Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 7, Issue, 04, pp.15148-15155, April, 2015

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

ISSN: 0975-833X

RESEARCH ARTICLE

MYTHS AND MISCONCEPTION ON CONTRACEPTION AMONG WOMEN OF REPRODUCTIVE AGE GROUP IN OGBOMOSO, SOUTHWEST NIGERIA

***Kola M. Owonikoko, Wakeel O. Muritala, Aramide M. Tijani and OluseyiAtanda**

Department of Obstetrics and Gynecology, Ladoke Akintola University of Technology Teaching Hospital, Ogbomoso, Oyo State, Nigeria

ARTICLE INFO

Article History:
Received 10th January, 2015
Received in revised form
18th February, 2015
Accepted 23rd March, 2015
Published online 30th April, 2015

Key words:

Myths,
Misconceptions,
Contraception,
Reproductive age group.

ABSTRACT

Background: Sexual behavior among women of reproductive age group is characterized by erratic, infrequent and unplanned sexual activities, a trend that exposes them to unwanted pregnancy. While sexual activity among young women begins early, contraceptive knowledge and usage remain low.
Objective: To determine the existence of myths and misconceptions regarding contraception among various women of reproductive age group in Ogbomoso.
Methodology: It was a cross - sectional descriptive study among consenting women of reproductive age group atOra Market, General Outpatient Department of General Hospital, and LAUTECH undergraduates with the use of a structured, pretested, interviewer administered questionnaire.
Result: The mean age range of respondents was 27.9 $\pm$ 6.98 years. Majority of the respondents (53.3%) have never used any form of contraception. The most commonly used method of contraception was male condom. There was high level of existence of myth and misconceptions about contraception in general. Significant proportion of the participants 23.3% and 30.7% thought that pills causes cancer and weaken the ovaries respectively. More than half (57.6%) of the participants alleged that using injectables for long period makes one not to conceive in future.
Conclusion: There exist myths and misconceptions on various methods of contraception in our environment even among students and hospital patients. It may explain the reason for the high prevalence of unmet need on contraception in this country.

INTRODUCTION

Sexual behavior among women of reproductive age group is characterized by erratic, infrequent and unplanned sexual activities, a trend that exposes them to unwanted pregnancy and sexually transmitted infections including HIV. While sexual activity among young women begins early, contraceptive knowledge and use remain low (RhouneOchako *et al*., 2015). Throughout history, regardless of their culture, women have tried to avoid unwanted pregnancies by using more or less reliable method, however most cultures have certain myths based upon rumors without any medical or scientific proof, which are often linked to taboos (ShehlaChanna *et al*., 2013). To promote sexual health and avoid unintended pregnancy, women need a greater understanding about contraception use and associated risks. Contraceptive use in sub-Saharan Africa remains low despite the increase in awareness (Alkema *et al*., 2013 and Baird *et al*., 2012). Emerging evidence from different African settings revealedreal or perceived risks and misconceptions as a significant contributor to the low or ineffective adoption of modern contraceptives among women of reproductive ages (Bajos *et al*., 2013; Hindin *et al*., 2014; Kotb *et al*., 2011 and Mandara, 2012). An estimated 215 million women in the developing world have an unmet need for modern contraceptions (Francis Okello and YaredGetachew 2013). Cultural and traditional values that openly support high fertility within marriage would readily promote low use of contraceptives (AgunbiadeOjo *et al*., 2014). Poor education and illiteracy, which fosters high fertility and low contraceptive use, has been a feature of most sub-Saharan Africa countries, especially in the rural communities (Augustine Ankomah 2011).

Nigeria's fertility has remained high, with total fertility rates reducing only marginally from 6.0 in 1990 to 5.7 in 2008 (Nigeria Demographic and Health Survey 2008). In 1990, modern contraceptive use among all women was only 4% (National Demographic and Health Survey 1990), increased to 9% in 1999 Nigeria Demographic and Health Survey 1999), stayed the same (9%) in 2003, and rose slightly to 11% in 2008 (Nigeria Demographic and Health Survey 2008). The consistently low figure for uptake of contraception over the past 20 years, despite the existence of family planning

Corresponding author: Kola M. Owonikoko,
Department of Obstetrics and Gynecology, Ladoke Akintola University of Technology Teaching Hospital, Ogbomoso, Oyo State, Nigeria.

programs, indicates a need to re-examine some of the obstacles to modern contraceptive use in Nigeria with a view to improving the situation. Other background indicators that affect contraceptive use include sexual behavior, differences in demographic characteristics, such as urban–rural residence, age, gender, and education (Augustine Ankomah*et al*., 2011).

Major reasons for not using contraceptives included lack of knowledge, wanting more children, fear of side effects, husband's disapproval, with 28% indicating other reasons not mentioned (UNFPA 2010). The other reasons not mentioned could be myths and disbelief about contraception. Women and men discussed a wide range of fears centered on the following; infertility, contraceptive failure, method expulsion or shift, cancerous growths, and birth defects (Daniel, 2012). Participants linked many of these fears to specific methods of contraception. Pills and injectable contraceptives were most often implicated in participants' reported fears. They believed that the pill and injectable contraceptives were associated with infertility, cancerous growths, especially following prolonged use. The two methods were also believed to be associated with an increased chance of birth defects, especially when one failed to adhere to the pill regimen, or received an expired injectable (Daniel, 2012).

The key views of respondents on myths, misinformation, and communication about family planning and contraceptive use in Nigeria include the misinformation that family planning makes unmarried people "loose" (46%), encourages female promiscuity (39%), is for married couples only (35%),encourages male infidelity (34%) and 33% believed it leads to infertility in women (Augustine Ankomah *et al*., 2011). Effective adoption of modern contraceptives among women of reproductive age remains critical to sexual and reproductive health promotion and could lead to a possible reduction in a number of maternal health challenges (Cleland *et al*., 2006). Effective contraceptive use also empowers women (Hindin *et al*., 2014) by enabling them to contribute more to meeting household expenses, including nutrition and to reduce unmet need for family planning (Augustine Ankomah *et al*., 2011). Fears, misconceptions or misinformation, and side effects (actual or perceived) of methods are common barriers to the adoption and continuation of modern contraception. Understanding barriers to fertility regulation is important for providing programming guidance in relation to the provision of family planning services (Augustine Ankomah *et al*., 2011).

On the whole, belief in myths and misinformation correlated negatively with use of modern contraceptives, while having correct knowledge about contraception and family planning was positively associated with use of contraception. Therefore, the objectives of this study were to determine the existence of various myths regarding contraception and to clarify those myths for women to have better factual information.

MATERIALS AND METHODS

This study was cross-sectional and carried out in multi-sites in Ogbomoso, Southwest Nigeria. The study population involved Market women at Ora Market in Ogbomoso; (to elicit the existence of Myths and Misconception at the community level), women of reproductive age group attending General Outpatient Department of General Hospital, Sunsun in Ogbomoso, (this wasto elicit the impact of health education on the existence of Myths and Misconceptions on contraception) and Undergraduate ladies at Ladoke Akintola University Technology (LAUTECH), Ogbomoso; (for assessment of the impact of Western education on the existence of Myths and Misconceptions on Contraception).

The sample size of 420 participants was obtained by assumption that total population of women of reproductive age group in Ogbomoso was more than 10,000 with 50% prevalence rate of myth and misconception and increase of 10% of calculated sample size was made to allow for attrition or non-completion of the questionnaire. Participants were consenting women of reproductive age group at Ora Market, General Outpatient Department of General Hospital, Sunsun and LAUTECH undergraduates. Excluded from the study were non-consenting women, Medical practitioner, wife of medical practitioner and Medical students or other students of Faculty of Health Sciences. The final selection of the participants was done through simple randomization. The ethical clearance for the study was obtained from the management of General Hospital, Sunsun, Dean of Student Affairs and Ora's market leaders were approached for their support of the study. Respondents were also duly counseled and the freedom of participation and non-participation was emphasized.

The instrument of survey was a structured questionnaire which consisted of 8 sections. SECTION A was employed to collect the demographic data, Section B: sought information about respondent's knowledge on contraception and Section C – H:were employed to assess myths and misconceptions on various contraceptives methods. The questionnaires were interviewer-administered. The pretesting of the questionnaires was done among 20 female health attendants of LTH and ambiguous questions were re-phrased. The raw data from the field was screened for inconsistencies. Analysis of data was by computer using statistical package for social sciences (SPSS) version 20 of windows evaluation version. Descriptive statistics was done for assessing the demographic characteristics of the respondents. Myths and misconceptions are presented in frequencies and percentages. "Chi square test" and p value was used to establish the significant of those myths among the groups. The p value was set at < 0.05 at 95% confident intervals.

RESULTS

The age range of respondents was between 15 and 45 years, mean age was 27.9±6.98 years. There was relatively younger age group among the students with majority(47.9%) in age group 21-25,whereas 32.9% and 29.3% of hospital patients and market women respectively were in age group 26-30 (X^2= 177.6; $p < 0.001$). All the students interviewed were undergraduates, 45.7% of hospital patients had tertiary and postgraduate level of education, whereas majority of the market women (88.6%) had secondary school level of education and below (X^2= 406.9; $p < 0.001$).Only 16(11.4%) of the students were married against 112 (80.0%) and 118(84.3%) of hospital patients and market women respectively (X^2= 215.5; $p < 0.001$). Details as in Table 1.

Table 1. Comparison of socio-demographic status of participants

Characteristics	StudentsN (%)	Hospital PatientsN (%)	Market women N (%)	X^2	P VALUE
AGE GROUP (YEARS)					
15- 20	53 (37.9)	14 (10.0)	15 (10.7)		
21- 25	67 (47.9)	16 (11.4)	18 (12.9)		
26- 30	19 (13.5)	46 (32.9)	41 (29.3)	177.6	<0.001*
31- 35	1 (0.7)	39 (27.9)	21 (15.0)		
36- 40	0 (0)	14 (10.0)	30 (21.4)		
41- 45	0 (0)	11 (7.9)	15 (10.7)		
EDU. STATUS					
NONE	0 (0)	7 (5.0)	15 ((10.7)		
PRIMARY	0 (0)	16 (11.4)	27 (19.3)		
SECONDARY	0 (0)	53 (37.9)	82 (58.6)	406.9	<0.001*
UNDERGRADUATE	140 (100)	14(10.0)	1 (0.7)		
TERTIARY	0 (0)	50 (35.7)	15 (10.7)		
MARITAL STATUS					
NEVER MARRIED	123 (87.9)	21 (15.0)	22 (15.7)		
MARRIED	16 (11.4)	112 (80.0)	118 (84.3)	215.535	<0.001*
DIVORCED	1 (0.7)	3 (2.1)	0 (0)		
WIDOW	0 (0)	4 (2.9)	0 (0)		
OCCUPATION					
UNSKILLED	0 (0)	29 (20.7)	56 (40.0)		
SEMISKILLED	0 (0)	45 (32.1)	37 (26.4)		
SKILLED	0 (0)	25 (17.9)	21 (15.0)	390.116	<0.001*
PROFESSIONAL	0 (0)	36 (25.7)	18 (12.9)		
UNDERGRADUATE	140 (100)	5 (3.6)	8 (5.7)		

Statistically significant at $p < 0.05$

The respondents knowledge/level of awareness on various methods of contraception showed greatest level of awareness for male condoms (84.8%), followed in descending order by injectables (78.1%), oral pills (74%), female condom (70.7%), withdrawal method (70%), IUCD (57.6%), bilateral tubal ligation(56.4%) and implants (53.6%). However, 46% of the respondents of which more were market women (Market women-82, Hospital patient- 56, and Students -55), believed in use of local rings as a form of contraception. This finding was statistically significant (X^2= 24.0; p <0.001).

Majority of the respondents, 224 (53.3%) have never used any form of contraception. Only 46.7% of respondents had ever used or currently on contraception (56.4% hospital patients, 44.3% market women and 39.3% students), this finding was statistically related (X^2 =8.74; $p < 0.013$). The most commonly used method of contraception was male condom (27.1%), withdrawal method (20.7%), oral pills (13.3%), injectables (10%), IUCD (8.8), calendar method (8.5%), Female Condom (7.4%), Implants (0.9%) and Sterilization (0.5%). Reasons given for not using contraception included; fear of side effects (27.1%), wanting more children (17.6%), partners disapproval (10.9%), lack of knowledge (10.9%), lack of access (5.2%), non- availability (3.5%) and too expensive (3.5%). The major source of information of the respondents was hospital, followed by mass media (41.4%), others included; personal efforts (38.6%), peers/ friends (33.1%), educational institution (28.8%), husband/spouse (20.2%), religion leaders (15.7%), and parents/elders (15.5%). Majority of the respondents (53.8%) did not have any plan to limit their children, while 46.9% of them want the number of children as given by God, 6.9% don't know, 30.2% want 2-4 children, 9.3% want more than four children and 3.3% want only 1 child.

Table 2 showed myths and misconceptions on contraception in general. Majority 241(57.4%) of the respondents especially the market women 95(67.9%) were of the opinion that contraception causes inability to conceive even after stopping, followed by the hospital patient 75(53.6%) and 71(50.7%) students (X^2=22.7, $p < 0.001$). More of the hospital patients 91(65%) disagreed that contraception is equated to being sinful, when compared with 68(48.6%) of the market women and 60(42.9%) of the student (X^2= 16.5p < 0.002). In addition, more than half (52.9%) of students did not know if contraception was associated with giving birth to a child with congenital malformation whereas, close to half (48.6%) of hospital patients and 43.6% of market women disagreed (X^2= 28.5 $p < 0.001$). About 42% of market women agreed that contraception make one miss menstruation and lead to menstrual dirt being retained in the body, close to half (47.9%) disagreed with this (X^2= 25.8 $p < 0.001$). About half (54.3%) of the market women agreed that contraception was only meant for married couple, however, more than half (52.9%) of student disagreed. (X^2= 39.8 $p < 0.001$).

Table 3 showed myths and misconceptions on Oral pills. Majority of respondents 243(57.9%), especially the students (64.3%) and hospital patients (56.4%) agreed that oral pills can delay menstruation, more than the market women (52.9%). However, 39.3% of market women believed that oral pills can make one sick, only 28.6% of hospital patients and 25% of students agreed. (X^2= 20.7;$p < 0.001$). Fifty-two (37.1%) market women, 27.9% of hospital patients and 29.3% of students thought that oral pills make one missed menses and subsequently develop wound in the uterus (X^2= 14.4; $p < 0.05$). More than half of respondents (53.6%) alleged that oral pills can make one not to conceive if used for long, this belief was particularly more common among hospital patients 58.6%. (X^2= 10.6; $p< 0.05$). More than half (58.6%) of students don't know if oral pills make one give birth to a paralyzed child, however, 41.1% of hospital patients disagreed with this (X^2= 24.4; $p < 0.001$). Majority 247(57.4%) of respondents alleged that pills encouraged early sex, this was particularly more among the hospital patients (63.7%).

Table 2. Myths on contraception (general)

CHARECTERISTICS	GROUP			TOTAL	X^2	P VALUE
	STUDENT N (%)	HOSPITAL PATIENTS N (%)	MARKET WOMEN N (%)			
Contraception is bad						
AGREE	34 (24.3)	33 (23.6)	47 (33.6)	114 (27.1)		
DISAGREE	83 (59.3)	97 (69.3)	72 (51.4)	252 (60.0)	12.393	0.015
DON'T KNOW	23 (16.4)	10 (7.1)	21 (15.0)	54 (12.9)		
Make one not to conceive						
AGREE	71 (50.7)	75 (53.6)	95 (67.9)	241 (57.4)		
DISAGREE	39 (27.9)	54 (38.6)	27 (19.3)	120 (28.6)	22.656	<0.001*
DON'T KNOW	30 (12.4)	11 (7.9)	18 (12.9)	59 (14.0)		
Can harm the body						
AGREE	70 (50.0)	68 (48.6)	73 (52.1)	211 (50.2)		
DISAGREE	40 (28.6)	55 (39.3)	44 (31.4)	139 (33.1)	6.413	0.170
DON'T KNOW	30 (21.4)	17 (12.1)	23 (16.4)	70 (16.7)		
Use is equated to being sinful						
AGREE	44 (31.4)	33 (23.6)	42 (30.0)	119 (28.3)		
DISAGREE	60 (42.9)	91 (65.0)	68 (48.6)	219 (52.1)	16.534	0.002*
DON'T KNOW	36 (25.7	16 (11.4)	30 (21.4)	82 (19.5)		
Make women become promiscus						
AGREE	55 (39.3)	64 (45.7)	76 (54.3)	195 (46.4)		
DISAGREE	45 (32.1)	56 (40.0)	36 (25.7)	36 (25.7)	14.719	0.005*
DON'T KNOW	40 (28.6)	20 (14.3)	28 (20.0)	28 (20.0)		
Can lead to given birth to disable child						
AGREE	24 (17.1)	36 (25.7)	40 (28.6)	100 (23.8)		
DISAGREE	42 (30.0)	68 (48.6)	61 (43.6)	171 (40.7)	28.484	<0.001*
DON'T KNOW	74 (52.9)	36 (25.7)	39 (27.9)	149 (35.5)		
Can lead to spread of HIV						
AGREE	32 (22.9)	42 (30.0)	54 (38.6)	128 (30.5)		
DISAGREE	49 (35.0)	69 (49.3)	44 (31.4)	162 (38.6)	22.615	<0.001*
DON'T KNOW	59 (42.1)	29 (20.7)	42 (30.0)	130 (31.0)		
Miss menses and retain dirt in blood						
AGREE	54 (38.6)	42 (30.0)	58 (41.4)	154(36.7)		
DISAGREE	30 (21.4)	67 (47.9)	41 (29.3)	138 (32.9)	25.819	<0.001*
DON'T KNOW	56 (40.0)	31 (22.1)	41 (29.3)	128 (30.5)		
Side effects are permanent						
AGREE	22 (15.7)	24 (17.1)	38 (27.1)	84 (20.0)		
DISAGREE	58 (41.4)	71 (50.7)	55 (39.3)	184 (43.8)	10.406	0.034
DON'T KNOW	60 (42.9)	45 (32.1)	47 (33.6)	152 (36.2)		
Is met only for married people						
AGREE	30 (21.4)	60 (42.9)	76 (54.3)	166 (39.5)		
DISAGREE	74 (52.9)	67 (47.9)	44 (31.4)	185 (44.0)	39.787	
DON'T KNOW	36 (25.7)	13 (9.3)	20 (14.3)	69 (16.4)		<0.001*

Statistically significant at p <0. 05

Table 3. Myths and Misconceptions on Oral pills

CHARATERISTICS	GROUPS			TOTAL	X^2	P VALUE
	STUDENT N (%)	HOSPITAL PATIENTS N (%)	MARKET WOMEN N (%)			
Can delay menstrual period						
AGREE	90 (64.3)	79 (56.4)	74 (52.9)	243 (57.9)		
DISAGREE	11 (7.9)	24 (17.1)	25 (17.9)	60 (14.3)	7.959	0.093
DON'T KNOW	39 (27.9	37 (26.4)	41 (29.3)	117 (27.9)		
Can make one sick						
AGREE	35 (25.0	40 (28.6)	55 (39.3	130 (31.0)		
DISAGREE	53 (37.9)	67 (47.9)	34 (24.3	154 (36.7)	20.732	
DON'T KNOW	52 (37.1)	33 (23.6)	51 (36.4	136 (32.4)		<0.001*
Miss menses &develop wound in uterus						
AGREE	41 (29.3)	39 (27.9)	52 (37.1)	132 (31.4)		
DISAGREE	28 (20.0)	51 (36.4)	32 (22.9)	111 (26.4)	14.356	0.006*
DON'T KNOW	71 (50.7)	50 (35.7)	56 (40.0)	177 (42.1		
Can get stuck in the stomach						
AGREE	35 (25.0)	30 (21.4)	36 (25.7)	101 (24.0)		
DISAGREE	30 (21.4)	57 (40.7)	34 (24.3)	121 (28.8)	15.173	0.004*
DON'T KNOW	75 (53.6)	53 (37.9)	70 (50.0)	198 (47.1)		
Can cause cancer						
AGREE	30 (21.4)	34 (24.3)	34 (24.3)	98 (23.3)		
DISAGREE	26 (18.6)	43 930.7)	33 (23.6)	102 (24.3)	7.63	0.106
DON'T KNOW	84 (60.0)	63 (45.0)	73 (52.1)	220 (52.4)		
Can weaken the ovaries						
AGREE	45 (32.1)	40 (28.6)	44 (31.4)	129 (30.7)		
DISAGREE	14 (10.0)	38 (27.1)	33 (23.6)	85 (20.2)	14.973	0.005*
DON'T KNOW	81 (57.9)	62 (44.3)	63 (45.0)	206 (49.0)		

Continue……..

Can make one not to conceive if use for too long						
AGREE	69 (49.3)	82 (58.6)	74 (52.9)	225 (53.6)		
DISAGREE	15 (10.7)	26 (18.6)	20 (14.3)	61 (14.5)		
DON'T KNOW	56 (40.0)	32 (22.9)	46 (32.9)	134 (31.9	10.638	0.031*
Can lead to complication in pregnancy						
AGREE	44 (31.4)	45 (32.1)	43 (30.7)	132 (31.4)		
DISAGREE	18 (12.9)	46 (32.9)	33 (23.6)	97 (23.1)	18.797	<0.001*
DON'T KNOW	78 (55.7)	49 (35.0)	64 (45.7)	191 (45.5)		
Make one give birth to a paralyzed child						
AGREE	30 (21.4)	38 (27.1)	26 (18.6)	94 (22.4)		
DISAGREE	28 (20.0)	58 (41.4)	50 35.7)	136 (32.4)	24.441	<0.001*
DON'T KNOW	82 (58.6)	44 (31.4)	64 (45.7)	190 (45.2)		
Can help in prevention of HIV						
AGREE	25 (17.9)	41 (29.3)	37 (26.4)	103 (24.5)		
DISAGREE	51 (36.4)	56 (40.0)	48 (34.3)	155 (36.9)	8.782	0.067
DON'T KNOW	64 (45.7)	43 (30.7)	55 (39.3)	162 (38.6)		
Encourage early sex						
AGREE	74 (52.9)	89 (63.6)	78 (55.7)	241 (57.4)		
DISAGREE	35 (25.0)	25 (17.9)	23 (16.4)	83 (19.8)	7.178	0.127
DON'T KNOW	31 (22.1)	26 (18.6)	39 (27.9)	96 (22.9)		

Statistically significant at p <0.05

Table 4. Myths on male condom

CHARACTERISTICS	GROUPS			TOTAL	X^2	P VALUE
	STUDENT N (%)	HOSPITAL PATIENTS N (%)	MARKET WOMEN N (%)			
Cause partners discomfort & displeasure						
AGREE	63 (45.0)	71 (50.7)	58 (41.4)	192 (45.7)		
DISAGREE	27 (19.3)	37 (26.4)	21 (15.0)	85 (20.2)	14.949	0.005*
DON'T KNOW	50 (35.7)	32 (22.9)	61 (43.6)	143 (34.0)		
Make penetration forceful & thus pain						
AGREE	47 (33.6)	48 (34.3)	44 (31.4)	139 (33.1)		
DISAGREE	39 (27.9)	55 (39.3)	26 (18.6)	120 (28.6)	20.886	
DON'T KNOW	54 (38.6)	37 (26.4)	70 (50.0)	161 (38.3)		<0.001*
Affect men after sex						
AGREE	29 (20.7)	33 (23.6)	26 (18.6)	88 (21.0)		
DISAGREE	43 (30.7)	57 (40.7)	39 (27.9)	139 (33.1)	9.868	0.043*
DON'T KNOW	68 (48.6)	50 (35.7)	75 (53.6)	193 (46.0)		
Can pose serious health risk						
AGREE	19 (13.6)	27 (19.3)	25 (17.9)	71 (16.9)		
DISAGREE	35 (25.0)	54 (38.6)	22 (15.7)	111 (26.4)	23.591	
DON'T KNOW	86 (61.4)	59 (42.1)	93 (63.4)	238 (56.7)		<0.001*
Lubricant give bad smell						
AGREE	28 (20.0)	26 (18.6)	26 (18.6)	80 (19.0)		
DISAGREE	38 (27.1)	51 (36.4)	36 (25.7)	125 (29.8)	4.968	0.291
DON'T KNOW	74 (52.9	63 (45.0)	78 (55)	215 (51.2)		
Can get stuck in uterus or stomach						
AGREE	27 (20.0)	26 (18.6)	31 (22.1)	84 (20.0)		
DISAGREE	32 (22.9)	36 (25.7)	28 (20.0)	96 (22.9)	1.575	0.813
DON'T KNOW	81 (57.1)	78 (55.7)	81 (57.9)	240 (57.1)		
Can lead to serious health issue & death						
AGREE	31 (22.1)	33 (23.6)	26 (18.6)	90 (21.4)		
DISAGREE	20 (14.3)	57 (40.7)	24 (17.1)	101 (24.0)	38.995	
DON'T KNOW	89 (63.6)	50 (35.7)	90 (64.3)	229 (54.5)		<0.001*
Lubricant is infectious						
AGREE	33 (23.6)	33 (23.6)	25 (17.9)	91 (21.7)		
DISAGREE	24 (17.1)	42 (30.0)	26 (18.6)	92 (21.9)	11.704	0.020*
DON'T KNOW	83 (59.3)	65 (46.4)	89 (63.6)	237 (56.4)		
It reduces pleasure						
AGREE	50 (35.7)	70 (50.0)	50 (35.7)	170 (40.5)		
DISAGREE	28 (20.0)	33 (23.6)	21 (15.0)	82 (19.5)	17.472	0.002*
DON'T KNOW	62 (44.3)	37 (26.4)	69 (49.3	168 (40.0)		
It reduces erection						
AGREE	36 (25.7)	43 (30.7)	32 (22.9)	111 (26.4)		
DISAGREE	37 (26.4)	44 (31.4)	29 (20.7)	110 (26.2)	9.854	0.043*
DON'T KNOW	67 (47.9)	53 (37.9)	79 (56.4)	199 (47.4)		

Statistically significant at p < 0.05

Myths and misconceptions on condom as shown in Table 4 revealed that the hospital patients followed by the students purported at a much more extent compare with the market women with those myths and misconceptions. More Students 63(45%) and Hospital patients 71(50.7%) assumed that condom causes discomfort and displeasure during intercourse as against only 58(41.4%) of market women (X^2= 14.949; p < 0.05).

Table 5: showed myths and misconceptions on IUCD. Market women (36.4%) agreed that IUCD can interfere with internal organ more than the hospital patients and students (X^2= 15.639; P < 0.05). Majority of respondents especially students don't know if IUCD can interfere with libido, can get pushed inside during sex or fall off in bathroom or toilets, however, market women agreed more with these statements.

Table 6 showed myths and misconceptions on Injectables. Majority (64.8%) of respondents especially hospital patients and market women agreed that injectables can make one fat. Majority of respondents especially, the market women (64.3%) followed by hospital patients (61.4%) agreed that injectable contraception can make one not to get pregnant when used for long (X^2=12.368 P < 0.05). Close to half of respondents (47.6%)) don't know if injectables can cause elevated blood pressure, however, 32.1% of market women agreed with this belief. Less than half of hospital patients (47.1%) follow by market women (45.7%) then the students (39.3%) agreed that injectables can cause blood clot during menses (X^2=10.4; P < 0.05). About half of respondents don't know if injectables can cause pain, lead to birth defects, make one disinterested in sex or make one cold, however, hospital patients disagreed with these myths and misconceptions most, followed by the market women than the students.

Table 5. Myths and Misconceptions on IUCD

CHARASTERISTICS	GROUPS			TOTAL	X^2	P VALUE
	STUDENTS N (%)	HOSPITAL PATIENTS N (%)	MARKET WOMEN N (%)			
Can interfere with internal organ						
AGREE	40 (28.6)	40 (28.6)	51 (36.4)	131 (31.2)		
DISAGREE	24 (17.1)	47 (33.6)	27 (19.3)	98 (23.3)	15.639	0.004*
DON'T KNOW	76 (54.3)	53 (37.9)	62 (44.3)	191 (45.5)		
Can interfere with libido						
AGREE	30 (21.4)	28 (20.0)	38 (27.1)	96 (22.9)		
DISAGREE	22 (15.7)	49 (35.0)	27 (19.3)	98 (23.3)	18.533	<0.001*
DON'T KNOW	88 (62.9)	63 (45.0)	75 (53.6)	226 (53.8)		
Can get push inside during sex						
AGREE	41 (29.3)	43 (30.7)	53 (37.9)	137 (32.6)		
DISAGREE	22 (15.7)	39 (27.9)	25 (17.9)	86 (20.5)	10.610	0.031*
DON'T KNOW	77 (55.0)	58 (41.4)	62 (44.3)	197 (46.9)		
Can fall off in bathroom or toilet						
AGREE	36 (25.7)	27 (19.3)	38 (27.1)	101 (24.0)		
DISAGREE	33 (23.6)	51 (36.4)	38 (27.1)	122 (29.0)	6.966	0.138
DON'T KNOW	71 (50.7)	62 (44.3)	64 (45.7)	197 (46.9)		
Can cause discomfort to partner during sex						
AGREE	53 (37.9)	58 (41.4)	49 (35.0)	160 (38.1)		
DISAGREE	17 (12.1)	26 (18.6)	29 (20.7)	72 (17.1)	5.587	0.232
DON'T KNOW	70 (50.0)	56 (40.0)	62 (44.3)	188 (44.8)		
Can drain men energy during sex						
AGREE	30 (21.4)	32 (22.9)	27 (19.3)	99 (21.2)		
DISAGREE	38 (27.1)	57 (40.7)	41 (29.3)	136 (32.4)	9.553	0.049
DON'T KNOW	72 (51.4)	51 (36.4)	72 (51.4)	195 (46.4)		
Can make one sick						
AGREE	21 (15.0)	32 (22.9)	34 (24.3)	87 (20.7)		
DISAGREE	38 (27.1)	54 (38.6)	34 (24.3)	126 (30.0)	14.191	0.007*
DON'T KNOW	81 (57.9)	54 (38.6)	72 (51.4)	207 (49.3)		
Can cause miscarriage during pregnancy.						
AGREE	26 (18.6)	34 (24.3)	24 (17.1)	84 (20.0)		
DISAGREE	23 (16.4)	28 (20.0)	33 (23.6)	84 (20.0	4.810	0.307
DON'T KNOW	91 (65.0)	78 (55.7)	83 (59.3)	252 (60.0)		
One can develop complication during delivery						
AGREE						
DISAGREE	26 (18.6)	32 (22.9)	25 (17.9)	83 (19.8)		
DON'T KNOW	19 (13.6)	29 (20.7)	27 (19.3)	75 (17.9)	4.749	0.314
	95 (67.9)	79 (56.4)	88 (62.4)	262 (62.4)		

*Statistically significant at p <0. 05

Table 6. Myths and Misconceptions on Injectables

CHARACTERISTICS	GROUPS			TOTAL	X^2	P VALUE
	STUDENTS N (%)	HOSPITAL PATIENTS N (%)	MARKET WOMEN			
Can make one fat						
AGREE	81 (57.9)	96 (68.6)	95 (67.9)	272 (64.8)		
DISAGREE	18 (12.9)	15 (10.7)	17 (12.1)	50 (11.9)	5.036	0.284
DON'T KNOW	41 (29.3)	29 (20.7)	28 (20.0)	98 (23.3)		
Can change one skin colour						
AGREE	30 (21.4)	43 (30.7)	53 (37.9)	126 (30.0)		
DISAGREE	43 (30.7)	56 (40.0)	40 (28.6)	139 (33.1)	16.630	0.002*
DON'T KNOW	67 (47.9)	41 (29.3)	47 (33.6)	155 (36.9)		

Continue……..

Can cause high blood pressure						
AGREE	34 (24.3)	41 (29.3)	45 (32.1)	120 (28.6)		
DISAGREE	22 (15.7)	36 (25.7)	42 (30.0)	100 (23.8)	15.380	0.004*
DON'T KNOW	84 (60.0)	63 (45.0)	53 (37.9)	200 (47.6)		
Can ,make one not to get pregnant when use for long						
AGREE	66 (47.1)	86 (61.4)	90 (64.3)	242 (57.6)		
DISAGREE	19 (13.6)	21 (15.0)	16 (11.4)	56 (13.3)	12.368	0.015*
DON'T KNOW	55 (39.3)	33 (23.6)	34 (24.3)	122 (29.0)		
Can cause blood clot during menses						
AGREE	55 (39.3)	66 (47.1)	64 (45.7)	185 (44.0)		
DISAGREE	17 (12.1)	30 (21.4)	20 (14.3)	67 (16.0)	10.406	0.034*
DON'T KNOW	68 (48.6)	44 (31.4)	56 (40.0)	168 (40.0)		
Cause pain &disrupts daily chores						
AGREE	27 (19.3)	39 (27.9)	40 (28.6)	106 (25.2)		
DISAGREE	34 (24.3)	47 (33.6)	39 (27.9)	120 (28.6)	10.257	0.036*
DON'T KNOW	79 (56.4)	54 (38.6)	61 (43.6)	194 (46.2)		
Birth of babies whose head are joined						
AGREE	20 (14.3)	20 (14.3)	14 (10.0)	54 (12.99)		
DISAGREE	35 (25.0)	57 (40.7)	56 (40.0)	148 (35.2)	11.067	0.026*
DON'T KNOW	85 (60.7)	63 (45.0)	70 (50.0)	218 (51.9)		
Make women disinterested in sex						
AGREE	20 (14.3)	30 (21.4)	22 (15.7)	72 (17.1)		
DISAGREE	32 (22.9)	60 (42.9)	52 (37.1)	144 (34.3)	21.706	
DON'T KNOW	88 (62.9)	50 (35.7)	66 (47.1)	204 (48.6)		<0.001*
Make women cold						
AGREE	25 (17.9)	23 (16.4)	18 (12.9)	66 (15.7)		
DISAGREE	28 (20.0)	56 (40.0)	52 (37.1)	136 (32.4)	16.098	0.003*
DON'T KNOW	87 (62.1)	61 (43.6)	70 (50.0)	218 (51.9)		

Statistically significant at $p < 0.05$

Majority of the respondents have limited knowledge about implant as their responses concerning the existence of myths and misconceptions on implants was I "don't know", for example, the rumors about the shift of implants from the arm to other part of the body showed that 71.4%, 50.7% and 72.1% of Students, Hospital patients and Market women respectively don't know of this (X^2=22.2; $P < 0.001$).

DISCUSSION

The study was carried out in Ogbomoso, a major town in Oyo state that is predominantly inhabited by the Yoruba ethnic group. The Yorubas in southwestern Nigeria are among one of the most educated tribes in Nigeria and many women might have access to lots of information on contraception. The southwestern Nigeria has a relatively higher contraceptive prevalence rate (CPR) among the regional zones in Nigeria with a CPR of 28.5 compare with CPR of 2.7 in the North West (National Demographic and Health Survey 1999). However, the rate in the zone is still low; the existence of myths and misconceptions on various methods of contraception may explainthe reasons for the low CPR. Research studies by (Larsson *et al*., 2006; Orji *et al*., 2006) showed that people often learn about reproductive health and sexual behaviour, as well as obtain information on HIV and AIDS from radio dramas, where there might be distortion of information. However, in this study most of the respondent's source of information was the hospital, followed by mass media. Despite this, there still exists high level of misinformation about contraception in general in all group of respondents. The fear of side effects, myths and wanting more children topped the list of reasons for not using contraception among the participants. In this study, all the respondents that had used contraception before, used condom followed by injectables and oral pills, which was similar to the finding reported in the study conducted by in North Gonder (Fantahun*et al*., 1995) andin Nigeria (Araoye *et al*., 1998), that the most preferred method of contraception in young adults was the condom followed by OCPs.

This study also showed that majority of respondents (53.3%) have never used any form of contraception before, while only 46.7% had ever used contraception. Hospital patients were more likely to have used, the number of students that have ever used being the least. This is similar to a gallop poll finding that being literate was similar to being illiterate when it comes to uptake of contraception (ShehlaChanna *et al*., 2013). This study also revealed the existence of myths and misconceptions on various methods of contraception which may account for the high unmet need for contraception in this environment. In addition, western education and health information contribute just little to dispel the existence of these myths and misconceptions as it is shown in this study, though there are areas where hospital patients and students disagreed with these myths more than the market women, but there are a lot of areas in which they have similar perception on those misconceptions or even higher, especially on the myths and misconceptions on OCPs. It is probably so because the mass media seems focusing more on the side effects of OCPs and even some health professionals may have handed down their misperception to today's potential users. For example the American Life League claimed that birth control pills "kill women" and "can also cause cancer, pelvic inflammatory disease, depression and much more, grossly mischaracterizing the risk of birth control. [2]Similarly, in 1993 a Gallop poll conducted by the American College of Obstetrician and Gynecologist (ACOG) found that 65% and 29% of patient believe doral pills use to be at least as dangerous as pregnancy and cancer respectively (ShehlaChanna *et al*., 2013). This is in agreement with our finding where 23.3% of respondents believed that there exist a risk of cancer associated with OCPs use.

Conclusion and Recommendation

The study has shown clearly the existence of myths and misconceptions on various methods of contraception in our environment even among students and hospital patients. This may explain the reason for the high prevalence of unmet need on contraception in this country. Emphasizing the need for proper reproductive health education and the need for it to be incorporated in our educational curriculum including mass media and various health talks in hospitals.The more we can put across appropriate information to the public about the availability of different methods of contraception, about their advantages and disadvantages, the better. It is important that access to advice is made as easily available as possible for all ages. Also myths communicated via the social network can have a significant impact on acceptance or rejection of effective contraceptive methods. More intensive awareness about benefits of contraception should be propagated through print and electronic platforms and even through social networking platforms as they now represent veritable tools of information dissemination.

Also fostering support groups where women can share experiences with each other with regards to contraceptive usage and such forums should be used to dispel misconceptions with regards to contraceptive practices. While marginal gains have been made with regards to maternal mortality reduction globally, things can still get better when women are sufficiently empowered to decide on when, what form of contraception they want to use.

REFERENCES

AgunbiadeOjo Melvin, OsezuaClementina, Department of Sociology and Anthropology, ObafemiAwolowo University, Ile-Ife, Nigeria, A Paper Presented at the 2014 Annual Conference of the Population Association of America. Email:ojomelvin@yahoo.com

Alkema L, Kantorova V, Menozzi C, Biddlecom A. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *The Lancet*. 2013. 381(9878):1642-52. doi: 10.1016/S0140-6736(12)62204-1

Araoye MO, Fakeye OO, JolayemiET.Contraceptive method choices among adolescents in a Nigerian tertiary institution.*West Afr J Med.,* 1998; 17: 227-31.

Augustine Ankomah, Jennifer Anyanti, MuyiwaOladosu. Myths, misinformation, and communication about family planning and contraceptive use in Nigeria; Society for Family Health, Abuja; *Open Access Journal of Contraception Dovepress*, 2011; 2:95-105

Baird D, Evers J, Gemzell-Danielsson K, Glasier A, Killick S, Van Look P, *et al*. Family planning 2011: better use of existing methods, new strategies and more informed choices for female contraception. *Human Reproduction Update*, 2012; 18(6): 670-81.

Bajos N, Teixeira M, Adjamagbo A, Ferrand M, Guillaume A, Rossie C. Normative Tensions and Women's Contraceptive Attitudes and Practices in Four African Countries. Population (English Edition). 2013; 68(1):15-36.

Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. *The Lancet*, 2006; 368(9549): 1810-27.

Daniel Yaw Fiaveh; Condom Myths and Misconceptions; The Male Perspective.Global*Journal of Medical Research*, 2012;12(5): 42-50.

Fantahun M, Chala F, Loha M. Knowledge, attitude and practice of family planning among senior high school students in North Gondar. *Ethiop Med J*., 1995; 33: 21-9.

Francis Okello, YaredGetachew, ; Using Decision Trees to Examine the Characteristics of Users and Non-users of Modern Family Planning in Ethiopia; Friday, November 15, 2013; *International Conference on Family Planning*.

Hindin, M. J., McGough, L. J., and Adanu, R. M.Misperceptions, misinformation and myths about modern contraceptive use in Ghana. *Journal of Family Planning and Reproductive Health Care*, 2014; 40(1), 30-35.

Kotb MM, Bakr I, Ismail NA, Arafa N, El-Gewaily M. Women in Cairo, Egypt and their risk factors for unmet contraceptive need: a community-based study. *Journal of Family Planning and Reproductive Health Care*, 2011; 37(1): 26-31.

Larsson, M., Eurenius, K. and Westerling, R. Evaluation of a sexual education intervention amongst Swedish high school students.*Scandinavian Journal of Public Health*, 2006; 34, 124–31.http://dx.doi.org/10.1080/14034940510032266, PMid:16581704

Mandara M. Family planning in Nigeria and prospects for the future.*International Journal of Gynecology & Obstetrics,* 2012; 117(1):1-4.

Nigeria Demographic and Health Survey; 1990. Colombia, MD: Federal Office of Statistics and Institute for Resource Development Macro International Inc; 1992.

Nigeria Demographic and Health Survey; 1999. Calverton, MD: National Population Commission and Opinion Research Corporation Macro International Inc; 2000.

Nigeria Demographic and Health Survey 2008. Calverton, MD: National Population Commission, Nigeria and Opinion Research Corporation Macro International Inc; 2009.

.

Orji, E.O., Adegbenro, C.A., Olalekan, A.W. Prevalence of sexual activity and family planning use amongst undergraduates in South West Nigeria. *European Journal of Contraception and Reproductive Health Care.* 2006; 10(4), 255–260. http://dx.doi.org/10.1080/13625180500331259, PMid:16448953

RhouneOchako, MwendeMbondo, Stephen Aloo, Susan Kaimenyi*et al*. Barriers to moderns uptake among young women in Kenya: a qualitative study. BMC Public Health 2015; 15:118. Available http://www.biomedcentral.com/1471-2458/15/118

ShehlaChanna, Shahzadilubna, FarkhundaKhursheed, RaheelabilalShaikh, Tabassum. Contraception Myths in women attending a tertiary care Hospital. *Medical Channel*, 2013 19(2): 36-39.

****