. Inclusion criteria required participants to have direct experience or involvement with family planning, willingness to participate, and the ability to provide relevant information representing different perspectives (IUD users, non-users, and unmet need groups).

Data Collection

Data were collected between June 15 and June 30, 2025, through multiple methods to ensure richness of information. Primary data were obtained through in-depth interviews and focus group discussions (FGDs), while secondary data were retrieved from health center records, contraceptive service reports, and district-level statistics on contraceptive supply and utilization. In-depth interviews lasted approximately 25 minutes and were conducted at the DPPKB office, the Family Planning Sub-

district Office in Belitang, and Gumawang Community Health Center. FGDs lasted 40 minutes, with groups of 4–6 participants, held at the community health post (Posyandu) and Gumawang Health Center. Interviews and FGDs were guided by a semi-structured protocol, recorded using voice recorders and mobile devices, and supplemented with field notes. Data saturation was achieved when recurring themes emerged, and no new information was identified.

Data Analysis

Data were analyzed using a thematic analysis framework aligned with phenomenological inquiry. The process included: (1) data reduction, where transcripts were repeatedly read, coded, and grouped into meaningful categories; (2) data display, where findings were organized into narrative descriptions and thematic matrices; and (3) conclusion drawing, where patterns, similarities, and differences were synthesized into final themes. Credibility was enhanced through triangulation of methods (interviews, FGDs, and document reviews) and sources (community health workers, midwives, program officers, and women of reproductive age). Data from these diverse sources were cross-checked to identify convergent, divergent, and unique perspectives.

Trustworthiness

To ensure rigor, the study applied Lincoln and Guba's criteria of trustworthiness, including credibility, transferability, dependability, and confirmability. Credibility was established through prolonged engagement, triangulation, and member checking. Transferability was supported by providing thick descriptions of the research context and participants. Dependability was maintained by documenting the research process systematically to allow replication. Confirmability was addressed by maintaining reflexivity and an audit trail of decisions during data collection and analysis.

Ethical Consideration

Ethical approval was obtained from the appropriate institutional review board prior to data collection. All participants were informed about the purpose, procedures, and voluntary nature of the study. Written informed consent was obtained from each participant before interviews and FGDs commenced. Participants were assured of confidentiality, anonymity, and the right to withdraw at any stage without penalty. Personal identifiers were removed from transcripts, and pseudocodes were used (e.g., P1–P17) to protect identities. Audio recordings and transcripts were stored securely and used solely for research purposes.

Results

The researcher collected data from a total of 17 informants using in-depth interview methods. These included one Head of the Family Planning Division at the OKU Timur District Office of Population Control and Family Planning (key informant), one Section Head, one Midwife Coordinator at Gumawang Community Health Center, one Family Planning officer in Belitang Subdistrict, four IUD acceptors, and three women of reproductive age with unmet need status. In addition, six non-IUD acceptors participated through both in-depth interviews and focus group discussions (FGDs). Complementary to these methods, the researcher also employed an observation checklist that covered all informants. The characteristics of the key and supporting informants, based on the data collection process, are presented in Table 1. The themes and subthemes identified in this study can be seen in Table 2.

1. Knowledge of IUD Contraceptive Use

Knowledge emerged as a central factor influencing women's decisions in contraceptive use, as it provides the foundation for making informed choices. Therefore, the researcher explored participants' understanding of IUDs in depth.

1.a. Understanding of IUD

The findings revealed that most supporting informants were able to correctly explain what an IUD is. This is illustrated in the following interview excerpt:

"*An IUD is a long-term contraceptive method (LARC) that does not contain hormones, can be used for an extended duration, and is inserted into the uterus in a T-shape*" (P6).

However, there were also informants who could not clearly describe the definition of an IUD, as reflected in the following statement:

"*Actually, I don't really understand, but as far as I know, an IUD is a contraceptive inserted into the uterus*" (P9).

Table 1. Characteristics of Key and Supporting Informants

Informant Code	Gender	Age (years)	Position/ Occupation
P1	Female	57	Head of Family Planning Division
P2	Male	41	Head of Family Planning Service Assurance Section
P3	Female	50	Midwife Coordinator
P4	Male	30	Family Planning Officer / Field Educator
P5	Female	31	IUD Acceptor
P6	Female	35	IUD Acceptor
P7	Female	29	IUD Acceptor
P8	Female	43	IUD Acceptor
P9	Female	31	Woman with Unmet Need
P10	Female	34	Woman with Unmet Need
P11	Female	31	Woman with Unmet Need
P12	Female	37	Non-IUD Acceptor
P13	Female	35	Non-IUD Acceptor
P14	Female	32	Non-IUD Acceptor
P15	Female	28	Non-IUD Acceptor
P16	Female	38	Non-IUD Acceptor
P17	Female	42	Non-IUD Acceptor

Table 2. Themes and Subtheme

Themes	Subthemes
1. Knowledge	a. Understanding of IUD as a contraceptive method
	b. Duration of IUD use
	c. Benefits and side effects of IUD use
2. Beliefs	a. Religious perspectives
	b. Personal beliefs
3. Culture	a. Cultural views on family planning
	b. Community perceptions and beliefs regarding IUD use

1.b. Duration of IUD Use

The findings indicated that most supporting informants were able to explain the duration of IUD use. For instance, one participant stated:

"*The duration is long, it can last up to eight years, and it does not contain hormones, with fewer side effects compared to other contraceptives*" (P5).

In contrast, some informants could not provide an accurate response regarding the length of IUD use, as illustrated by the following statement:

"*The IUD is a spiral that is inserted inside, right ma'am? That is why I am afraid to use it, and I am not sure how long it can be used*" (P12).

1.c. Benefits and Side Effects of IUD

Similarly, most informants were able to describe the benefits and side effects of IUD use. The following excerpts demonstrate this:

"*The IUD has no severe side effects. If there is bleeding, it usually means the insertion technique was incorrect, so not everyone can place an IUD properly*" (P3).

"*The IUD is a very effective contraceptive, and it does not really have side effects. If there are any, they do not interfere with my daily activities—at most, just mild abdominal pain*" (P5).

However, some informants admitted limited knowledge on this aspect, as reflected in the following response:

"*In my area, very few women have it inserted, so I don't really know*" (P17).

To validate these responses, the researcher compared them with statements from the key informant:

"*The IUD is a contraceptive inserted into the uterus. It does not contain hormones, so it does not have major systemic effects on the body. It can last for 5–10 years or until menopause, and its side effects are almost negligible*" (P1).

From these comparisons, it was observed that nine participants (Informants 2–8, 10, and 11) gave responses consistent with the key informant, while seven participants (Informants 9, 12–17) provided differing or incomplete answers. Overall, knowledge regarding the IUD was considered adequate when participants could answer questions about its definition, duration of use, and associated benefits or side effects. Divergent responses, particularly about the duration of use, highlighted knowledge gaps among certain groups.

These differences appeared to be related to occupational background and prior experience. Informants with professional or practical exposure—such as Informant 5, an IUD acceptor working as a midwife, and Informant 7, an IUD acceptor employed as a civil servant—demonstrated accurate knowledge. In contrast, informants who were not formally employed or had never used an IUD tended to have limited understanding and provided less accurate answers.

2. Beliefs Related to IUD Use

Beliefs were identified as an important factor influencing whether women chose to use or reject the intrauterine device (IUD). These beliefs were expressed through two subthemes: religious perspectives and personal beliefs.

2.a. Religious Perspectives

Some participants highlighted religious considerations when deciding whether to use an IUD. For example, one participant explained: "*According to the ulama, delaying childbirth is allowed. What is prohibited is permanent sterilization, so IUDs can still be used*" (P11).

Another participant stated:n"*I have never heard of any prohibition so far*" (P15).

These views were consistent with the perspective of the key informant, who emphasized that there were no religious barriers to IUD use:

"*From a religious standpoint, there is no problem in delaying childbirth. Sometimes there are differences in opinion, but throughout my tenure there has been no issue. In fact, family planning provides many benefits: preventing postpartum depression from unintended pregnancies, reducing maternal and infant mortality, and now family planning is also linked to the prevention of stunting*" (P1).

From these findings, the researcher inferred that different religions hold varying perspectives on family planning, including IUD use. While Islam was generally permissive, participants noted that some Christian and Catholic communities in Belitang Subdistrict did not support contraceptive use, including IUDs.

2.b. Personal Beliefs

Beyond religion, participants' individual perceptions strongly influenced their decisions. For instance, one participant stated: *"I have hypertension, so that is why I believe I should use the IUD*" (P8). Another expressed concern: *"I am afraid that if I use contraceptives, it will affect my body. I often hear from friends that they gained weight or had acne*" (P9). Similarly, one participant revealed: *"I am just afraid and embarrassed to have the IUD inserted*" (P12).

These statements indicate that personal beliefs were often dominated by fear and shame, which served as major barriers to IUD acceptance. However, some IUD acceptors expressed contrasting, more positive beliefs, viewing the IUD as safe, effective for women with chronic conditions such as hypertension, and a method recommended by health professionals that does not affect hormonal balance.

The key informant supported this interpretation: *"In our society, there is still a sense of taboo around IUD insertion because it involves a uterine procedure. This taboo is largely due to limited knowledge. Once women*

experience using the IUD, they usually realize it is not as frightening as people say. So, fear mainly comes from a lack of understanding" (P1).

Based on these findings, the researcher concluded that women with adequate knowledge and prior experience tended to hold positive beliefs about IUD use, whereas those lacking information or direct exposure often developed negative or fearful perceptions.

3. Culture

The researcher also explored cultural aspects in the community that could potentially influence IUD acceptance. Two subthemes were identified: cultural views on family planning and community perceptions of IUDs.

3.a. Cultural Views on Family Planning

Culture has often been considered a factor influencing contraceptive choices. However, in this study, most participants reported that there were no specific cultural traditions in Gumawang that directly prohibited or discouraged IUD use. Instead, reluctance was often associated with fear or personal hesitation rather than cultural norms. This was reflected in the following statements:

"Not really, ma'am. If you ask most women, they usually just say they are afraid" (P5).

"I don't think there is any culture or myth about family planning in my neighborhood" (P10).

3.b. Community Perceptions of IUDs

Despite the absence of explicit cultural prohibitions, community narratives and myths shaped women's perceptions of IUD safety. Several participants shared stories circulating in their communities:

"In my village, there are many stories—like the IUD can shift, disappear, or other things like that" (P11).

"Yes, ma'am. For example, my neighbor got pregnant, and they said the IUD stuck to the baby's head. But I'm not sure whether the IUD had been removed or not before she conceived" (P13).

"I have heard that IUDs can cause bleeding" (P16).

To validate these perspectives, the researcher compared them with the statement of the key informant, who explained: *"There is no cultural prohibition against IUDs. What actually happens is that women are afraid and embarrassed because the procedure requires an internal examination. This fear arises from limited knowledge about IUDs*" (P1).

Based on these findings, the researcher concluded that there were no specific cultural practices in the Gumawang community restricting IUD use. Instead, the low acceptance of IUDs was primarily influenced by misinformation and stories circulating within the community. These narratives, although not rooted in formal cultural traditions, acted as social beliefs that shaped women's decision-making regarding family planning.

Discussion

The study revealed three main themes—knowledge, beliefs, and cultural perceptions—that influenced women's decisions regarding intrauterine device (IUD) use at Gumawang Community Health Center. First, seven informants, primarily non-IUD acceptors and one with unmet need, were unable to define the IUD correctly and provided inconsistent responses compared to the key informant. This lack of knowledge highlights why IUD prevalence remains low in the study area. Similar to previous findings, knowledge plays a pivotal role in shaping contraceptive choices, as accurate understanding enables women to evaluate the benefits and risks of IUD use (Anggrainy et al., 2022).

Participants with professional or experiential exposure, such as health workers and IUD users, demonstrated better understanding, while non-users with no direct experience exhibited knowledge gaps. This aligns with studies by Lidya et al. (2020) and Radja et al. (2022), which showed that women with broader access to information and work-related interactions tend to have higher contraceptive knowledge, influencing their willingness to adopt long-term methods. Furthermore, knowledge-based perceptions directly affect decision-making processes, as supported by Rahayu (2022), who

emphasized that adequate knowledge facilitates behavioral adoption of modern contraceptive methods.

The effectiveness and advantages of IUDs—low failure rates (0.6–0.8 pregnancies per 100 women), long duration of use, absence of hormonal effects, and rapid return to fertility—further reinforce the importance of improving public awareness (Kemenkes, 2021). Misconceptions, however, persist, often discouraging women from choosing IUDs. Ratna et al. (2023) highlighted that women informed through offline channels were four times more likely to use IUDs compared to those receiving online information. Similarly, Bamegawati et al. (2023) noted that misinformation from non-professional sources reduced trust in IUD services. These findings support the need for frequent, clear, and repeated health education interventions to correct misconceptions and increase acceptance.

Beliefs also played a critical role. From a religious perspective, most Muslim informants acknowledged that IUD use was permissible, consistent with findings by Yusran et al. (2025) and Suwardi et al. (2024), who affirmed that contraception is acceptable in Islam if it preserves health and family welfare. Conversely, some informants reported that Christian and Catholic communities discouraged artificial contraceptives, aligning with Satrio et al. (2024), who stated that Catholic doctrine prohibits contraceptive use based on theological and moral grounds. These variations demonstrate that religious interpretations significantly shape contraceptive acceptance (Yanti, Asiani, & Wahyudi, 2025).

In addition to religious influences, personal beliefs emerged as another barrier. Many participants expressed fear of side effects such as weight gain or infertility, while others reported feelings of embarrassment regarding IUD insertion. Such findings resonate with Nuzul et al. (2021) and Harneli et al. (2020), who found that lack of prior experience fosters negative attitudes and fear. Jumiati et al. (2023) further emphasized that younger women often perceive IUDs as taboo, avoiding them despite their effectiveness. Similarly, Puspita (2024) noted that myths and misinformation in communities perpetuate fear and shame, reducing IUD uptake.

Cultural perceptions also shaped decision-making. While participants generally denied the existence of explicit cultural prohibitions against IUD use, many recounted stories circulating in their communities, such as IUDs causing bleeding, shifting position, or attaching to the fetus. Although not rooted in formal cultural practices, these narratives functioned as cultural beliefs influencing contraceptive decisions. Fatikhin et al. (2025) and Mahmudah et al. (2023) argued that culture evolves through human behavior and can perpetuate misconceptions across generations. Similarly, Novitasari et al. (2022) demonstrated that ethnic and cultural backgrounds affect acceptance of intrauterine contraception, particularly in communities holding pronatalist values such as “many children, much fortune.”

The persistence of pronatalist cultural values further complicates contraceptive decision-making in Indonesia. As noted by Kholidah and Widjayatri (2025), large family size can strain household resources, leading to school dropouts and intergenerational poverty. In this context, IUDs offer both economic and health advantages, being cost-effective and non-hormonal while ensuring long-term protection. Addressing negative cultural narratives requires targeted community engagement, particularly through collaboration with local leaders and repeated educational campaigns (Anita, Aisyah, & Anggraini, 2024; Haryanti, 2023).

Overall, the findings underscore that low IUD acceptance is not solely due to lack of availability but is shaped by intertwined factors of limited knowledge, misinformed beliefs, and cultural perceptions. Efforts to improve uptake should prioritize comprehensive counseling, repeated community-based education, and active involvement of religious and cultural leaders to dispel myths and normalize IUD use as a safe, effective, and culturally acceptable contraceptive option.

Conclusion and Recommendation

Informants' knowledge of IUDs strongly influenced the decisions of women of reproductive age in choosing contraceptive methods. The findings confirm that the better the knowledge, the higher the likelihood of IUD acceptance. In contrast, beliefs expressed by participants were predominantly shaped by fear and shame, which largely stemmed from misinformation circulating in the community. Misconceptions such as IUDs causing bleeding, disappearing, or attaching to the fetus represented negative cultural narratives that continue to spread across generations, reinforcing resistance to IUD use.

These three factors—knowledge, beliefs, and cultural perceptions—emerged as the main determinants underlying the persistently low prevalence of IUD adoption in the study setting. Therefore, it is recommended that family planning officers, both at the community and district levels, strengthen knowledge dissemination by enhancing communication networks through health education, counseling, and more engaging use of social media platforms. Furthermore, health and family planning providers should establish community-based forums involving women of reproductive age to ensure wider access to accurate information. Strengthening partnerships with community and religious leaders is also essential to foster positive local cultural values surrounding IUD use.

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Declaration on the Use of AI
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