## ***Original Research Article***

**Contraceptive Use an evolving challenge; Perception and Misconception among women of reproductive age at University of Nigeria Nsukka, Nigeria**.



**ABSTRACT**

**Introduction:** Contraceptive is a component of family planning which enables individuals to achieve a desired number of pregnancies by controlling the spacing and timing of conception This improves the general wellbeing of women and children.

**Objective:** This study aimed to determine the use, perception and misconception of contraceptives among women of reproductive age at University of Nigeria Nsukka.

**Methodology**: Descriptive cross sectional study using pretested, interviewer administered questionnaire was employed. Simple random sampling technique was used to select a representative sample of 350 women aged 15-49 years. Statistical package for social sciences (SPSS) version 23.0 was used for Data analysis. Chi square test and Binary logistic regression were used. The level of significance was $p < 0.05$.

**Result**: Majority of the participants (94.1%) had some knowledge on contraceptives. The prevalence of contraceptive use was 35.5%. Overall positive perception on contraceptives was 83.3% although 22.6% believed that contraceptives are for women alone. Overall misconception was 69.3%. About 43.3% believed that contraceptives are harmful to the womb, 46.9% agreed that contraceptives can render one infertile. Male condom at 16.3% followed by pill at 15.4%

were most commonly used form of contraceptives while Pharmacy shops were commonest source at 65.5%. Religion was identified as predictor of misconceptions of contraceptives.

**Conclusion**: There was good knowledge but poor use of contraceptives in the population. Effect of myths and negative perceptions surrounding the use of contraceptives was observed, hence, the need for contraceptive education and enlightenment programs in this community.

**Keywords**: Contraceptive, Use, Perception, Misconception, Women, University



## INTRODUCTION

Women sexual and reproductive health is related to multiple human rights, including right to life, right to freedom, right to health, right to be free from torture, right to privacy, right to education and the prohibition of discrimination.[1] According to the United Nations Human Rights Commission, women are entitled to reproductive health care services, goods and facilities that are available in adequate numbers, accessible physically and economically, accessible without discrimination and of good quality.[1] The socio-economic importance of contraceptives arises from the fact that uncontrolled population growth will inevitably lead to overpopulation and its attendant negative consequences.

Of the estimated 208 million pregnancies that occur yearly worldwide, approximately 41% are unplanned and 22% are terminated.[2] According to the 2015 world contraceptive pattern, 64% of married women use contraceptives, 216 million have an unmet need for modern contraceptive method, 9 out of 10 contraceptive users rely on modern method, and only 60% of demand for family planning in Africa is satisfied.[3] The United Nations in a 2013 report explain that globally, contraceptive prevalence is 63%, with nine out of ten woman of reproductive age in a union who

uses a contraceptives, relies on a modern contraceptive.[4] The same report states that sub-Saharan Africa has a prevalence of 25%, and that the most common methods worldwide are female sterilization (26%), IUDs (14%) and the emergency contraceptive (the pill at 9%).[4]

The Nigeria Demographic Health Survey in 2018 reported that 17% of currently married women use a method of family planning [12% use modern method and 5% traditional method].[7] The most popular methods are implants, injectables, and withdrawal (each used by 3%), followed by male condoms (used by 2%).[5] The contraceptive prevalence rate (CPR) among married women varies with age, rising from 3% among women age 15-19 to a peak of 23% among women age 35-39 before declining to 13% among women age 45-49.[5]

In developing nations, the use of contraceptives is not openly discussed among young unmarried women due to strong cultural and religious beliefs.[6] As such, many unmarried females who get unintended pregnancies seek abortions services for fear of societal judgment. In a study carried out in North western Nigeria for instance, 57.8% of the respondents believe that use of contraceptives conflicts with their moral, cultural and religious beliefs.[7] The use of contraceptives is believed by some people to promote promiscuity. For example, a study carried out in Northwest Nigeria, 18.75% of the respondents opined that contraceptives encourage promiscuity[7] while 32.5% of respondents in a different study in Delta state believed same.[8] Furthermore, the perception that contraception could lead to infertility later in life is one of the reasons that Nigerian women have always cited for not accepting effective contraception.[9]

Myths and misconceptions about family planning are barriers to modern contraceptive use. Some of these are exaggerated or erroneous reports about side effects, misconceptions about short- or long-term health problems and negative stereotypes about persons who practice family planning.[10,11] In a study conducted in Mali, many women feared that the pill and the injectable could cause permanent infertility.[12] A qualitative study in Kenya demonstrated that many women had misconceptions about the side effects of modern contraceptives (e.g., that they cause infertility or can harm a woman's uterus), but few had experienced or knew someone who had experienced an actual side effect (e.g., weight gain).[13] In a similar study in one respondent reported that the pill "can accumulate into a life-threatening mass in the stomach, can cause blood to flow out of the nose and mouth, and can cause delivery of children with two heads and no skin".[14] Findings from Nigeria demonstrate that fear of side effects and concerns about long-term infertility are major reasons for not using modern contraceptives.[15-17] Similar results were found in Mexico, where women who had never practiced contraception reported that they had chosen not to use the pill for safety reasons.[18] Cultural and Religious factors have notoriously been implicated in poor use of contraceptives.[7] Various research have found that utilization of contraceptives was higher among Christians than those practicing Islam.[19.20]

Research has proven that effective contraceptive uptake prevents an estimated 2.7 million infant deaths and the loss of 60 million of healthy life in a year.[21, 22,] Promotion of family planning could reduce poverty, hunger, avert 32% of all maternal deaths and nearly 10% of childhood deaths.[22] This study explores the use, perception and misconception of contraceptives among women of reproductive age in a University community. This would serve to provide information to policy makers on what areas to develop programmes and policies especially in a society that

women still feel restricted to access contraceptive methods due to social cultural barriers. It would also guide non-governmental organizations in developing objectives, activities and outcomes of projects aimed at improving contraceptive use.

## MATERIALS AND METHOD

### Study Area

The study was carried out at University of Nigeria Nsukka, a federal university located in Nsukka Local Government Area of Enugu state, Southeast Nigeria. There are a number of Federal parastatal ~~in~~ on the Nsukka campus such as Centre for Basic Space Research, a Federal Medical Centre and the Energy Research Centre. Also present in the community are, 6 different banks, a secondary school, a primary school, two main churches (a Catholic church and an Interdenominational church) and a mosque. The University of Nigeria Nsukka has a population of over 42,000 undergraduate students. The predominant ethnic group is Igbo. Majority of the dwellers are students, civil servants, bankers and traders. The community has a predominant population of Christians who are mostly monogamous. The community under study is a highly organized area with spaces clearly mapped out for residential houses, businesses, student hostels, recreation and academic purposes.

### Study Design, Instrument and Data Collection

This was a descriptive cross-sectional study using a pretested, semi-structured, self-administered questionnaire. Data was collected by researcher and three trained research assistants.

**Comment [K1]:** Describe more about instruments

### Study Population

These consisted of women of reproductive (ages 15 to 45 years) in University of Nigeria Nsukka including; academic staff, non academic staff, students and others living in the community who gave consent.

**Sample size determination and sampling**

The sample size was determined using single population proportion formula *[$n=Z^2pq/d2$]* taking 28.1% contraceptive prevalence rate among women of reproductive age in south east Nigeria,[5] marginal error of 5%, confidence level of 95% and a non-response rate of 10%. A total of 350 women were studied. The university was divided into four units to ensure that all areas were approximately equally represented. The sample tool was likewise divided into four, that is, 87 tools for each unit and the remaining 2 tools were randomly assigned to two different units. Participants were now enlisted house to house, office to office and class to class (depending on the nature of the unit) until the desired number of sample size was obtained.

**Data Management**

Data analysis was done using IBM Statistical package for social sciences (SPSS) version 23.0. The data were summarized using frequencies, proportions and percentages. Pearson Chi square test was used to establish association of socio-demographic characteristics with knowledge, perception and misconceptions on contraceptive use. Statistical significant variable (religion) was further analyzed using binary logistic regression. Level of significance was at $p < 0.05$.

**Ethical Considerations**

Ethical clearance was obtained from the Health Research and Ethics Committee of University of Nigeria Teaching Hospital (UNTH). Permission was obtained from authority of the institution to embark on the study. Informed consent was obtained verbally from all those interviewed after the purpose of the study was explained to the participants. Information obtained from

participants were kept confidential. Participant's freedom to withdraw from the study at any point in time in spite of the consent was also respected.

**RESULTS**

Table 1 shows that the mean age group of the respondents was 25 ± 8.2 with 161(47.2%) of them aged between 19-24 years. Among the respondents, 249(73%) were single, 243(71.3%) had received ~~a~~ tertiary education, 331(97.1%) were Christians and 236(69.2%) were students. Women with zero parity constituted 251(73.6%) of the respondents while those with no monthly income made up 178(52.2%) of the respondents.

Table 2 shows that 321 (94.1%) of the respondents had good knowledge of contraceptives. Also 204 (59.8%) of the respondents reported that there is a difference between contraception and family planning. The highest source of information on contraceptives was from school 147 (44.8%) while family was the least source of knowledge about contraceptives 26 (7.9%). About, 234 (69.4%) believed that contraceptives are for married women while 130 (38.6%) believed it to be for single women. It equally shows that Pill 245(72.9%), male condom 196(58.3%), female condom 131(39%), withdrawal method 127(37.8) and implant 110(32.7%) were the most common forms of contraceptives known by the respondents. Pharmacy was identified as the foremost source of contraceptives 222(65.5%).

Table 3 shows that the prevalence of contraceptives among the respondents was 121(35.5%). The most commonly used contraceptive method was male condom 55(45.5%). Of the 35.5% of respondents that have ever used a form of contraceptive, 49(40.5%) reported having experienced menstrual abnormalities while 63(52.1%) reported no side effects. Also safety was the

commonest reason for choice of contraceptive 86(71.1%). The most prevalent reason for non-use of contraceptive was uneasiness at purchasing it 23(10.5%) followed by partner hates it 22(10.0%)

Table 4 shows that the overall positive perception on contraception was 284(83.3%). Among the respondents, 313(91.8%) reported their Husband/Partner thinks that modern contraceptives were important, 311(91.1%) would discuss with husband/partner on modern contraceptives. 310(90.1%) affirmed that contraceptives benefits men too, 269(78.9%) stated that it is not wrong to use contraceptives and 282(82.7%) reported that the benefits of modern contraceptives outweighed its draw-backs. Table also shows that 236(69.3%) of the respondents reported misconceptions on contraceptive use. Of the respondents, 34(9.9%) reported that contraceptive is not essential for family planning, 172(50.5%) that contraceptives encourage promiscuity, 224(65.6%) agreed that contraceptives cause cancer and 181(47.0%) that contraceptives can make one infertile.

Table 5 shows that there was no significant association between any of the socio-demographic factors and the use of contraceptive among respondents (all $p > 0.05$).

Table 6 shows that there was no significant association between any of the socio-demographic factors and the perception of contraception among the respondents (all $p > 0.05$)..

Table 7 shows that only religion had a significant association between socio-demographic factors and misconceptions of contraceptive ($p = 0.006$)..

Table 8 shows that Christians were about 12% times likely to have misconceptions on contraceptive use than other religion [AOR 0.119; 95%CI: 0.025-0.573].

**DISCUSSION**

The knowledge on contraceptives to a great extent determines its use. Having knowledge about fertility control is an important stage towards attaining access to and using an appropriate contraceptive method timely and in an effective manner.[23] There was a high knowledge of contraceptives among the respondents (94.7%). This is in line with findings in a similar studies in Ondo and Ekiti states, Nigeria where 100% knowledge was reported[24] and in Enugu, Nigeria which reported 91.1%.[25] Also, another study carried out in Enugu documented 81.7%.[26] The commonest source of knowledge was school while the least was family. This contrasts similar studies that observed commonest source as family/friends[8,25] and health facility.[27] These findings from current study may be as a result of location of the study which is a tertiary institution with series of courses, seminars, trainings and programmes. In course of these, contraceptive may be a topic of discussion. The high level of knowledge is encouraging. If sustained and translated into uptake will greatly impact positively on mortality status of women of reproductive age and boost economic status of the nation at large.

The most widely known form of contraceptive among the respondents was pill followed by male condom. A similar study in Tanzania as well as other several studies have also identified pill and male condom as the predominant known form of contraceptives.[22, 24, 25,28] Pharmacy shops were the highest source of contraceptives. This can equally be explained by location of the study and

the educational level of the respondents. In a study conducted in Delta state Nigeria, pharmacy was also identified as the most common source of contraceptives.[22]

Despite the high level of knowledge of contraceptives in the University community, the proportion that uses contraceptives was low (35.5%). This implies that high and good knowledge of contraceptive does not mirror the use. This gap could be partly due to the fact that the prevailing religion in University is Christianity. The influence of culture and religion on contraceptive usage was crystal clear in this population of women. This has been reported by several other previous studies.[29-31] According to 2018 NDHS, the prevalence of contraceptive use in Enugu state was 30.9%[7]. A similar study conducted in Kano reported a prevalence rate of 31.5%.[32] The NDHS further revealed that contraceptive use is more prevalent among sexually active unmarried women (37.0%) than married women (16.6%).[7]

Globally, it has been shown that women generally prefer injectables.[33] However, this study reported Male condom and Pill as the most widely used contraceptives at 45.5% and 43.0% respectively. Emergency contraceptive and withdrawal had the similar rate of use at 20.7%. Tubal litigation, vasectomy, foam and spermicide had the lowest use rate. Studies conducted in Tanzania and Ukraine reported pill and condom (97.9%) each as the most widely used form of contraceptives among the respondents.[28,34]

The most reported side effect experienced was menstrual abnormalities which are common side effect of contraceptive pill and emergency contraceptive. Weight gain, headache as well as Irritation [side effect observed in some users of male and female condom] were reported. Above

all, a high proportion of the respondents reported no side effects. Contraceptives when used as prescribed are safe and have limited side effects if any. However, these vary according to type of contraceptive and individual involved. There is need for adequate screening, counseling and guided choice by trained providers tailored to meet individual needs as some are contra-indicated in particular conditions. Reasons for choice of contraceptive method varied among the respondents. Safety was the most predominant choice followed by reliability and ease of use.

Uneasiness at purchasing a form of contraceptive was the most common reason for non-use of contraceptives among the respondents. This could be as a result of shyness and fear of judgment by the provider. Partner's dislike of contraceptives was also reported as a key reason for non-use of contraceptive. In a society that is male dominated, this is a common observation. Not wanting a birth control and fear of side effects were other reason for not using it. Cost and provider's attitude were the least reported reason for non-use. A focus group discussion may help probe further and uncover the reason for this.

All the respondents in this study have at least one concern about contraceptive use. Nonetheless, there was an overall high positive perception and minimal misconceptions on contraceptives among this population. Note worthy is the perception regards discussing modern contraceptives with partners and partners positive thoughts on contraceptives. However, there were negative perceptions such as opinion that it is not for the poor, that they were for females alone and that it is wrong to use contraceptives. This opinion could have been formed out of religious and cultural beliefs. Over a half of the respondents did not agree with the popular opinion that contraceptives are harmful to the womb and about two third of respondents agreed that contraceptives do not

cause infertility. There is need for enlightenment and education to reinforce the benefits of contraceptives while correcting the negative perceptions and misconceptions.

The myths and misconceptions surrounding contraceptives especially in developing countries are as old as time. Religion and culture have been shown to influence negatively the usage of contraceptives. No religious organization encourage the use of modern contraception, rather they preach abstinence or at most the 'calendar method' of family planning.[35] In addition, discussions on sex and contraception with young persons are still considered inappropriate in Nigeria, even among health workers.[36] Such opinions should be addressed by using appropriate behavioral change communication. Myths abound in Nigeria about modern contraceptives and this is not restricted only to the rural areas. Even among the educated and enlightened females there are still lots of concern about issues of reproductive health. The need for more organized education on contraceptives cannot be overemphasized.

Religion was found to be the only predictor for misconception about contraceptives. This may be explained by religious indoctrinations and beliefs. Numerous other studies however, have however found associations between socio-demographics and contraceptive use.[38-41] A study in Osun state Nigeria reported that one of the most significant socio-demographic determinants to the use of contraceptives was religion.[37]

**Comment [K2]:** Add strength, implication and limitations

## CONCLUSION

The knowledge of contraceptives was high but its use low. There was an overall positive perception and minimal misconception of contraceptives among the respondents. Some negative

perceptions and misconceptions were observed. There is need for proper structured education or enlightenment regarding sex and contraceptive use in order to bridge the gap between the knowledge and the use of contraceptives in this community and in Nigeria as a whole.

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**Table 1: Socio-demographic Characteristics of the Respondents**

| Variables | Frequency(n =341) | % |
|---|---|---|
| **Age Group** | | |
| <18 | 48 | 14.1 |
| 19-24 | 161 | 47.2 |
| 25-35 | 86 | 25.2 |
| >35 | 46 | 13.5 |
| ***Mean (SD)*** | ***25.32*** | ***8.21*** |
| **Level of Education** | | |
| Primary& below | 6 | 1.8 |
| Secondary | 17 | 5.0 |
| Tertiary | 243 | 71.3 |
| Higher | 75 | 22.0 |
| **Marital Status** | | |
| Single | 249 | 73.0 |
| Married | 87 | 25.5 |
| Others | 5 | 1.5 |
| **Religion** | | |
| Christianity | 331 | 97.1 |
| Others | 10 | 2.9 |
| **Tribe** | | |
| Igbo | 307 | 90.0 |
| Others | 34 | 10.0 |
| **Parity Status** | | |
| None | 251 | 73.6 |
| 1-2 | 36 | 10.6 |
| 3-4 | 35 | 10.3 |
| >5 | 19 | 5.6 |
| **Monthly Income** | | |
| No Income | 178 | 52.2 |
| Below 20,000 | 40 | 11.7 |

| | | |
|---|---|---|
| 20,000 - 50,000 | 51 | 15.0 |
| Above 50,000 | 72 | 21.1 |
| **Place of Residence** | | |
| On Campus | 196 | 57.5 |
| Town | 145 | 42.5 |
| **Occupation** | | |
| House Wife/Business | 23 | 6.8 |
| Teaching Staff | 29 | 8.5 |
| Non-teaching Staff | 53 | 15.5 |
| Students | 236 | 69.2 |

**Table 2: Knowledge of Contraceptive Methods and Sources among Respondents**

| **Variables** | **Yes (%)** | **No (%)** |
|---|---|---|
| | **Freq (%)** | **Freq (%)** |
| Knowledge of Contraceptives | 321(94.1) | 20(5.9) |
| Any difference between Contraception and Family Planning | 204(59.8) | 137(40.2) |
| **Source of Knowledge about Contraceptives** | | |
| Family | 26(7.9) | 315(92.1) |
| Friend | 95(29.0) | 246(71.0) |
| School | 147(44.8) | 194(55.2) |
| Mass media | 88(26.9) | 253(73.1) |
| Health personnel | 55(16.8) | 286(83.2) |
| **Who should use contraceptives** | | |
| Married men | 103(30.6) | 238(69.4) |
| Married women | 234(69.4) | 107(30.6) |
| Single men | 60(17.8) | 281(82.2) |
| Single women | 130(38.6) | 211(61.4) |
| None | 31(9.2) | 310(90.8) |
| **Knowledge of Contraceptive Methods** | | |
| Pill | 245(72.9) | 95(27.1) |
| Injectable | 98(29.2) | 243(70.8) |
| Emergency contraceptive | 82(24.4) | 259(75.6) |
| Implant | 110(32.7) | 231(67.3) |
| Male condom | 196(58.3) | 145(41.7) |
| Female condom | 131(39.0) | 210(61.0) |
| IUCD | 69(20.5) | 272(79.5) |
| Tubal Ligation | 50(14.9) | 291(85.1) |
| Vasectomy | 79(23.5) | 262(76.5) |
| Diaphragm | 62(18.5) | 279(81.5) |
| Foam | 25(7.4) | 316(92.6) |
| Spermicide | 46(13.7) | 295(86.3) |

| | | |
|---|---|---|
| Contraceptive ring | 44(13.1) | 297(86.9) |
| Lactationalamenorroea | 23(6.8) | 318(93.2) |
| Withdrawal | 127(37.8) | 214(62.2) |
| None | 35(10.4) | 306(89.6) |
| **Knowledge of Contraceptives Sources** | | |
| Government hospital | 106(31.3) | 235(68.7) |
| Health Centers | 125(36.9) | 216(63.1) |
| Family planning clinic | 103(30.4) | 238(69.6) |
| Private hospital | 73(21.5) | 268(78.5) |
| Pharmacy | 222(65.5) | 119(34.5) |
| Others | 9(2.7) | 332(97.3) |
| No idea | 35(10.3) | 306(89.7) |

**Table 3: Distribution of Contraceptive Use and reasons among Respondents**

| **Variables** | **Yes Freq (%)** | **No Freq (%)** |
|---|---|---|
| **Contraceptive use** | 121(35.5) | 220(64.5) |
| **Kind of Contraceptive Used (n = 121)** | | |
| Pill | 52(43.0) | 69(57.0) |
| Injectable | 6(5.0) | 115(95.0) |
| Emergency contraceptive | 25(20.7) | 96(79.3) |
| Implant | 6(5.0) | 115(95.0) |
| Male condom | 55(45.5) | 66(54.5) |
| Female condom | 17(14.1) | 104(85.9) |
| IUCD | 5(4.1) | 116(95.9) |
| Tubal Ligation | 1(0.8) | 120(99.2) |
| Vasectomy | 1(0.8) | 120(99.2) |
| Diaphragm | 2(1.7) | 119(98.3) |
| Foam | 1(0.8) | 120(99.2) |
| Spermicide | 1(0.8) | 120(99.2) |
| Contraceptive ring | 2(1.7) | 119(98.3) |
| Lactationalamenorroea | 2(1.7) | 119(98.3) |
| Withdrawal | 25(20.7) | 96(79.3) |
| **Side Effects of Contraceptives (n = 121)** | | |
| Headache | 14(11.6) | 107(88.4) |
| Menstrual abnormalities | 49(40.5) | 72(59.4) |
| Irritation | 13(10.7) | 108(89.3) |
| Weight gain | 18(14.9) | 103(85.1) |
| None | 63(52.1) | 58(47.9) |
| **Reason for choice of contraceptive (n = 121)** | | |
| Safety | 86 (71.1) | 35(38.9) |
| Reliability | 36(30.0) | 85(70.0) |
| Accessibility | 25(20.7) | 96(79.3) |
| Cost | 11(9.1) | 110(90.9) |
| Ease of use | 43(35.5) | 78(64.5) |

| | | |
|---|---|---|
| **Reason for Non-use of Contraceptives (n = 220)** | | |
| Fear of side effects | 16(7.3) | 204(92.7) |
| It is expensive | 1(0.5) | 219(99.5) |
| I don't feel comfortable purchasing it | 23(10.5) | 197(89.5) |
| My partner hates it | 21(9.6) | 199(90.4) |
| I don't want birth control | 22(10.0) | 198(90.0) |
| Provider's attitude | 1(0.5) | 219(99.5) |
| | 21(9.6) | 199(90.4) |
| **In case of Contraceptive Failure** | | |
| **Management of Unplanned Pregnancy** | | |
| Abortion | 7(2.1) | 334(97.9) |
| Baby was given up for adoption | 1(0.3) | 340(99.7) |
| Miscarriage | 4(1.2) | 337(98.8) |
| Accepted my fate | 30(9.1) | 311(90.9) |

**Table 4 Perception and misconceptions on Contraceptives among Respondents**

| | | N = 341 |
|---|---|---|
| **Variables** | **Positive (%)** | **Negative (%)** |
| **PERCEPTIONS** | | |
| Modern contraceptive services and commodities are inaccessible | 260 (76.3) | 81 (23.7) |
| Contraceptive are for females only | 264 (77.4) | 77 (22.6) |
| Contraceptives are acceptable in our community | 267 (78.2) | 74 (21.8) |
| Contraceptives benefits males too | 310 (90.1) | 31 (9.1) |
| Contraceptives is not for the poor | 266 (78.0) | 75 (22.0) |
| It is wrong to use contraceptives | 269 (78.9) | 72 (21.1) |
| Benefits of modern contraceptives outweigh negative effects | 282 (82.7) | 59 (17.3) |
| Would recommend the use of modern contraceptive to a friend | 292 (85.6) | 49 (14.4) |
| Would use modern contraceptives in future | 292 (85.6) | 49 (14.4) |
| Would discuss with husband/partner on modern contraceptives | 311 (91.1) | 30 (8.9) |
| Husband/Partner thinks that modern contraceptives are important | 313 (91.8) | 28 (8.2) |
| **Overall perception** | **284 (83.3)** | **57 (16.7)** |
| **MISCONCEPTIONS** | 193 (56.6) | 148 (43.4) |
| Contraceptives are harmful to the womb | | |
| Contraceptives use will make you increase in weight | 246 (72.2) | 95 (27.8) |
| Contraceptives use can cause cancer | 224 (65.6) | 117 (34.4) |
| Contraceptives use can make you infertile | 181 (53.1) | 160 (46.9) |
| Contraceptives are meant for married people only | 212 (62.2) | 129 (37.8) |
| Contraceptives use is against the will of God | 236 (69.2) | 105 (30.8) |
| Contraceptives should only be used by women because they become Pregnant | 260 (76.3) | 81 (23.7) |
| Contraceptives are essential for family planning | 307 (90.1) | 34 (9.9) |

| | | |
|---|---|---|
| Contraceptives allow women to pursue their career | 279 (81.8) | 62 (18.2) |
| Contraceptives encourages promiscuity | 169 (49.5) | 172 (50.5) |
| Contraceptive use is against my cultural norms and values | 229 (67.2) | 112 (32.8) |
| Use of contraceptives is irrelevant | 299 (87.7) | 42 (12.3) |
| **Overall misconception** | **236 (69.3)** | **105(30.7)** |



**Table 5 Socio-demographic factors and use of Contraceptives among Respondents**

| Variables | Use of contraceptive during sex | | Bivariate analysis $X^2$(p-value) |
|---|---|---|---|
| | Yes (%) | No (%) | |
| **Grouped Age** | | | |
| <18 | 9 (3.8) | 14 (5.9) | 2.603 (0.457) |
| 19-24 | 52 (21.9) | 46 (19.4) | |
| 25-35 | 40 (16.9) | 32 (13.5) | |
| >35 | 20 (8.4) | 24 (3.8) | |
| **Level of Education** | | | |
| Primary & Below | 2 (0.8) | 3 (1.3) | 0.473 (0.925) |
| Secondary | 6 (2.5) | 7 (3.0) | |
| Tertiary | 78 (32.9) | 75 (31.6) | |
| Higher | 35 (14.8) | 31 (13.1) | |
| **Marital Status** | | | |
| Single | 75 (31.6%) | 72 (30.4%) | 0.168 (0.920) |
| Married | 43 (18.1%) | 42 (17.7%) | |
| Others | 3 (1.3) | 2 (0.8%) | |
| **Religion** | | | |
| Christianity | 117 (49.4) | 113 (47.7) | 0.107 (0.744) |
| Others | 4 (1.7) | 3 (1.3) | |
| **Tribe** | | | |
| Igbo | 108 (45.6) | 103 (43.5) | 0.013 (0.909) |
| Others | 13 (5.5) | 13 (5.5) | |
| **Occupation** | | | |
| House Wife/Business | 15 (6.3) | 8 (3.4) | 2.112 (0.549) |
| Teaching Staff | 14 (5.9) | 14 (5.9) | |
| Non-teaching Staff | 25 (10.5) | 24 (10.1) | |
| Student | 67 (28.3) | 70 (29.5) | |

| | | | |
|---|---|---|---|
| **Parity Status** | | | |
| None | 76 (32.1) | 74 (31.2) | 3.331 |
| 1-2 | 20 (8.4) | 16 (6.8) | (0.343) |
| 3-4 | 20 (8.4) | 15 (6.3) | |
| 5 and above | 5 (2.1) | 11 (4.6) | |
| **Monthly Income** | | | |
| None | 49 (20.7) | 53 (22.4) | 3.517 |
| Below 20,000 | 12 (5.1) | 12 (5.1) | (0.319) |
| 20,000 - 50,000 | 19 (8.0) | 24 (10.1) | |
| Above 50,000 | 41 (17.3) | 27 (11.4) | |

**Table 6: Socio-demographic factors and Perception of Contraception among Respondents**

| Variables | Perception of Contraception (N=341) | | Bivariateanalysis $X^2$(p-value) |
|---|---|---|---|
| | Positive (%) | Negative (%) | |
| **Age Group** | | | |
| <18 | 39 (11.4) | 9 (26) | 1.037 |
| 19-24 | 130 (28.1) | 31(9.1) | (0.792) |
| 25-35 | 73(21.4) | 13 (3.8) | |
| >35 | 36 (10.6) | 10 (2.9) | |
| **Level of Education** | | | |
| Primary & Below | 4(1.2) | 2 (0.6) | 1.486 |
| Secondary | 15(4.4) | 2(0.6) | (0.686) |
| Tertiary | 197(57.8) | 46(13.5) | |
| Higher | 62(18.2) | 13(3.8) | |
| **Marital Status** | | | |
| Single | 204(59.8) | 45 (13.2) | 0.1 |
| Married | 70(20.5) | 17(5.0) | (0.951) |
| Others | 4(1.2) | 1(0.3) | |
| **Religion** | | | |
| Christianity | 271(79.5) | 60 (17.6) | 0.909 |
| Others | 7(2.1) | 3(0.9) | (0.341) |
| **Tribe** | | | |
| Igbo | 254(74.5) | 53(15.5) | 2.999 |
| Others | 24(7.0) | 10(2.9) | (0.083) |
| **Occupation** | | | |
| House Wife/Business | 19(5.6) | 4(1.2) | 2.029 |
| Teaching Staff | 21(6.2) | 8(2.3) | (0.566) |
| Non-teaching Staff | 45(13.2) | 8(2.3) | |
| Student | 193(56.6) | 43(12.6) | |
| **Parity Status** | | | |
| None | 206(60.4) | 45(13.2) | 0.210 |
| 1-2 | 29(8.5) | 7(2.1) | (0.976) |
| 3-4 | 28(8.2) | 7(2.1) | |
| 5 and above | 15(4.4) | 4(1.2) | |
| **Monthly Income** | | | |
| None | 142(41.6) | 36(10.6) | 2.012 |

| | | | |
|---|---|---|---|
| Below 20,000 | 34(10.0) | 6(1.8) | (0.570) |
| 20,000 - 50,000 | 40(11.7) | 11(3.2) | |
| Above 50,000 | 62(18.2) | 10(2.9) | |
| **Place of Residence** | | | |
| On Campus | 160(46.9) | 37(10.9) | 0.29 |
| Town | 118(34.6) | 26(7.6) | (0.864) |

**Table 7: Socio-demographic factors and Misconceptions of Contraceptives among Respondents**

| | Misconception about Contraceptive | | Bivariate analysis |
|---|---|---|---|
| **Variables** | **Yes (%)** | **No (%)** | **$X^2$(p-value)** |
| **Age Group** | | | |
| <18 | 29(8.5) | 19(5.6) | 2.850 |
| 19-24 | 112(32.8) | 49(14.4) | (0.415) |
| 25-35 | 64(18.8) | 22(6.5) | |
| >35 | 32(9.4) | 14(4.1) | |
| **Level of Education** | | | |
| Primary & Below | 4(1.2) | 2(0.6) | 0.322 |
| Secondary | 12(3.5) | 5(1.5) | (0.956) |
| Tertiary | 167(49.0) | 76(22.3) | |
| Higher | 54(15.8) | 21(6.2) | |
| **Marital Status** | | | |
| Single | 175(51.3) | 74(21.7) | 2.136 |
| Married | 60(17.6) | 27(7.9) | (0.344) |
| Others | 2(0.6) | 3(0.9) | |
| **Religion** | | | |
| Christianity | 234(68.6) | 97(28.4) | 7.584 |
| Others | 3(0.9) | 7(2.1) | (0.006) |
| **Tribe** | | | |
| Igbo | 216(63.3) | 91(26.7) | 1.066 |
| Others | 21(6.2) | 13(3.8) | (0.302) |
| **Occupation** | | | |
| House Wife/Business | 15(4.4) | 8(2.3) | 1.819 |
| Teaching Staff | 23(6.7) | 6(1.8) | (0.611) |
| Non-teaching Staff | 38(11.1) | 15(4.4) | |
| Student | 161(47.2) | 75(22.0) | |
| **Parity Status** | | | |
| None | 177(51.9) | 74(21.7) | 4.400 |
| 1-2 | 20(5.9) | 16(4.7) | (0.221) |
| 3-4 | 27(7.9) | 8(2.3) | |
| 5 and above | 13(3.8) | 6(1.8) | |
| **Monthly Income** | | | |
| None | 128(37.5) | 50 (14.7) | 5.740 |
| Below 20,000 | 26(7.6) | 14(4.1) | (0.125) |
| 20,000 - 50,000 | 29(8.5) | 22(6.5) | |
| Above 50,000 | 54(15.8) | 18(5.3) | |
| **Place of Residence** | | | |

| | | | |
|---|---|---|---|
| On Campus | 139(40.8) | 58(17.0) | 0.246 |
| Town | 98(28.7) | 46(13.5) | (0.620) |

**Table 8: Factor influencing Misconception of Contraceptives among Respondents**
**Multivariate analysis**

| Variable | AOR | 95% C. I. for AOR |
|---|---|---|
| **Religion** | | |
| Christianity | 0.119 | 0.025-0.573 |
| Others | | 1 |