



# Knowledge, Perception and Misconceptions on Family Planning among Women Living in an Urban Slum in Enugu, Enugu State, Nigeria

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## Authors' contributions

This work was carried out in collaboration between all authors. Authors ECA, OAJ and OLU designed the study. Authors ECA, OAJ, OLU, OOE and OFK wrote the protocol and wrote the first draft of the manuscript. Authors OAJ, OLU, OOE and OFK managed the literature searches. Author ECA did data analyses of the study. All authors read and approved the final manuscript.

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## ABSTRACT

**Introduction:** Family planning is a vital and integral component of primary health care which aims at promoting responsible parenthood, controlling population and improving the quality of life of people. It has a major role to play globally in challenges of rapid population growth. This study aimed to identify knowledge gaps, perceptions and misconceptions on family planning.

**Methodology:** This was descriptive cross sectional study using pretested, interviewer administered questionnaire. It was community based involving house to house visit. Due to the scattered nature of the houses, the researcher roughly grouped the area into zones to ensure approximately equal representation then proportionately respondents were recruited consecutively. Chi square test was used to assess associations between socio-demographics characteristics and ever heard of family planning while binary logistic regression was further used to establish associated factors. The level of significance was at  $p \leq 0.05$ .

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**Results:** A total of 281 women of reproductive age (15-49) were studied. About 91.1% of respondents have heard of family planning, 69.4% heard of it from their friends/relatives. Condom (81.5%) was the commonest method of contraceptive they knew about. Also 85% believe that family planning was important and 79% stated that it helps one to have the desired number of children while 44 % of them stated that it predisposes one to infertility. Educational level was the only identified predictor (secondary education AOR 0.33; tertiary education AOR 0.16).

**Conclusion:** High proportions of respondents from this study were aware of family planning and believe that it is important. However, a small proportion agrees to the negative effects. Understanding the myths and misconceptions about family planning will greatly influence the knowledge and perceptions as well as bring about behavioral change on family planning with increased uptake. Their education though good still needed improvement since it is a key determinant.

*Keywords: Knowledge; perception; misconceptions on family planning; urban slum.*

## 1. INTRODUCTION

The twentieth century has witnessed a lot of interlinked issues of global concern. This is part of the reasons why overcoming poverty, hunger, poor education, gender inequality, inability to achieve universal health coverage, maternal and child mortality form the core goals of the Sustainable developmental goals (SDG) [1]. Of all these challenges rapid population growth seems to have taken a central role in the midst of all this, therefore family planning inarguably has a major role to play globally. Family planning is a vital and integral component of primary health care which aims at promoting responsible parenthood, controlling population and improving the quality of life of people [2].

World health Organization, defines family planning as allowing individuals and couples to anticipate and attain their desired number of children as well as the spacing and timing of their births. However many individuals and couples with unmet need for either spacing or limiting births do not practice contraception because they lack adequate knowledge of the social, economic and health benefits of family planning [3]. Many others do not know family planning methods available, types appropriate for them or where to access them [3]. This poor and inappropriate knowledge of family planning methods has been associated with low uptake and use [4]. Ironically, in places where knowledge of family planning is high, myths and misconceptions are largely responsible for the low demand and use of contraceptives [4,5]. Studies have demonstrated that these myths and misinformation are centered around concerns about perceived side effects or perceived future infertility [6-10].

Across Sub-Saharan Africa, myths and misinformation as a reason for nonuse varied. In Nigeria 33-57% women and 25-48% men, in Kenya 65-82% and in Senegal about 50% of nonusers were due to side effects and health concerns which is attributable to myths and misinformation [11-13]. In most cases these side effects are exaggerated or erroneously reported [14,15]. This is the case in both developed and less developed countries. For instance; many women perceive use of oral contraceptives to be more dangerous than pregnancy [16], that pill and injectable can cause harm to woman's uterus leading to permanent infertility [17,18], that pill can accumulate into mass in the stomach leading to serious problem, can cause bleeding from nose and mouth, as well as can cause delivery of children with two heads [7]. Similarly, a study stated that; pills and injections were associated with infertility, cancerous growths and birth defects, implants could get lost in the body via the blood stream and that IUCD could shift during sexual intercourse with serious implications for birth outcomes [19].

Socio-cultural or religious beliefs and disapprovals of contraception continually constitute obstacles to the adoption and use of a contraceptive method [20]. A study in Nigeria documented that few Hausa women have any knowledge of birth control and of these few, most consider family planning as the moral agnate of murder [21]. They believe that giving birth is remedy for those passing on and that children are considered a divine benefaction. Traditionally children are viewed as the greatest self-actualization of being a woman [21]. Another study in Uganda reported socio-cultural contradictions as a major obstacle to the use of contraceptives [22].

Moreover, these myths and misconceptions on family planning has been documented to be associated with family planning discontinuation [23]. Although some contraceptive methods have recognized side effects, however when women are informed of these side effects in advance, they are more likely to tolerate them or choose from alternatives rather than discontinue use [14,24]. A study in Mexico reported that a considerable percentage of the women discontinued pill use because of fear of reported side effects [25].

Appreciation of the knowledge gaps, perceptions and misconceptions on family planning is important for the development of programs and policies on family planning. These if well addressed will bring about behavioral change and ultimately increase contraceptive use.

## 2. METHODS

### 2.1 Study Area

The study area was at Ngenevu an urban slum in Enugu north Local Government Areas (LGA) of Enugu state. Enugu Metropolis is made up of Enugu North, Enugu South and Enugu East LGAs. Ngenevu shares boundary with coal camp and university of Nigeria teaching hospital, Enugu (old site). It is located on top of Onyeama coal mine. The occupations are mainly artisan, petty trading with few civil/public servants. There are 3 primary schools and no primary health facility in the area. The houses are scattered nature without clear cut streets or zones.

### 2.2 Study Design, Instrument and Data Collection

A descriptive cross sectional study was done. It was community based involving house to house visit. Self-developed, pretested, interviewer administered questionnaire divided into sections including social demographics, perception and misconceptions of family planning was used. Instrument was pre-tested in a similar urban slum in another location of the metropolis after which observed gaps were filled. Four research assistants who were medical students were trained for 3 hours on the tool and data collection. Data collection was between September and November 2016.

### 2.3 Study Population

Women aged 15-49 years resident in the area that gave consent were studied. Women who are

celibates like Reverend Sisters, postmenopausal, and those that were not sexually active were excluded.

### 2.4 Sample Size Determination

The minimum sample size formula for descriptive study involving proportion was used.

$$n = \frac{Z\alpha^2 \times P(1-P)}{d^2}$$

Where  $Z\alpha$  is two sided confidence level at 95% (taken as 1.96),  $d$  is margin of error tolerated taken as 5%,  $p$  is prevalence of family planning use amongst women in low income and high density area =20% [26]. An addition of 10% was added to make for the non-response. A total of 280 women were studied.

### 2.5 Sampling Technique

Due to the scattered nature of the houses, the researcher roughly grouped the area into zones to ensure approximately equal representation. Respondents were then recruited consecutively house to house until sample size was achieved. In a situation where more than one person is qualified, all eligible persons were studied as most houses had multiple families.

### 2.6 Data Management

Data was analyzed using IBM Statistical Package for Social Science (SPSS) version 20.0. Data were summarized using proportion as well as percentages and presented in tables. Chi square test was used to assess associations between socio-demographics characteristics and ever heard of family planning while binary logistic regression was further used to establish associated factors. The level of significance was at  $p \leq 0.05$ .

### 2.7 Ethical Considerations

Ethical clearance was from Health research and Ethics Committee, University of Nigeria Teaching Hospital (UNTH), Ituku/Ozalla, informed Consent was obtained from each participant after explanation on what the research is all about. Participants were informed that they must not participate in the study. Confidentiality was maintained throughout the study even beyond.

## 2.8 Limitations of the Study

It would have been better if random sampling technique was used as respondents would have had equal chance of being selected. This will increase generalizability of the study.

## 3. RESULTS

Table 1 shows that 38.1% of the respondents were aged between 25-34 years, 66.9% of the respondents were Catholics, 59.8% were married, while 60.1% have secondary level of education as their highest level of education. 38.4% respondents are traders by occupation and 24.6% have more than 3 children while 42.7% have no child.

Table 2 shows that 91.1% of respondents have heard of family planning, 69.4% heard of it from their friends/relatives, 56.2% have ever been counselled on need for family planning. Condom (81.5%) was the commonest method of contraceptive they knew about, followed by

abstinence (68.8%), then withdrawal method (60.9%).

Table 3 shows that 85% believe that family planning is important with 79% stated that it helps one to have the desired number of children, 71.5% stated that it allows women have more time for other things. Only 27% stated that family planning was not accepted by their culture or religion, 44 % of the stated that it predisposes one to infertility. Generally a smaller size of the sample agrees to the negative effects of family planning.

Table 4 shows that there were statistical significant association of age(years), marital status, educational level, occupation and number of children of respondents with ever heard of family planning.( $p < 0.05$  for each) and there is no statistical significant association with religion of respondents  $p = 0.699$ . Educational level is the only identified predictor (secondary education AOR 0.33; 95% CI: 0.11-0.97 ( $p = 0.034$ ), tertiary education AOR 0.16 95% CI: 0.04-0.71 ( $p = 0.018$ ).

**Table 1. Socio-demographics characteristics of respondents**

Variables	Frequency (n =281)	Percent (100%)
<b>Age in category (years)</b>		
15-24	98	34.9
25-34	107	38.1
>35	76	27.0
<b>Religion</b>		
Catholic	188	66.9
Anglican	42	14.9
Moslem	51	18.1
<b>Marital status</b>		
Single	113	40.2
Married	168	59.8
<b>Educational level</b>		
Primary & below	47	16.7
Secondary	169	60.1
Tertiary	65	23.1
<b>Occupation</b>		
Civil/public servant	41	14.6
Trading	108	38.4
Student	59	21.0
Others	73	26.0
<b>Number of children</b>		
None	120	42.7
1-3	92	32.7
>3	69	24.6

Table 2. Knowledge on family planning

Variables	n = 281	
	Yes n (%)	No n (%)
<b>Have you ever heard of family planning</b>	256(91.1)	25(8.9)
<b>sources of information</b>		
Hospital	179(63.7)	102(36.3)
TV/Radio	159(56.6)	122(43.4)
Relatives/friend	195(69.4)	86(30.6)
Internet	60(21.4)	221(78.6)
Church/mosque	113(40.2)	168(59.8)
Teacher/school	36(12.8)	245(87.2)
<b>Ever been counselled on need for family planning</b>	158(56.2)	123(43.8)
<b>If yes, by who</b>		
Hospital/medical personnel	109(38.8)	172(61.2)
Chemist	30(10.7)	251(89.3)
friends and relatives	82(29.2)	199(70.8)
TBA	23(8.2)	258(91.8)
School/teachers	23(8.2)	258(91.8)
<b>Family planning methods you know about</b>		
Condom	229(81.5)	52(18.5)
Withdrawal	171(60.9)	110(39.1)
Abstinence	192(68.3)	89(31.7)
Contraceptive pills	146(52.0)	135(48.0)
Breastfeeding	140(49.8)	141(50.2)
IUCD	99(35.2)	182(64.8)
Implant	118(42.0)	163(58.0)
Sterilization	83(29.5)	198(70.5)
Billing method	102(36.3)	179(63.7)

Table 3. Perception and misconceptions on family planning

Variables	n = 281	
	Yes n(%)	No n(%)
<b>Belief that family planning is important</b>	239 (85.1)	42(14.9)
<b>If yes, why do you think it is important</b>		
family spacing	219 (77.9)	62 (22.1)
Prevention sexually transmitted Disease	155 (55.2)	126 (44.8)
Helps one have the desired number of children	222 (79.0)	59 (21.0)
Helps one have more time for other things	201 (71.5)	80 (28.5)
Helps one ease financial burden	214 (76.2)	67 (23.8)
Prevention of unwanted pregnancy	165 (58.7)	116 (41.3)
<b>Perceived negative effects of family planning</b>		
Predisposes one to infertility	125 (44.5)	156 (55.5)
Affects my general well being	101 (35.9)	180 (64.1)
Makes people promiscuous	105 (37.4)	176 (62.6)
Affects ones' relationship with husband and his family	108 (38.4)	173 (61.6)
Make one gain weight	110 (39.1)	171 (60.9)
Increased my appetite	91 (32.4)	190 (67.6)
Make ones menses irregular	110 (39.1)	171 (60.9)
Makes one experience mood swings	76 (27.0)	205 (73.0)
Not acceptable by my religion/culture	78 (27.8)	203 (72.2)
<b>Overall perception</b>	<b>Negative 100 (35.7)</b>	<b>Positive 181 (64.3)</b>

**Table 4. Associations between Socio-demographics and ever heard of family planning**

Socio-demographics	Yes	No	Bivariate analysis X <sup>2</sup> (p value)	Multivariate analysis AOR (95% C.I for AOR)
	n (%)	n (%)		
<b>Age in cat (years)</b>				
24 and below	79(80.6)	19(19.4)	20.505 (0.000)	0.419(0.098-1.818) 0.841(0.123-5.742)
25-34	104(97.2)	3(2.8)		
35 and above	73(96.1)	3(3.9)		
<b>Religion</b>				
Catholic	173(92.0)	15(8.0)	0.716 (0.699)	2.117(0.566-7.926) 0.984(0.274-3.530)
Anglican	37(88.1)	5(11.9)		
Pentecostal	46(90.2)	5(9.8)		
<b>Marital status</b>				
Single	91(80.5)	22(19.5)	26.064 (0.000)	0.200(0.014-2.825)
Married	165(98.2)	3(1.8)		
<b>Educational level</b>				
Primary & Below	35(74.5)	12(25.5)	19.368 (0.000)	0.327(0.110-0.971) 0.162(0.037-0.712)
Secondary	159(94.1)	10(5.9)		
Tertiary	62(95.4)	3(4.6)		
<b>Occupation</b>				
Civil/Public Servant	40(97.6)	1(2.4)	25.544 (0.000)	2.705(0.276-26.547) 4.243(0.457-39.424) 1.742(0.150-20.292)
Trading	102(94.4)	6(5.6)		
Student	44(74.6)	15(25.4)		
Others	70(95.9)	3(4.1)		
<b>Number of children</b>				
None	98(81.7)	22(18.3)	23.170 (0.000)	0.378(0.019-7.554) 0.772(0.043-14.012)
1-3	91(98.9)	1(1.1)		
>3	67(97.1)	2(2.9)		

#### 4. DISCUSSION

Family planning services are facing a complicated process, entangled in social, political, moral and cultural network in many African countries [27]. These beliefs are embedded in a complex web of socio-cultural belief systems, values, and practices [28]. The demand for contraception in Africa is driven by a wish to postpone and space births rather than a desire to control family size [29].

Findings from this study were that over 90% of respondents were aware of family planning, with commonest source of awareness from their friends/relatives. Condom was the commonest method of family planning they knew about followed by abstinence. This is good and commendable. Condom serves a dual function. Though a means of family planning, it equally protects against Sexually Transmitted Infections including HIV/AIDS. Another study in Enugu Nigeria had a similar finding with documented level of awareness of 81.7% [26]. A study in Tanzania reported that two-thirds (67.4%) of the respondents had adequate level of knowledge on family planning services and the most popular

source of information was the radio (65.8 %) [30]. Similarly a study in Iraq reported that knowledge regarding family planning generally were good [31]. In Kenya over 90% of men and women are aware of at least one family planning method [32]. Study in Ghana found that 60% and 30% of respondents obtained knowledge about contraception from the media (TV/Radio) and peers (friends) respectively. However, almost 32% of the study participants thought contraceptives are for only adult married [33]. Another study in Ghana reported that 76% of female and 88% of males all aged between 15 and 19 years were aware of at least one modern family planning method [34]. In Africa traditionally postpartum abstinence was used to postpone and space births rather than to control family size [29].

High proportion of respondents from this study believe that family planning is important as it helps one to have the desired number of children and so allows women have more time for other things. This is welcomed as it is in line with meaning of family as stated by World Health Organisation "allowing individuals and couples to anticipate and attain their desired number of

children as well as the spacing and timing of their births". The implication is that if this perception is built on, the objective of family planning will be achieved with its enormous benefits. A similar work in Gulu district, Uganda concurred with this finding that family planning is important and beneficial [35].

Generally this study found that a smaller size of the sample agrees to the negative effects of family planning. This is in contrast to findings from other studies in which exaggerated or erroneous reports about side effects, misconceptions about short- or long-term health problems and negative stereotypes about persons who practice family planning serve as major hindrance to uptake of family planning [14,19]. Current study documented that 44% of respondents stated that family planning predisposes one to infertility. Many other similar studies documented that pills and injectables could cause permanent infertility [17-19,36-41]. Other documented side effects from studies includes; having a baby with a deformity [7,8], cancerous growths, birth defects, backaches and headaches, and bleeding continuously for those on the pill [31]. Findings from Nigeria demonstrate that fear of side effects and concerns about long-term infertility are major reasons for not using modern contraceptives [42].

In rural Malawi, there is common belief among female respondents that contraceptives affect male reproductive organs, causing men to be impotent as well as that condoms cause blisters and sores in their genitalia while others felt that condoms have an oily substance which kills their manhood and weakens their sexual strength [43]. The same study stated equally that most women do not use family planning methods because of fear of side effects like prolonged menstruation, weight loss and that they feel ashamed as people suspect them of having HIV/AIDS [43].

This study reported that only a few stated that family planning was not accepted by their culture or religion. This is supported by findings among Chinese female asylum seekers in United Kingdom where choice of contraceptive method was influenced by traditional cultural beliefs and values [44].

There were statistical significant association of age, marital status, educational level, occupation and number of children of respondents' with

awareness of family planning from this study. However, educational level is the only identified predictor. Those that had secondary education were 33 percent likely and tertiary education 16 percent likely not to be aware of family planning compared to those that had primary education and below. In line with this finding a study in Tanzania identified being in a lower class as predictor of inadequate level of knowledge on family planning services [30].

Conversely it was indicated in a study that a lack of proper information in relation to family planning and a lack of acceptance of the concept of family planning by some health workers have contributed to its low impact [32]. This is not surprising because some and misconceptions. Equally informal communication via social networks helps in spread of these misconceptions and lead to continued negative perceptions [43,45]. However, in a study of family planning services in Bangladesh, found that culturally appropriate counseling can mobilize the presumably latent demand for contraception by reassuring potential clients of the social acceptability and by allaying their fears about side effects of contraceptive methods [46].

## 5. CONCLUSION

There are many myths and misconceptions surrounding contraception, and sometimes they prevent a woman from making an informed choice. Understanding these myths and misconceptions about family planning will greatly influence the knowledge and perceptions as well as bring about behavioral change on family planning. High proportions of respondents from this study are aware of family planning and believe that it is important. A smaller size of the sample agrees to the negative effects of family planning while educational level is the only identified predictor. There is a need for aggressive advocacy, education and dissemination of information on family planning as increasing adoption of such healthy behavior is critical to enabling individuals, households, and communities to achieve improved health outcomes with its attendant far reaching benefits.

## COMPETING INTERESTS

Authors have declared that no competing interests exist.

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