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Women's Myths and Misconceptions as Barriers to Contraceptive Use: A Comparative Study: Mitos dan Kesalahpahaman di Kalangan Perempuan sebagai Hambatan dalam Penggunaan Kontrasepsi: Sebuah Studi Komparatif

Amal Fadil Noori Radi, amal.f@uokerbala.edu.iq (*)
Department of Maternal and Child Health Nursing, College of Nursing, University of Karbala, Iraq

(*) Corresponding author

Abstract

General Background: Contraceptive use remains a central component of reproductive health, yet persistent myths continue to hinder its adoption globally. **Specific Background:** In Iraq, despite the availability of family planning services, misconceptions about contraception remain widespread, contributing to unmet needs and high fertility rates. **Knowledge Gap:** Limited comparative evidence exists on how these misconceptions vary across different Iraqi regions and cultural contexts. **Aims:** This study aimed to assess the prevalence of contraceptive myths among multiparous women and examine regional differences in perceptions across three Iraqi cities. **Results:** Findings revealed high levels of misconceptions, particularly related to menstrual disruption (66.4%), body changes (64.6%), and complexity of use (65.6%). Over half of participants endorsed beliefs about fertility risks and health concerns. Significant regional differences were observed, with higher levels of health-related concerns and religious opposition in Karbala. Social media emerged as the primary information source, while reliance on healthcare professionals remained limited. **Novelty:** The study provides a comparative regional analysis highlighting the persistence of misconceptions despite relatively high educational attainment. **Implications:** These findings underscore the need for culturally tailored educational interventions, improved provider communication, and evidence-based information dissemination strategies to address misinformation and support informed contraceptive decision-making.

Keywords: Contraception, Reproductive Health, Misconceptions, Cultural Factors, Regional Differences

Key Findings Highlights

High prevalence of false beliefs related to menstrual and physical effects

Strong regional variation linked to cultural and religious context

Dominance of non-medical information channels in shaping perceptions

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1. Introduction

Taking of contraceptives is a foundation of reproductive health that ensures women are able to avoid unwanted pregnancies, spacing of pregnancies and mortality of the mother and the children. However, even now, there are still myths and misconceptions about contraceptive methods that stop their adoption in the whole world, especially in low- and middle-income countries (Jonas et al., 2022). These myths, including the fear of infertility, cancer, and even religious restrictions, tend to prompt women to either abstain from contraceptives altogether or use less effective contraceptives or to stop using contraceptives early, which increases the risk of negative reproductive health results.

There are also widely spread myths about oral contraceptive pills that lead to permanent infertility, although it is proven that fertility will be restored within three months of use (Freidenfelds, 2020). On the same note, there are misleading beliefs that intrauterine devices (IUDs) may move around the body although scientific data confirms their safety and the uncommon occurrence of spontaneous displacement under the condition that they are placed correctly (Walker et al., 2018). In the developing countries, the dissemination of such misinformation is aggravated by the lack of health literacy and access to the correct information (Chalernphon, 2021). Moreover, apprehension of not being accepted by male partners often causes fear of discussing contraception, which only contributes to secrecy and rumors (Nkonde et al., 2023).

Cultural and religious elements in Middle Eastern environments make the use of contraception even more difficult. Many Muslim communities have superstitious views, which discourages the use of contraception due to unfounded beliefs that contraception is religiously forbidden (haram), although Islamic jurisprudence mostly allows family planning (Najimudeen, 2020). The socio-cultural values of having a big family, provider biases, and insufficient counseling support the negative attitudes and lead to the discontinuation of the methods (Yiga et al., 2021).

Reproductive health issues are unique in Iraq. Prevalence rates of contraceptives are still at 58 percent, which is below most of the neighboring countries in the Eastern Mediterranean Region, and the unmet need is at 12 percent, with the total fertility rate of 4.2 children per woman (World Health Organization, 2021). Although free or highly subsidized contraceptive services are available in state-run healthcare centers, the uptake is still less than ideal as a result of cultural, religious, and educational biases. It is likely that regional differences in attitudes towards contraceptive use are of great importance in Iraq, as it is highly heterogeneous based on various cultural, educational, and socioeconomic factors that have been developed through historical disputes and regional religious values.

So far, there is little research done in a systematic fashion in comparison of contraceptive attitudes in various regions of Iraq. The present research aims at filling this gap by investigating the issue of prevalence and the nature of contraceptive myths among multiparous women in three Iraqi cities that are culturally different: Mosul, Karbala, and Nasiriyah. This study will help shape specific, culturally sensitive interventions that would help debunk contraceptive myths and achieve better reproductive health outcomes in all of Iraq because it will help establish regional differences in attitudes and sources of information.

Study Objectives

The main aim of the study was to test the existence of contraceptive-related myths and misconceptions among multiparous women in the three cities of Iraq. The secondary objectives included; compare the attitude to contraceptive use in different geographical areas; determine demographic and cultural pressures of contraceptive beliefs; Survey differences in source of contraceptive information in regions; and examine the correlation between educational level and the use of contraceptive myths.

Methods

2.1 Study Design and Setting

A cross-sectional, descriptive comparative research design was adopted to assess beliefs on contraceptives myths in women in three Iraq cities. The data collection process took place between 18 weeks, between October 15, 2023 and March 7, 2024, at the location in consultation clinics of teaching hospitals in:

Mosul (Governorate of Nineveh): Al-Batoul, Al-Salam, and Al-Khansa Teaching Hospitals, Karbala (Karbala Governorate): Karbala Teaching Hospital and Al-Hussein Medical City, and Nasiriyah (Dhi Qar Governorate): Bint Al-Huda Teaching Hospital and Al-Hussein Teaching Hospital.

These cities were specifically chosen to reflect different geographical locations and cultural backgrounds in Iraq: Mosul in the north with its mixed ethnic background, Karbala which is a major Shi'a religious center and Nasiriyah in the south with its strong tribal orientation.

2.2 Participants and Sampling

2.2.1 Eligibility Criteria

Inclusion Criteria:

Women between 18 and 50 years old; who lived in one of the three cities being studied; who were multiparous ([?]2 live births); who had never used contraceptive or had stopped using it; and who could give informed consent.

Exclusion Criteria:

Women who are already on the regular use of contraceptive methods; the ones who have undergone surgical sterilization; those who cannot give informed consent; women who cannot give informed consent; and those who cannot give informed consent because they are nulliparous.

2.2.2 Sample Size and Recruitment

Non-probability convenience sampling was used to recruit 839 women, with the following proportions, Mosul (n = 298; 35.5%), Karbala (n = 263; 31.3%), and Nasiriyah (n = 278; 33.1%). In spite of the inherent limitation of convenience sampling to the generalizability of the results, such an approach was considered the right choice due to the lack of resources and the sensitivity of the research issue. The selection of the sample in cities was fairly proportional to their respective population.

2.3 Data Collection Instrument

A questionnaire was prepared in a structured form and it contained three sections; Section 1: Demographic, such as age, educational level, occupation, children and past use of contraceptives, source of information; Section 2: Contraceptive methods (assessed individually and not reported as part of this study), and Section 3: Perceptions of contraceptive myth and misconceptions, measured using 15 statements on a three-point Likert scale (1 = disagree, 2 = neutral, 3 = agree). This culturally sensitive background necessitated the use of three-point scale to minimize the burden on the respondents and to minimize the number of neutral responses.

2.4 Validity and Reliability

The questionnaire had been heavily tested by ten subject matter experts in the nursing, obstetrics and public health to be relevant, clear and culturally appropriate. The updates were made on the basis of the expert opinion.

In a pilot test of 36 (12 per city) participants, Cronbachs alpha yielded 0.83, and thus, there was strong internal consistency. Pilot participants were not included in the final analysis of data.

2.5 Data Collection Procedures

The structured face to face interviews were completed through trained female researchers that were within the private consultation rooms and had a duration of about 10-15 minutes. The data collectors were provided with standard training which included informed consent issues,

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administration of questionnaires and cultural sensitivity. The study allowed the provision of full verbal and written informed consent to the respondents before participation. The researchers noted responses right after the study and confirmed them as complete.

2.6 Data Analysis

The statistical analyses were performed by the SPSS version 27.0. The descriptive statistics were used to outline demographic factors, contraceptive use patterns and myths attitude, the frequencies, percentages, means, and standard deviations were used. Chi-square tests were used to compare the categorical variables performed in the three cities, and the level of statistical significance was set at $p < 0.05$. Myth-supporting percentages were provided as the percentages of agree responses.

2.7 Ethical Considerations

The research received the ethical clearance of the institutional review boards of all the hospitals in the three cities. Formal written informed consent was obtained with each participant after being thoroughly informed about the voluntary nature of the study, the protection of confidentiality and the fact that he/she would be free to withdraw at any point, without retribution. All data were coded and kept in a safe way. Participation was not given any financial or material incentives.

3. Results

3.1 Participant Characteristics

Table 1 presents the sociodemographic characteristics of participants. The mean age was 31.9±7.2 years (range: 19-56), with no significant differences across cities. Educational attainment was evenly distributed: primary (33.9%), secondary (23.1%), and tertiary (43.0%). Housewives comprised the majority (59.6%), followed by employees (23.5%) and students (16.9%). Most women were multiparous (73.7%) rather than grand multiparous (26.3%), with similar distributions across all cities.

Table 1: Sociodemographic Characteristics by City

Variable	Mosul (n=298)	Karbala (n=263)	Nasiriyah (n=278)	Total (n=839)	p-value
Age (years)					
Mean ± SD	31.9 ± 7.3	32.3 ± 6.8	31.4 ± 7.5	31.9 ± 7.2	0.541†
Range	20-56	21-54	19-55	19-56	-
Education Level					
Primary	99 (33.2%)	94 (35.7%)	91 (32.7%)	284 (33.9%)	0.783
Secondary	71 (23.8%)	56 (21.3%)	67 (24.1%)	194 (23.1%)	
Tertiary	128 (43.0%)	113 (43.0%)	120 (43.2%)	361 (43.0%)	
Occupation					
Employee	72 (24.2%)	57 (21.7%)	68 (24.5%)	197 (23.5%)	0.704
Student	53 (17.8%)	42 (16.0%)	47 (16.9%)	142 (16.9%)	
Housewife	173 (58.1%)	164 (62.4%)	163 (58.6%)	500 (59.6%)	
Parity					
Multiparity	220 (73.8%)	192 (73.0%)	206 (74.1%)	618 (73.7%)	0.944
Grand multiparity	78 (26.2%)	71 (27.0%)	72 (25.9%)	221 (26.3%)	

†ANOVA test; all others chi-square test

3.2 Previous Contraceptive Use and Information Sources

Table 2 shows significant differences in contraceptive method preferences (p=0.041) and information sources (p=0.019) across cities. Oral contraceptive pills were the most commonly previously used method overall (34.0%), with higher use in Mosul (36.2%) and Nasiriyah (34.2%) compared to Karbala (31.2%). IUD use was highest in Karbala (30.0%). Condoms were used by approximately one-quarter of participants across all cities.

Social media emerged as the predominant information source (43.4%), followed by medical staff (27.2%) and family/friends (26.3%). In Karbala city, the highest dependence on social media is 44.1%. while dependence on books and articles was rarely consulted at 3.1%.

Table 2: Previous Contraceptive Use and Information Sources by City

Variable	Mosul (n=298)	Karbala (n=263)	Nasiriyah (n=278)	Total (n=839)	p-value
Previous Contraceptive Method					0.041*
Condom	84 (28.2%)	63 (23.9%)	74 (26.6%)	221 (26.3%)	
Oral contraceptive pill	108 (36.2%)	82 (31.2%)	95 (34.2%)	285 (34.0%)	
IUD	75 (25.2%)	79 (30.0%)	74 (26.6%)	228 (27.2%)	

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Implanon	9 (3.0%)	11 (4.2%)	9 (3.2%)	29 (3.5%)	
Injection	22 (7.4%)	28 (10.6%)	26 (9.4%)	76 (9.1%)	
Primary Information Source					0.019*
Family & Friends	72 (24.2%)	75 (28.5%)	74 (26.6%)	221 (26.3%)	
Medical Staff	89 (29.9%)	68 (25.9%)	71 (25.5%)	228 (27.2%)	
Social Media	127 (42.6%)	116 (44.1%)	121 (43.5%)	364 (43.4%)	
Books/Articles	10 (3.4%)	4 (1.5%)	12 (4.3%)	26 (3.1%)	

* Statistical significance at the level of)p<0.05(

3.3 Familiarity with Birth Control Myths and Misconceptions

The third table presents a comparative analysis of attitudes regarding contraception myths, revealing that false conceptions were greatly prevalent across all study sites, with Karbala city consistently exhibiting the elevated agreement rates.

The very often endorsed myths were worried about in menstrual disruption (66.4%), recognizing body changes or weight gain (64.6%), and difficulty of use (65.6%). Also, a lot of the participants agreed on menstrual ceasing (60.6%), later fertility problems (55.6%), and general health worry (54.6%). Approximately two-fifths show consensus with misconceptions regarding lower libido (41.5%), affordability (41.7%), and also infertility (39.9%).

While the high mistake rate and most misconceptions did not show statistically significant distinction among the cities, a consistent style appeared wherein Karbala recorded agreement rates 5–8 percentage points higher than those observed in Nasiriyah and Mosul across most of the myths.

Table 3: Attitudes Toward Contraceptive Myths and Misconceptions by City

Misconception	Mosul (n=298)	Karbala (n=263)	Nasiriyah (n=278)	Total (n=839)
	Agree %	Agree %	Agree %	Agree %
Health-Related Myths				
Causes infertility	37.6	43.3	38.8	39.9
Causes severe health problems	51.7	59.3	52.9	54.6
Causes future fertility difficulties	53.4	58.6	54.7	55.6
Increases cancer risk	27.9	33.8	28.4	29.9
Damages reproductive organs	34.6	41.4	36.3	37.4
Physical and Psychological Concerns				
Causes body changes/weight gain	61.4	69.6	62.9	64.6
Decreases sexual desire	38.6	45.6	40.3	41.5
Causes physical discomfort	59.4	66.9	61.2	62.5
Menstrual-Related Beliefs				
Interrupts menstruation	57.7	64.6	59.4	60.6
Disrupts menstrual cycle	63.8	70.3	65.1	66.4
Social and Cultural Factors				
Prohibited by religion	35.9	43.7	37.4	38.9
Woman's sole responsibility	16.4	21.3	16.9	18.1
Practical Concerns				
Too expensive	38.9	45.6	40.6	41.7
Too complicated to use	62.8	69.6	64.4	65.6
Incompatible with breastfeeding	34.2	40.3	35.6	36.7

3.4 Statistically Significant Regional Differences

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Table 4 explains that regional variations are statistically significant in attitudes toward birth control. Karbala shows especially higher approval rates regarding health-related worry (59.3%) compared to 51.7% in Mosul ($\chi^2 = 5.987$, $p = 0.050$) and religious resistance (43.7% versus 35.9% in Mosul; $\chi^2 = 6.123$, $p = 0.047$). Conversely, Karbala present basically lower dissent rates concerning gender responsibility (60.1% compared to 69.5% in Mosul and 70.1% in Nasiriyah; $\chi^2 = 8.234$, $p = 0.016$), advisable a stronger adherence to traditional views that position contraception as primarily a woman's responsibility.

Table 4: Regional Variations in Contraceptive Attitudes: Statistically Significant Findings

Attitude Domain	Mosul	Karbala	Nasiriyah	Chi-square	p-value
Health concerns (% agree)	51.7	59.3	52.9	5.987	0.050*
Religious opposition (% agree)	35.9	43.7	37.4	6.123	0.047*
Gender responsibility (% disagree)	69.5	60.1	70.1	8.234	0.016*
Body changes (% agree)	61.4	69.6	62.9	5.789	0.055

* Results were considered statistically significant at a threshold of $p < 0.05$.

4. Discussion

This research indicates that comparative analysis reveals that myths and misconceptions concerning contraceptive use remain very prevalent among women in three Iraqi cities, in spite of prevalence of supportive contraceptive services as well as high educational attainment among the women. It is found that the results learn both general tendencies of disinformation and considerable regional variation, as an action of varying cultural, religious, and social influences in the Iraqian context.

4.1 Principal Findings

Poor understanding between the participants concerning menstrual disruption, anticipated bodily modifications, and hardiness to use were allowed by about two out of three to all study locations. Over half of the participants felt that contraceptives would in the future cause fertility issues and health risks of severe consequences. Karbala showed a greater level of myth endorsement especially on matters concerning health related matters and religious objections in addition to being more conservative with regard to gender responsibility in family planning decisions. The primary source of information seems to be social media, whereas However, hormonal contraceptives can result in some side events; such perceptions are often empowering and unsupported by strong clinical evidence.

4.2 Contraceptive Myths in Regional Context.

The observation that 66.4 percent of respondents reckoned contraceptives induce menstrual cycle disorders is comparable to a report in Kenya and Ghana where menstrualanxiety was found to be a primary constraint in using contraceptives (Jonas et al., 2022). Equally, the high prevalence of disorder in terms of body changes (64.6) indicates trends across sub-Saharan Africa and Southeast Asia of worry of weight gain as a strong driver of methods choice and persistence (Chalernphon, 2021).

The persistence of myths on infertility (39.9% agreement), irrespective of scientific evidence on how quickly fertility is restored after cessation underlines the widespread status of fake information. The same falsehoods have been documented in South Sudan, where the myths that contraceptives burn the ovaries and permanently harm them are still prevalent (Achola et al., 2024), which denotes that the myths do not just stop at the national boundaries. Concerningly, 29.9 percent of respondents thought that contraceptives increase the chances of developing cancer, even though there are sufficient evidence that combined oral contraceptives lower the risk of developing ovarian and uterus cancer (Freidenfelds, 2020).

4.3 Regional Differences and Culture.

The significantly higher stabilization of health-related worry (59.3) and religious opposition (43.7) at Karbala perhaps takes into account that the situation is in an important Shiite religious centre, in which traditional models and religious beliefs have a greater potential to be entrenched. The presence of such a monitoring strategy with Ethiopian data suggests that the influence of socio-cultural factors and religious beliefs on the attitudes to contraceptives is rather high (Yiga et al., 2021). However, it should be stressed that the Islamic jurisprudence is not a priori anti-family planning, so the latter should be related to cultural interpretation instead of the prohibitions by the doctrine (Najimudeen, 2020).

The differences in the perceptions regarding gender responsibility in the region are also interesting. The lowest rate of difference (60.1) at the bottom of the scale in Karbala which states that contraception should be solely the responsibility of women is more of a patriarchal response than those of Mosul (69.5%), and Nasiriyah (70.1%). This trend compares to those in Pakistan where male partner objection became the most common factor prompting the discontinuation of intrauterine device use in two-thirds of the women (Sajjad et al., 2023). The persistence of such gender relations highlights the necessity to incorporate male partner engagement strategies in family planning programs.

4.4 Information Sources and Misinformation.

The high usage of social media as a primary source of contraception information (43.4%) offers an opportunity of considerable bread and prospects. Although social media makes it easy to spread misinformation, it can also provide the platform of the selected educational intrusion that can reach a big population. The fact that dependence on healthcare professionals (27.2) is not that high has shed some light on the key gaps in provider-patient imparting. Evidence at Egypt confirm that the healthcare providers play a critical role in dispelling the myths by applying effective counselling but most of the providers themselves are either misconceived or prejudiced. (Yiga et al., 2021).

Moreover, the fact that a high proportion of people (26.3%) rely on family and friends when receiving contraceptive information serves as a continuation of myths across generations. This trend is consistent with the results of the Democratic Republic of Congo, where the impact of family and rumor networks on contraceptive perceptions was quite strong (Nkonde et al., 2023). Therefore, non-medical sources, such as social-media, family, and friends, comprised 69.7% of information accessness, which requires the emergence of evidence-based community education programs.

4.5 Education Paradox

Irrespective of the fact that 43 percent of contributors have tertiary teaching, errors made concerning contraception remain widespread. This is a preferable finding that extensive schooling is insufficient to overcome the knowledge gap on reproductive health- a step always observed at the word level (Besoain-Saldana et al., 2023). Thus, there is urgency to provide culturally sensitive evidence-based reproductive health teaching by experts. The fact that myths of women are still persistent in educated women supports the high power of the cultural standards and social processes that in many cases surpass the impact of school education.

4.6 Implications for Policy and Practice

These results hold notable implications for reproductive health strategy and pursuit in Iraq. Initial, culturally sensitive educational interventions

that address region-specific disquiet are needed. For example, the plan in Karbala must explicitly implement religious error through cooperation with esteemed religious leaders who can resolve the Islamic viewpoint on family planning. Second, healthcare provider training must confirm contraceptive advice skills, myth-removal strategies, and culturally sensitive connection. Third, evidence-based social media drive leveraging the most used program should be perform to counter false information and reach large meeting cost-effectively.

The result that 41.7% of contributors construct affordability deals regardless of the availability of subsidized services suggests either concealed costs (e.g., transport, time off action) or insufficient awareness of free services. Simplified service carriage models, community-based division, and public awareness beginning may help lessen these barriers. Lastly, programs endeavouring to engage male partners are critical to encouraging shared responsibility and lessening objection-related discontinuation.

5. Conclusion

The contraceptive myths remain general in Iraq in the context of multiparous women whose almost two-thirds believe the misunderstandings about menstrual disruption, somatic change, and complication of methods. Geographic imbalance--particularly, the concern about health hazards and religious assent expressed by Karbala, creates the necessity of culturally sensitive learning methods, which is reinforced by the reliance on social media and unofficial web as the main sources of learning, with relatively little integration into the work by medical experts signifying a set of challenges and possibilities to apply at the moment. Despite the comparatively high level of formal instruction, the persistent lack of information supports the critical need in the evidence-based selective teaching in the field of reproductive health.

Redress these misconceptions is an essential core health primacy to reduce unmet family planning request, prevent unintended conception, and improve maternal and baby health, active interventions should impact a multi-level answer, including healthcare system strengthening, provider education, community involvement, collaboration with religious figures, participation of male partners, and social media campaigns with evidence-based messages. To determine the effectiveness of the intervention and investigate the mechanisms of myth transportation in the community, future research should employ linear and specific methods to evaluate the success of intervention.

Declarations

Ethics Approval and Consent to Participate

This research has received ethical agreement from institutional review boards at all participating hospitals in Karbala, Mosul, and Nasiriyah. Written informed agreement was gotten from all participants next, demonstrating the study's willing nature, confidentiality measures, and right to withdraw without sequel.

Consent for Publication

Not applicable.

Availability of Data and Materials

in this study, the generated data sets and analyses are available from the conformable author at feasible demand and with appropriate

Competing Interests

The writers announce no competing conflicts of interest.

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Authors' Contributions

Both authors contributes in conceptualization, methodology, investigation, formal analysis, writing—original draft, writing—review and editing, supervision.

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