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MISCONCEPTIONS AS PREDICTORS OF CONTRACEPTIVE USE AMONG MARRIED WOMEN IN SOUTHWEST NIGERIA

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Abstract

The low prevalence of contraceptive use in sub-Saharan Africa has been largely ascribed to a lot of factors. Among such factors is false impression about family planning use. This study examined misconceptions as determinants of contraceptive uptake among married women in Southwest, Nigeria. A cross sectional study was carried out among 1187 women of reproductive age (15-49) years in Southwest, Nigeria. The study adopted a multi-stage sampling procedure to select the study participants and questionnaire method was employed to elicit responses from them. The study employed statistical product for services solution (SPSS version 20) to analyze the data collected. Frequency distribution was employed to explain the socio-demographic characteristics of the study participants, while chi-square test and logistic regression analysis were employed at the bivariate and multivariate level. The study showed that the mean age of the respondents was 33.7 ± 7.7 S. D, while the mean age at first marriage was 24 years. The study further showed that contraceptive use is still low in the region despite marginal improvement. Moreover, there were significant positive relationships between misconceptions such as family planning causes promiscuity, embarrassment at the point of uptake and contraceptive use. However, there were significant negative relationship between women who believe that contraception causes cultural inhibition/lack of openness among spouses as well as irregular menstruation. The study concludes that misconceptions such as family planning causes promiscuity, infertility, weight gain, irregular menstruation, cultural inhibition and lack of openness between couples and lead to embarrassment at the points of uptakes still exist in the study area. The study recommends that to witness improved contraceptive use in the area, program interventions tailored to contraceptive needs of married women such as health education and awareness campaign at both the national and local level should be embarked upon.

Keywords

misconceptions, predictors, contraceptive use, married women, southwest

Introduction

In spite of globalization of family planning, many sub-Saharan nations still wallow in abysmally low contraceptive prevalence rates (Boadu, 2022). In a study carried out in sub-Saharan Africa to determine contraceptive rates in 2022, it was discovered that the overall contraceptive rate in the region was 22%, with regional variations (Boadu, 2022). The study showed that Namibia (49.7%), Lesotho (48.5%), Zimbabwe (47.9%), South Africa (47.9%) and Malawi (45.2%) had the highest rates in the region, while Comoros (9.9%), Democratic Republic of Congo CDR (8.1%), Gambia (6.5%) and Chad (4.8%) had the least rates. Similar study carried out in the region showed that contraceptive prevalence rates remain low though the rate increased marginally to 24.32% in 2024 (Donkoh et al., 2024). Chad had the least

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contraceptive prevalence rate (5.07%), while Zimbabwe had the highest prevalence rates (66.81%) (Donkoh et al., 2024). This low contraceptive rate is largely due to a web of interconnected factors ranging from socio-demographic such as illiteracy, poverty, rural residence, age and age at marriage, fewer or no living children (Apanga et al., 2020; Ba et al., 2019), to cultural influences such as the desire for large family size, son preference especially as an insurance against widowhood and inheritances purposes (Abdi et al., 2020). In addition, other cultural factors identified as predictors of low level of contraceptive in tropical Africa are male disapproval and patriarchy (Blackstone et al., 2017). Other studies have emphasized the influential impact of misinformation, misconceptions and myths on family planning use. It was reported that there are widespread misconceptions about family planning use in sub-Saharan Africa. These range from infidelity, infertility, cancer and faulty births (Mwaisaka et al., 2020; Stats et al., 2020). Other misconceptions are irregular menstrual flow, weight gain, bleeding, high blood pressure, disruption of sexual intercourse, infections, spontaneous withdrawal of sperm from the uterus and disturbance of daily activities (Engelbert Bain et al., 2021; Tadele, 2022). These misconceptions were some of the factors that have contributed to low contraceptive use in the region, even in areas perceived to be enlightened and educated.

Misconception about family planning among married women is also widespread in Nigeria. The misconceptions range from infidelity, promiscuity, is equal to abortion, delays menstruation, weaken ovaries and can lead to health hazards (Meskele et al., 2024) (Mwaisaka et al., 2020.). Other misconceptions reported as the causal effect of family planning were cancer and infertility (Ankomah et al., 2011). For the country to experience improved contraceptive prevalence rate among married women, misconceptions associated should be totally eradicated through pragmatic and targeted health promotion programs designed for married women. This study examined misconceptions as predictors of contraceptive use in Southwest, Nigeria.

Theoretical foundation

The study employed social cognitive theory (SCT) to explain misconceptions as predictors of contraceptive use among married women in Southwest Nigeria. The theory was developed by Albert Bandura in the 1960s as a social learning theory (SLT), but later transformed to a social cognitive theory (SCT) in 1986. The theory sees learning as occurring in a social context through interactive and dynamic intermingling between persons, environment and behavior. The theory is anchored on how individuals acquire behaviors by observing, imitating and modeling behaviors within a social context. The theory focuses on the shared dealings between individual dynamics, environmental effects, and behavior. The theory highlights the significance of self-efficacy, as a bedrock for one's belief in his/her ability to effectively accomplish a task.

The main components of the theory are;

i. people learn behaviors they find rewarding and useful to them by replicating what they see in the life of others;
ii. one's capacity reinforces the ability to execute behaviors needed to generate specific results. It is believed that higher self-efficacy will lead to more incentives to carry out needed tasks;
iii. behavior is affected by the interface between individual dynamics such as attitudes and philosophies, the environment, and the behavior of individuals.
iv. behaviors are more likely to be repetitive if they are followed by positive reinforcement, such as rewards or social approval.

However, the theory deemphasizes the effect of non-cognitive and environmental factors on behavior. The theory exemplifies that women are likely to replicate what they see in the life of others not because it is correct, but because others are doing it and it is socially

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approved by the people in the society. In addition, the application of the theory will help to change the misconceptions associated with family planning through targeted intervention programs such as capacity building and health education for women.

Methods

Research Design

The study adopted a cross sectional research method to elicit responses from 1200 married women in Southwest Nigeria through questionnaire method. However, 1187 questionnaires were administered and returned

Sample design and sample size

The study employed multistage sampling technique to choose the sampled population of 1200 for the study. The sample size (1200) chosen was to enrich the quality of results as the more the sample size, the better the results findings will be. Using the population census of 2006, Southwest population was 27.581.992. The formula for determining sample size for finite population such as Taro Yamane or Krejcie and Morgan (1970), would have resulted in the highest sample size of 400. However, to enrich the study, sample size of 1200 was employed for the study. Nevertheless, 1187 questionnaires were returned. Lagos, Osun and Ekiti states respectively were purposively chosen in the region for the study. At the second stage, purposive sampling procedure was adopted to choose two towns in each of the states reflecting the state capital and another town remotely far from the state capital. Thus, in Lagos state, Ikeja was chosen as the state capital, while Itamaja situated in Ikorodu local government area was picked as the distant community in the state Lagos. In Osun state, Osogbo was chosen being the state capital, while Tonkere was chosen in Ife Central Local Government area as the faraway town. In Ekiti state, Ado Ekiti was selected being the state capital, while Ido-Ile was selected in Ekiti West local government. Two towns (urban/rural) were chosen in each state to achieve the study objectives. Based on the 2006 population census, 1200 was apportioned into the states using their proportion. In Lagos state, 729 women were chosen, split into 437 in Ikeja and 292 in Itamaja respectively. 277 were chosen in Osun, 166 in Osogbo and 111 in Tonkere, while in Ekiti state 174 women were chosen, 116 in Ado Ekiti and 78 in Ido ile respectively. The last phase was the application of simple random sampling to select eligible married women in each of the selected towns in the respective states.

Data Analysis

The data collected were analyzed with the use of Statistical Product for Services Solution (SPSS) software version 20. Analysis was done at the univariate stage, bivariate stage and multivariate level. At the univariate level, frequency distributions and percentages were used to describe the socio-demographic characteristics of the respondents. Analysis done at the bivariate and multivariate levels employed chi-square statistics, as well as logistic regression to quantify the relationship between response variable and predictor variables.

Results

Table 1 displays the spreading of the respondents by socio-demographic features. The average age of the respondents was 33.7 years. The analysis shows that more than two-fifth of the research subjects were aged 25 and 34 years. More than one-quarter of the research subjects were between the age of 35 and 44 years, while a little above one-tenth were aged 45 years and above. Women in age bracket 15-24 years have the least percentage of 9.8%. Furthermore, the analysis shows more than three-fifth of the research subjects had post-secondary education,

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while 17.2% had secondary education, 11.5% had below secondary education. Equally, a little above one-tenth of the research subjects had quranic or no formal education. In addition, more than two-fifth of the respondents (45.2%) were currently using contraceptive during the investigation while above half of the research subjects were non-users.

Characteristics	Frequency 1187 (100.0)
Age	
15-24	117 (9.8)
25-34	541 (45.5)
35-44	389 (32.8)
45 and above	140 (11.8)
Mean Age, SD	33.7, 7.7
Age at Marriage	
15-24	636 (53.6)
25-34	524 (44.1)
35 and above	27 (2.3)
Mean, S.D	24.0, 4.5
Education	
Non Formal/Quranic	121 (10.2)
Below Secondary	137 (11.5)
Secondary	204 (17.2)
Post-secondary	725 (61.1)
Contraceptive Use	
Use	537 (45.2)
Non-use	650 (54.8)
Working	
Yes	1052 (88.6)
No	135 (11.4)
Income	
Below N150,000	1149 (96.8)
N150,000 and above	38 (3.2)
Place of residence	
Urban	713 (60.1)
Rural	474 (39.9)
Religion	
Christianity	821 (69.2)
Muslim	337 (28.4)
Traditional	29 (2.4)
Type of marriage	
Monogamy	1075 (90.6)
Polygamy	112 (9.4)

Table 1. Distribution of respondents by socio-demographic characteristics

The table further showed that more than three-fourth of the respondents were working, while a little above one-tenth of the respondents were not working. Moreover, many of the ladies (96.8%) were earning below N 150,000.00. However, the remaining respondents were earning N 150,000.00 and above (3.2%). The table further showed that roughly 60% of the respondents were living in urban areas, while approximately 40% live in rural areas. From the table above, 69.2% of the respondents were practicing Christian religion, 28.4% were Muslims

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while a paltry 2.4% claimed to be traditionalist. Lastly, the majority of the respondents (90.6%) were in monogamous home, while the remaining were in polygynous marriage.

Table 2 displays respondents' responses in respect of misconception and belief about contraception. Some of the beliefs raised in the study were that contraception causes promiscuity (37.2% of the respondents held on to this belief, while 62.8% of the respondents did not). Of the 37.2% who believe that it causes promiscuity, 18.9% were living in urban areas, while 18.3% were living in rural areas. In the same vein, out of the 62.8% of the respondents who did not believe that contraception causes promiscuity, 41.1% were living in urban areas while 21.7% live in rural areas.

Moreover, the table also shows the distribution of responses to question of whether family planning causes infertility: slightly below half (47.6%) of the respondents held on to the belief, and 52.4% were of a contrary opinion. Out of the 47.6% of the women who believe that it causes infertility, 23.8% were urban dwellers, while 23.8% were rural dwellers. However, 36.2% of the urban dwellers and 16.2% of the rural dwellers out of 52.4% women did not believe that it causes infertility.

On the question of whether contraception causes lack of openness between husband and wives and cultural inhibition, the majority (87.7%) of the respondents did not believe that, and out of this number, 51.4% of the respondents were urban dwellers, while 36.3% were dwelling in rural areas. Moreover, on the question of whether contraception causes irregular menstruation, more than one-tenth (12.0%) of the respondents believed so, while more than three-quarter had contrary belief. In addition, on the question of whether contraception makes women to add weight, close to one-quarter (23.8%) believed so, while more than three-quarter (76.2%) had contrary opinion.

On the question of whether contraception causes embarrassment, 18.4% of the women believed that it causes embarrassment, especially at the point of uptakes, and from this percentage, 8.8% were living in urban areas, while 9.6% were living in rural areas. Also, 81.6% of the respondents did not believe that contraception causes embarrassment, 51.2% were living in urban areas, while 30.4% were living in rural areas. Consequently, it has been shown that while some of the respondents had misgivings and erroneous belief and negative attitude towards contraception, the majority of the respondents did not share in such view that contraception causes promiscuity, infertility, lack of openness/ cultural inhibition, irregular menstruation, makes women to add weight and embarrassment to up-takers. The analyses therefore showed that misconceptions and negative beliefs about family planning are gradually losing its grip on people. This could be due to level of education and awareness campaign in the area.

Misconception	**Urban (N=713)**		**Rural (N=474)**		**Total (N=1187)**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Causes Promiscuity	225 (18.9)	488 (41.1)	216 (18.3)	258 (21.7)	441 (37.2)	746 (62.8)
Causes Infertility	283 (23.8)	430 (36.2)	282 (23.8)	192 (16.2)	565 (47.6)	622 (52.4)
Cultural inhibition and lack of openness between spouse	103 (8.7)	610 (51.4)	43 (3.6)	431 (36.3)	146 (12.3)	1041 (87.7)
Causes irregular menstruation	98 (8.2)	556 (46.8)	44 (3.8)	430 (36.2)	142 (12.0)	1045 (88.0)
Makes women to add weight	157 (13.2)	556 (46.8)	126 (10.6)	348 (29.4)	283 (23.8)	904 (76.2)
Causes	105 (8.8)	608 (51.2)	113 (9.6)	361 (30.4)	218 (18.4)	969 (81.6)

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embarrassment						

Table 2. Distribution of respondents by misconception about contraception

Table 3 shows the relationship between misconceptions about contraception and family planning use. The analysis shows that there is an association between belief that contraceptive causes promiscuity and contraception use. This is because chi-square calculated (10.712) is greater than chi-square table value of 3.841. There is a significant correlation between the belief that family planning causes promiscuities and its uptakes. The analysis further shows that cultural inhibition and lack of openness between couples is significantly associated with contraception because chi-square calculated (19.427) is greater than chi-square table value of 3.841.

Furthermore, the study revealed that there is a significant association between beliefs that contraceptive causes irregular menstruation and contraceptive uptake. This is because chi-square calculated (4.849 is greater than chi-square table values 3.841 at 1 degree of freedom, which is significant at 5%. Lastly, the table further shows that there is a significant correlation between the belief that contraception causes embarrassment at the point of uptake and contraception. This is because chi-square calculated (4.340) is higher than chi-square values (3.841) at 1 degree of freedom using 5% level of significance.

The analysis shows that though the percentage of women who had misconceptions about family planning in the study areas has reduced, there are statistical evidences to show that some of the misconceptions have significant relationships with contraceptive use.

Misconception/ Belief	**Contraception**			**Chi-square**	**Chi-square T-value**	**Degree of Freedom**
	Yes	No	Total			
Causes promiscuity						
Yes	294 (24.8)	157 (13.2)	451 (38.0)	10.712***	3.841	1
No	409 (34.5)	327 (27.5)	736 (62.0)			
Causes infertility						
Yes	343 (28.9)	217 (18.3)	560 (47.2)	1.800	3.841	1
No	360 (30.3)	267 (22.5)	627 (52.8)			
Causes cultural inhibition and lack of openness between spouse						
Yes	63 (5.3)	85 (7.2)	148 (12.5)	19.427***	3.841	1
No	640 (53.9)	399 (33.6)	1039 (87.5)			
Causes irregular menstruation						
Yes	72 (6.1)	70 (5.9)	142 (12.0)	4.849*	3.841	1
No	631 (53.2)	414 (34.9)	1045 (88.0)			
Causes weight gain						
Yes	156 (13.1)	127 (10.7)	283 (23.8)	2.588	3.841	1
No	547 (46.1)	357 (30.1)	904 (76.2)			
Causes embarrassment at the point of uptake						
Yes	144 (12.1)	76 (6.4)	220 (18.5)	4.340*	3.841	1

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No	559 (47.1)	408 (34.4)	(81.5)			

Table 3. Distribution of respondents by misconceptions about contraception and its usage

Table 4 shows that there is a significant association between misconceptions about contraception and its usage. Women who believed that contraception causes promiscuity were 1.438 more predisposed to adopt contraception than those who did not believe the same (OR=1.438; 95% C.I:1.123-1.840; P<0.05). However, there is a significant negative correlation between women who had misconception that contraception causes cultural inhibition and lack of openness among spouses.

Belief/Attitude	**Degree of Freedom**	**Chi-square**	**Beta Coefficient**	**Standard Error (S.E)**	**Exp(B)**	**Sig.**	**95% C.I for Exp(B)**	
							Lower	Upper
Contraception causes promiscuity	1	10.712	0.363	0.126	1.438	0.004	1.123	1.840
Contraception causes cultural inhibition and lack of openness	1	19.427	-0.775	0.184	0.461	0.000	0.321	0.660
Contraception causes irregular menstruation	1	4.849	-0.427	0.185	0.652	0.021	0.454	0.937
Contraception causes embarrassment	1	4.340	0.467	0.164	1.595	0.004	1.157	2.200

Table 4. Binary logistic regression on relationship between misconceptions and contraception

The analysis indicated that women who believe that contraception causes cultural inhibition and lack of openness between spouses were 0.461 less likely to use contraception than their counterpart who did not share such belief (OR=0.461; 95% C.I:0.321-0.660; P<0.05). Further investigation revealed that there is a significant negative correlation between misconception (contraception causes irregular menstruation) and contraception. Women who believe that contraception causes irregular menstruation were 0.652 times less likely to adopt family planning than their counterpart who did not believe the same (OR=0.652; 95% C.I:0.454-0.937; P<0.05). In addition, there is a significant positive correlation between those who believe that contraception causes embarrassment at the point of uptake and usage of contraception. This means that women in this category were more predisposed to contraception than their counterpart who did not share such belief (OR=1.595; 95% C.I:1.1570-2.200; P<0.05). All the variables in this category were significant both at the bivariate level and multivariate level.

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Discussions

The study examined the relationship between misconceptions about family planning with its use among women of reproductive age in Southwest Nigeria. The average age of the respondents was 33.7 years, with a standard deviation of 7.7. The study shows that the majority of the respondents had secondary education and were Yoruba speaking people. The study further showed that over half of the respondents lived in urban areas, the majority of them were gainfully employed and earning below N 150,000.00 only. In addition, the majority of the respondents were living in monogamous homes, and were Christians. The study further showed that contraceptive uptake is still low in the area, though there is an improvement over the previous studies (Abubakar & Abubakar, 2024; Oyinlola et al., 2020).

The study shows that misconceptions such as family planning causes promiscuities, infertility, cultural inhibition and openness between spouses still exist in the region. Other misconceptions are: family planning leads to weight gain, irregular menstruation and embarrassment at the point of uptakes. This outcome is reinforced by the study carried out among married women in six major cities in Nigeria, where it was discovered that misconception associated with family planning is still high (Saad et al., 2018).

The study discovered that despite the fact that the number of women who hold misconceptions about family planning is smaller to those who did not, there are strong relationships between some of the misconceptions and family planning use in the area. The study found that there are significant positive correlations between misconceptions such as family planning causes promiscuity and irregular menstruation and family planning use. This means women who hold misconceptions such as family planning causes promiscuity and irregular menstruation have the higher probability to use contraceptive than their counterpart who does not share such beliefs. This finding looks confounding. However, the implication of the outcome might be that women in this group did not have any option than to use family as a way of preventing unwanted pregnancies despite perceived misconceptions they held. The study further shows that there is negative correlation between misconception (family planning causes cultural inhibitions and lack of openness among couples) and family planning use. This outcome is buttressed by the studies conducted in Nigeria on the causes of low contraceptive prevalence among Nigerian women, as well as the unmet requests and obstacles to contraceptive use in Kaduna (Akamike et al., 2020; Sinai et al., 2020). Further result shows that there is negative relationship between the misconception that contraception causes embarrassment at the point of uptake and contraceptive use. This outcome is corroborated by the study carried out in Nigeria which investigated stigma and misconceptions associated with family planning (Black et al., 2024). The study shows that stigma associated with contraceptive use is a major predictor of contraceptive adoption in the area.

Limitation of the study

The study is restricted to misconceptions as determinants of contraceptive uptakes among married women in Southwest Nigeria. The non-inclusion of men as important factor in contraceptive usage may likely affect the quality of the results.

Conclusions

Though there were fewer number of women who hold misconceptions in Southwest Nigeria as those who did not hold such view, misconceptions still prevail and affect contraceptive use among married women in the area. Such misconceptions were family planning causes promiscuity among women, causes cultural inhibition and openness among

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couples. Furthermore, it leads to irregular menstruations and embarrassment at the point where women wish to procure family planning products.

Recommendation

The study proposes that health literacy should be given to married women in order to have proper understanding of family planning products available. In addition, health workers should be professional while attending to women who visit their hospitals and pharmaceutical centers for family planning services. Moreover, reproductive health campaign and promotions that target married women should be held be government and other stakeholders to disabuse their minds of any misconceptions associated with family planning.

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