Relationship between Contraceptive Misconception and Women's Access to Family Planning Services

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Abstract

Background: False beliefs about contraceptive misconception, including the fear of impaired fertility or sequelae to the disease are a key challenge in many cases. Effective use of access to family planning services. These commonly held myths adversely influence women's attitudes and reduce their confidence in health care systems, which results in Reduced engagement in programs which are available. knowing how these factors relate to each other is which is vital for developing effective health interventions that facilitate informed decision making and guarantee health.

Aim: This study aimed to assess the relationship between contraceptive misconception and women's access to family planning services.

Methods: A cross-sectional descriptive-analytical study was conducted among 200 women of reproductive age(15-49) attending the family planning unit at the Teaching Hospital for Obstetrics and Gynaecology in the Holy Karbala City, Participants were selected using a convenience sampling technique. Contraceptive misconceptions were assessed using the Perceived Contraceptive Misconception Scale, while access to family planning services was measured using the Access to Family Planning Services Scale. Data were analysed using descriptive statistics, Pearson's correlation coefficient,

Results: it indicates shows that there is a strong positive relationship of statistical significance between the level of misconceptions among participating mothers about contraception and the access to family planning services (P=0.028, R=0.692); meaning that the higher the level of misconceptions, the greater the barriers preventing access to family planning services**.**

Conclusion: Correcting misconceptions and improving knowledge is critical to enhance women's access to family planning services and optimize their utilization.

Keywords: family planning services; contraceptive misconceptions; Access to family planning services.

1. Introduction

Family planning is a fundamental component of reproductive health and a cornerstone for improving maternal and child health, promoting gender equality, and supporting sustainable social development. family planning services play a vital role in minimizing unplanned pregnancies and preventing associated health problem by enabling individuals and partner to make informed choices regarding the timing and intervals between childbirth. Access to these services is a prerequisite for attaining reproductive health objectives and enhancing population health(Idris et al., 2022). However, although efforts have been made to increase the reach of family planning, many Low- and Middle-Income Countries (LMICs) are still struggling with poor family planning use and availability(Rua et al., 2026). Structural limitation disparate services allocation, and individual hurdles continue women remain unable to efficiently obtain family planning services due to structural constraints, uneven service to prevent women from accessing these essential services effectively. It is specifically noted in(Duminy et al., 2021) that subjective perceptions, knowledge gap and perceived level of services are significant factors that shape women's engagement with family planning services. Moreover, findings from Iraq show that satisfaction with health services is an important factor in the uptake of health services, and findings from primary healthcare sites suggest that increasing satisfaction among the expectant mothers is related to higher uptake of maternal health services(Al-Abedi, 2021). Myths about contraceptive methods are a significant individual barrier to accessing services for women of reproductive age(Alrawi, 2021). The fallacies that frequently include are unfounded worries about contraception causing long-term reproductive problems, hormonal imbalance, ongoing health issues, and permanent sterility(Eshak, 2020) . These Misconceptions are often carried forward through informal social networks and traditional cultural facts, thus perpetuating within local communities, which can be active barriers to care, and not simply informational gaps – women who believe that contraceptives are dangerous are unlikely to use health facilities, delay medical consultation or even reject available options altogether(Oljira et al., 2023). The feared short-term health impacts from such falsehoods, as well as the fear of side effects, magnifies the risks of such misinformation(Wondmeneh, 2026). Women often overestimate the risks of using contraceptives and consequently visit fewer times. In fact, distorted perceptions of side effects are always tied to reduced levels of contraceptive use (Mukanga et al., 2023). These myths are frequently intertwined with socio-cultural norms and religious beliefs, and can have a more constraining effect(Tuvei et al., 2025). Whether at home, with a partner, or in the community, a woman's voice is silenced by the influence of a partner, family, and social stigma, and sometimes outweighs medical advice.

The available information indicates that family planning is currently available both because of its supply and demand-side availability. Physical availability is a precondition, but the degree to which it is used is highly dependent on attitudes and convictions of the women themselves. An increase in supply alone is not enough unless accompanied by tackling the underlying misconceptions and demand-side barriers, as research has shown(Sedlander et al., 2021). In all, misconceptions pose a major hurdle to the success of global family planning and improving access requires a coordinated effort to challenge these myths.

Health promotion models, such as Pender's Health Promotion Model, highlight the influence of personal beliefs and motivations on health habits(Faris et al., 2025). Recent studies indicate that motivational and cognitive factors have a significant impact on health-promoting behaviors. Therefore, even when services are available, women may be discouraged due to false perceptions.

Using rights-based and woman-centered strategies to overcome informational and perceptual barriers is necessary to improve access(Nabhan et al., 2023).

Recent international guidelines emphasize the significance of including reproductive health education into primary healthcare services. Recent data from Iraq, particularly during the COVID-19 pandemic, demonstrates the significance of health education in raising women's knowledge and acceptance of healthcare services(Al-Masoudi et al., 2025). Targeted interventions that address misconceptions within communities can increase trust in contraceptive techniques and rise service utilization. Healthcare workers, especially nurses, are essential in dispelling myths and expanding access. Nursing care includes psychological and emotional support in addition to physical health, which influences women's use of medical services(Abood&Oleiwi, 2025). Nurse-led education and counseling programs have been shown to be effective methods for enhancing women's knowledge and easing access to services(Fadil&Oleiwi, 2025). Finally, eliminating perceptual and informational barriers is critical for achieving universal access to family planning services.

2. Methodology

2.1 design of study

Descriptive cross-sectional study design was used to assess the relationship between contraceptive misconception and women’s access to family planning services.

2.2 Ethical considerations

The Ethics Committee of the College of Nursing, University of Karbala approved the study (Approval Code: UOK.N.C.25.095). Women were recruited as participants in the study, and written informed consent was obtained prior to data collection. Participation was voluntary, and no participant was coerced to take part in the study. Confidentiality, anonymity, and privacy were strictly maintained throughout the study.

2.3 Study tools

Data was gathered using validated instruments: the contraceptive misconception scale, (Dibia & Dibia, 2019). Access to family planning services scale,(Kigongo et al., 2024). A demographic questionnaire was also distributed to collect data on mothers' educational attainment, age, academic level, and current residence. The instruments were pre-tested on a small sample to ensure dependability and clarity for the intended audience. Data were collected through face-to-face interviews conducted by the researcher in the Family Planning Unit. The structured questionnaire was administered to eligible women attending the unit during their visit. All participants received a thorough explanation of the study's goals and purpose prior to data collection. Before the interview procedure started, participants were given the assurance of confidentiality and voluntary participation, and both verbal and written informed consent were obtained.

2.4 Validity and Reliability

Face validity was assessed by 19 experts, and their comments were incorporated to improve the questionnaire. A pilot study was conducted on 20 women of reproductive age attending the family planning unit to evaluate the clarity and feasibility of the questionnaire. The reliability of the instrument was assessed using Cronbach’s alpha coefficient. The Cronbach’s alpha value was 0.781

for the Misconceptions about Contraceptive Use scale and 0.745 for the Access to Family Planning Services scale, indicating acceptable internal consistency.

2.5 Data Analysis

Data were analysed using the Statistical Package for Social Sciences (SPSS) software version 27. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize participants' demographic characteristics as well as levels of misconceptions about contraceptive methods and access to family planning services. Pearson's correlation coefficient was applied to examine the relationship between contraceptive misconceptions and access to family planning services. A significance level of $p < 0.05$ was considered statistically significant for all analyses.

3. Results

Table 1. Distribution of mothers according to their demographic data.

Demographic data		**N=200**	**%**
Age (years)	<30	87	43.5
	30-40	76	38
	>40	37	18.5
Educational Level	Illiterate	5	2.5
	Reads and writes	18	9
	Primary certificate	30	15
	Intermediate school	31	15.5
	Secondary school	44	22
	Bachelor's degree	62	31
	Postgraduate degree	10	5
Economic status	Enough	62	31
	somewhat sufficient	89	44.5
	Not enough	49	24.5
Employment Status	Employed	96	48
	Student	11	5.5
	Housewife	91	45.5
	Freelance work	2	1
Residence	Rural	72	36

Demographic data		N=200	%
	urban	125	62.5
	Slums	3	1.5

The sample of 200 mothers show a diverse demographic profile across age, education, economic status, employment, and residence. So the table 1 show that The majority of mothers (81.5%) are under 40 years old, with the largest group being under 30 (43.5%). Also show that a significant portion of the sample has a Bachelor's degree (31%) or Secondary education (22%), indicating a moderately educated group. But there is significant variation: 15.5% intermediate education, 15% primary, 9% literacy (reads and writes), and (2.5%) are illiterate. The presence of postgraduate degrees (5%) adds to the educational range.

The table shows that nearly half (44.5%) say that their economic situation is "somewhat sufficient" and 31% say it is "enough", but 24.5% say it is "not enough", which could indicate a significant proportion could be experiencing economic difficulties.

Employment is almost evenly split between Employed (48%) and Housewives (45.5%). Very few are students (5.5%) or engaged in freelance work (1%). Also show that most mothers live in Urban (62.5%), followed by the countryside (36%). A small percentage (1.5%) reside in "informal housing,"

Table 2. Distribution of mothers according to their Obstetric and Reproductive History.

Data		N=200	%
Have you ever used contraception?	Yes	137	68.5
	No	63	31.5
Number of Children	One child	54	27
	Two children	58	29
	More than two children	88	44
family planning methods	Male condom	51	25.5
	Withdrawal	34	17
	Abstinence during ovulation	20	10
	Contraceptive pills	79	39.5
	Breastfeeding	41	20.5
	IUD (Intrauterine Device)	52	26

Data		N=200	%
	Implants	9	4.5
	Surgical sterilization	7	3.5
	Injections	15	7.5
Age at Menarche	10 years	2	1
	11 years	20	10
	12 years	54	27
	13 years	40	20
	14 years	43	21.5
	15 years	29	14.5
	16 years	12	6
Number of Pregnancies	One birth	54	27
	Two births	54	27
	More than two births	92	46
Menstrual Cycle	Regular	127	63.5
	Irregular	73	36.5
Breastfeeding	No	45	22.5
	Yes"<6 months"	62	31
	Yes"6-12 months"	34	17
	>12months	59	29.5
Birth Spacing	Less than one year	19	9.5
	One to two years	77	38.5
	More than two years	104	52

The table 2 show that (68.5%) of mothers reported having used contraception, indicating a moderate level of awareness and adoption of family planning methods. However, 31.5% had never used any method, and (44%) of mothers had more than two children, (29%) had two children and 27% had one child.

The table show also that Contraceptive pills were the most common method (39.5%), followed by IUD (26%) and male condom (25.5%). Traditional methods such as withdrawal (17%) and

breastfeeding (20.5%) were still frequently reported. Long-acting reversible contraceptives (LARCs) like implants (4.5%) and surgical sterilization (3.5%) were underutilized. Also the most common age at first menstruation was 12 years (27%), followed by 14 years (21.5%) and 13 years (20%) and Only 1% experienced menarche at 10 years. (63.5%) reported regular cycles, while (36.5)% reported irregular cycles.

In addition, the table shows That (31%) breastfed for less than 6 months, while (29.5) % breastfed for more than 12 months. (22.5%) did not breastfeed at all, (52%) had spacing of more than two years, which is generally associated with better maternal and child health outcomes. (38.5%) had spacing of 1–2 years, and (9.5%) had less than one year between births

Table 3. Participants Assessment Concerning Contraception's Misconception.

Items	**Yes**		**No**	
	N	**%**	**N**	**%**
Using the contraceptive injection can make a woman permanently infertile	58	29	142	71
Women who use contraceptives end up having health problems	167	83.5	33	16.5
Contraceptives can harm the uterus and lead to fibroids	139	69.5	61	30.5
Family planning methods cause or worsen acne	113	56.5	87	43.5
Contraceptives may cause cancer	93	46.5	107	53.5
Contraceptives may cause the birth of deformed babies	86	43	114	57
Using two condoms is safer to prevent tearing during intercourse	91	45.5	109	54.5
A condom may get lost inside a woman's vagina or uterus	83	41.5	117	58.5
Family planning methods are only for women who have children	123	61.5	77	38.5
Family planning methods are for married adults only	142	71	58	29
Family planning methods make a person gain weight	140	70	60	30
Family planning methods increase my appetite	123	61.5	77	38.5
Family planning methods (Hormonal) make the menstrual cycle irregular	133	66.5	67	33.5
Family planning methods cause a person to suffer from mood swings	170	85	30	15
Family planning methods affect a woman's relationship with her husband and his family	134	67	66	33
Family planning is a safe method to prevent pregnancy	145	72.5	55	27.5

Items	Yes		No	
	N	%	N	%
Family planning methods are intended only for women, and men do not have an important role in this area.	106	53	94	47
Using natural methods of family planning is less safe if not used correctly.	163	81.5	37	18.5
Family planning methods are used only after childbirth.	111	55.5	89	44.5

The table 3 show that The most widespread misconception is that family planning methods cause a person to suffer from mood swings (85%), A closely held belief is that women who use contraceptives end up having health problems (83.5%), and It is noteworthy that a correct statement is also among the most agreed-upon items: "Using natural methods of family planning is less safe if not used correctly."(81.5%).

Also the table indicates that the least believed misconception among those listed is that using the contraceptive injection can make a woman permanently infertile. While still a concern for 29% of women, it is significantly less widespread than other fears.

Table 4. Participants Assessment Concerning Access to Family Planning Services .

Items	Yes		No	
	N	%	N	%
unavailability of family planning methods when needed, and their failure to meet your family planning needs.	97	48.5	103	51.5
Inability to afford transportation to health centers, especially in remote areas.	113	56.5	87	43.5
Do religious or cultural beliefs consider family planning unacceptable or contrary to tradition?	67	33.5	133	66.5
Refusal of the partner or family to use contraception.	84	42	116	58
Fees must be paid for family planning services	99	49.5	101	50.5
There is a shortage of medical personnel trained to provide advice or services related to family planning.	112	56	88	44
Poor quality of services or lack of respect for privacy in healthcare facilities	126	63	74	37
Negative attitudes from healthcare providers towards women who request contraception.	94	47	106	53
Lack of awareness about family planning methods or how to use them.	140	70	60	30

The results in table 4 show that the three biggest obstacles to accessing family planning services are as follows:

Knowledge about family planning methods is identified as the most critical barrier, 7 out of 10 mothers reported lack of knowledge. This highlights a lack of information dissemination, health education, and community outreach.

A majority of mothers believe the quality of services is poor and they feel that they have not had enough privacy (63%). This is a serious disincentive that can compromise confidence in the health care system.

Being unable to pay for transport to health centers (56.5%): This is a very important economic and geographic access barrier, especially for people living in remote areas.

Table 5. Distribution of mothers according to their level of misconceptions.

Level	N	%
Low	6	3
Moderate	114	57
High	80	40
Total	200	100

Table 5 show that the majority of mothers (57%) exhibit a moderate level of misconceptions regarding contraception. A substantial proportion (40%) fall into the high misconception category, while very few (3%) have a low level of misconceptions

Table 6. Distribution of mothers according to access to family planning services.

Level	N	%
Low	58	29
Moderate	100	50
High	42	21
Total	200	100

Table 6 that Half of the mothers (50%) face a moderate level of access to family planning services. About 29% experience low level of access to family planning services, while 21% encounter high level of access to family planning services.

Table 7. The Correlation Between Contraceptive Misconception and Access to Family Planning Services.

Variables		**Misconception**	**access to family planning services**
Misconception	**R**	1.00	0.692

Variables		Misconception	access to family planning services
	Pearson correlation coefficient		
	P	1.00	0.000*
	p-value		
access to family planning services	**R**	0.692	1.00
	pearsoncorrelation		
	P	0.000*	1.00
	p-value		

Table (7) shows the relationship between the study variables. It indicates a strong positive statistically significant relationship between the level of misconceptions among participating mothers about contraception and access to family planning services (P = 0.000, R = 0.692), meaning that higher levels of misconceptions are associated with greater difficulties in accessing family planning services.

4. Discussion

The demographical attributes of the mothers were discussed

The sample of mothers is representative of the age, education, economic status, place of residence, and employment of mothers. The majority of the participants are relatively young, and there is a significant involvement of younger participants. Education levels are moderate with a large number of women having secondary school or Bachelor's degree instead of university , as well as primary and intermediate school education, and a smaller proportion having had some post-graduate degree.

There is economic variation – a significant portion say that their resources are only partly adequate, others say they are adequate, but a noteworthy proportion say that there is financial hardship. There is a fairly even balance between the number of women in formal employment and those who identify as housewives, with a small number having student and freelance employment. The most people reside in an urban setting, followed by those in rural areas, with a very small number living in informal housing

The present study showed that a considerable proportion of women had previous experience with contraceptive use, while others reported never using any method. This finding is consistent with the Iraq MICS report, which indicated that a proportion of women in Iraq still do not use contraceptive methods despite availability of services (UNICEF, 2018).

Regarding contraceptive methods, oral contraceptive pills were the most commonly used method, followed by IUDs and condoms. This result is in agreement with a study conducted in Iraq which reported that oral contraceptive pills and IUDs are the most frequently used modern contraceptive methods among women of reproductive age (Salih, 2024).

The present study also found that traditional methods such as withdrawal and breastfeeding are still practiced. This finding is consistent with WHO reports which indicate that traditional contraceptive methods are still used in some populations due to cultural beliefs and misconceptions.

In contrast, the low utilization of long-acting reversible contraceptives (LARCs) and permanent methods agrees with previous evidence showing that limited awareness and access barriers contribute to their low uptake. The results indicate that a significant number of the mothers have experience with using contraceptives, which shows a medium awareness and adoption of family planning practices, and a notable proportion of mothers have never used any method. There is variation in patterns of childbearing, some mothers report having larger families and others fewer children. The use of contraceptive pills becomes the most common contraceptive method, with IUDs and male condoms coming in second, while traditional methods like withdrawal and breastfeeding still are largely used. On the other hand, LARCs and permanent methods seem to be less commonly used.

The information also shows gender differences with respect to reproductive health parameters, such as age at menarche and regularity of menstrual cycles, where most women indicated that the cycle was regular. Breastfeeding durations range from short to long and some mothers who report they never breastfed. Birth spacing patterns also show differences; women that achieve longer intervals between pregnancies tend to have better maternal and child health outcomes, while women with shorter intervals tend not to have better maternal and child health outcomes.

The present study revealed that the moderate level of misconception about contraceptives was observed among the maximum number of participating mothers as shown in Table (5).

This can be attributed to limited health education, since many women receive health information from various sources of information (family, community, internet) rather than all in one place. Moreover, awareness campaigns are limited and may only provide medical information, without addressing common and prevalent misconceptions in the community.

The current result is consistent with the result of a study(Eshak, 2020) which showed that the highest percentage of participants had an moderate level of misconceptions about contraception(Eshak, 2020). The result was also consistent with the findings of a study(Aksu&Alkaş, 2025) which indicated that the majority of participating women had a moderate level of misconceptions about contraception (Aksu&Alkaş, 2025).

On the other hand, the current result did not agree with the result of the study(Calhoun et al., 2022) which suggested that the majority of participating mothers had a low level of misconceptions about contraception(Calhoun et al., 2022). The current result also contradicts the findings of a previous study(Mekonnen et al., 2020) which showed that the majority of mothers have a high level of misconceptions about contraception in all its forms(Mekonnen et al., 2020). The current result also contradicts the findings of a previous study(Fouad et al., 2025) which showed that the majority of mothers have a high level of misconceptions about contraception in all its forms(Fouad et al., 2025).

The highest proportion of participating mothers had a moderate level of access to family planning services.

This may be attributed to partial family support, where mothers receive assistance from some family members, such as a husband or mother, but not in a consistent or full manner. In addition, family members' work and social commitments may limit their ability to provide continuous support. Another possible explanation is the balance between acceptance and restriction within families, as some support the mother's involvement in health and reproductive decisions, while others impose certain limitations or reservations.

The current result is consistent with the result of a study(Radi, 2026) which showed that participating mothers had a moderate rate of access to services provided by family planning centres(Radi, 2026). The current result is also consistent with the result of a study(Frederic et al., 2017) which reported that mothers have a moderate rate of access to family planning services.(Frederic et al., 2017).

Conversely, the current result was inconsistent with the findings of a study(Islam & Hasan, 2016) which showed that women had low access to family planning services for preventing pregnancy. (Islam & Hasan, 2016). Furthermore, the current result was inconsistent with the findings of a study (Aksu et al, 2025) which showed that women had low access to family planning services.(Aksu&Alkaş, 2025) .

Demonstrated a strong positive and statistically significant relationship between the level of misconceptions about contraceptives among participating mothers and their level of access to family planning services

The positive relationship can be explained by the fact that greater access to family planning services does not necessarily ensure adequate health education, allowing misconceptions to persist. Frequent use of services without clear educational programs may generate conflicting information,.

The current result is consistent with the result of recent studies which indicated a significant relationship between women's misconceptions and their utilization of family planning services, where misconceptions and misinformation continue to influence access and decision-making regarding contraception (Radi, 2026).

The current result is also consistent with the result of the study(Frederic et al., 2017) which reported a positive statistically significant relationship between women's misconceptions and their rate of access to family planning services.(Frederic et al., 2017).

5. Conclusion

The study found that contraceptive misconceptions are still a primary "cognitive" barrier of mothers, mainly due to the dependence on informal information sources and myths in the society. Though the physical accessibility of services was moderate, the results showed that there was a paradoxical positive correlation; the more services are accessible, the more likely misconceptions are to be corrected, if the health education is not of quality. The study suggests that to improve uptake rates, there needs to be a strategy to "dismantling myths" in addition to service delivery, especially for women at reproductive age and rural people. The study has several strengths, including its conduct within a real healthcare setting, which enhances the practical relevance of the findings, and its focus on a key public health issue in reproductive health. However, it is limited by being conducted in a

single hospital, which restricts the generalizability of the findings, and by the possibility of socially desirable responses due to the sensitive nature of the topic.

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7. Recommendations

Healthcare institutions should ensure in-person counselling to correct misconceptions about contraceptives and enhance informed decision-making. Healthcare providers should be trained to improve their communication skills so that access to services results in consistent and effective contraceptive use.

In addition, community-based health education programs should be strengthened to increase awareness and reduce misconceptions about family planning methods. Expanding access to contraceptive services, especially in primary healthcare centres and underserved areas, is also recommended to improve utilization.

Finally, continuous training for healthcare providers and the use of reliable digital platforms are important strategies to improve knowledge and counter misinformation among women of reproductive age.

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