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Acceptance and Utilization of Contraceptive Practices among Women of Childbearing Age in Sapele Community, Delta State, Nigeria: A Cross-Sectional Study

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Abstract

Contraceptive use remains an important component of reproductive health because informed and consistent use can support pregnancy planning, birth spacing, and women's reproductive decision-making. This study examined contraceptive knowledge, attitudes, acceptance, utilization, communication, and perceived barriers among women of childbearing age in Sapele Community, Delta State, Nigeria. A descriptive cross-sectional survey was conducted among 109 women aged 15–49 years selected through a multistage sampling procedure. Data were collected using a structured, pre-tested questionnaire with reported internal consistency of Cronbach's $\alpha = 0.85$ and were summarized using frequencies and percentages. General awareness of contraception was reported by 69 respondents (63.3%); however, method-specific understanding remained limited, with 69 respondents (63.3%) classified as having poor contraceptive knowledge. Fifty-one women (46.8%) reported ever or current contraceptive use, while 58 (53.2%) reported no use, and only 13 (11.9%) indicated that they always used contraception. Condoms were the most frequently reported method (18.3%), followed by intrauterine devices (9.2%), injectables (approximately 8–9%), implants (5.5%), and oral contraceptive pills (4.6%). Attitudes were also generally unfavourable: 55.0% did not consider contraception important for women's health, 50.5% did not regard it as morally acceptable, and 64.2% did not believe that it was effective in preventing pregnancy. Fear of side effects (31.2%), inadequate contraceptive knowledge

(27.5%), partner opposition (22.9%), and religious or cultural beliefs (18.3%) were the principal reported barriers. Furthermore, 62.4% had never discussed contraception with a partner or healthcare provider, while 40.4% reported difficulty accessing contraception. The findings demonstrate a substantial gap between basic awareness and informed, consistent contraceptive practice in the study population. Strengthening method-specific education, respectful side-effect counseling, confidential nurse-led services, partner communication where appropriate, culturally responsive community engagement, and continuity of care may improve informed contraceptive decision-making and sustained utilization in Sapele.

Keywords: contraception; contraceptive acceptance; family planning; reproductive health; women of childbearing age; Sapele; Nigeria

1. Introduction

Family planning is a core component of sexual and reproductive health and a practical means of enabling individuals and couples to determine the number and spacing of their children. Access to safe, acceptable, and effective contraceptive methods reduces unintended pregnancy and pregnancy-related health risks and supports reproductive autonomy. The World Health Organization (WHO) estimates that, among women of reproductive age worldwide who had a need for family planning in 2021, 164 million had an unmet need for contraception [14]. Contraceptive access therefore remains both a public-health priority and a rights-based health-system obligation.

The benefits of contraception extend beyond pregnancy prevention. Appropriate birth spacing can reduce exposure to high-risk pregnancies, while condoms provide the additional benefit of reducing transmission of sexually transmitted infections when used correctly and consistently [13]. Long-acting reversible contraceptives, including implants and intrauterine devices, offer highly effective extended protection, whereas short-acting methods such as pills and injectables require greater continuity of use. WHO's updated medical eligibility guidance emphasizes individualized method selection according to health conditions, preferences, reproductive intentions, and clinical eligibility [15]. Thus, high-quality family-planning services require more than commodity availability: they require accurate information, informed choice, respectful counseling, continuity of care, and the ability to switch methods when needs change.

Nigeria continues to face substantial gaps in modern contraceptive uptake. The 2018 Nigeria Demographic and Health Survey documented marked differences in contraceptive knowledge and use by education, residence, wealth, marital status, and region [7]. Secondary analysis of the same national survey estimated modern contraceptive use at approximately 12% among married or partnered Nigerian women and identified education, wealth, number of living children, and sexual autonomy as important correlates [2]. Contemporary national programming continues to prioritize expansion of voluntary, rights-based family planning because contraceptive prevalence remains low and access is uneven [12].

The persistence of low or inconsistent use despite awareness reflects the multidimensional nature of contraceptive behaviour. A systematic review of sub-Saharan African evidence identified knowledge, perceived side effects, partner influence, social norms, service accessibility, and individual characteristics as recurring determinants [5]. Nigerian studies similarly demonstrate that male-partner attitudes and household decision-making can shape women's contraceptive choices [1, 8]. Recent qualitative evidence from Nigeria further indicates that open partner communication may facilitate shared decision-making, whereas health concerns, cultural expectations, and limited knowledge about side effects may constrain method choice [4].

Fear of side effects deserves particular attention because it can influence both initiation

and continuation. National evidence indicates that contraceptive discontinuation is common among previous users, reinforcing the importance of follow-up, anticipatory counseling, and method-switching support [3]. Counseling should neither dismiss women's concerns nor frame uptake as an end in itself. Rather, it should explain expected effects, identify warning signs, support voluntary switching, and preserve informed choice. WHO guidance also recognizes misinformation, social or religious opposition, provider bias, and gender inequality as barriers to family-planning access and use [14].

The Health Belief Model provides a useful framework for understanding these interacting influences. The model proposes that health behaviour is shaped by perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy [9]. Applied to contraception, a woman may be generally aware of family planning but still avoid or inconsistently use a method if she doubts its effectiveness, fears adverse effects, anticipates partner disapproval, lacks confidence in using the method correctly, or has limited access to trusted professional advice. Social and behaviour change interventions are therefore increasingly recommended as part of comprehensive family-planning programmes rather than relying on awareness campaigns alone [16].

Sapele is an urban and peri-urban community in Delta State, southern Nigeria, with heterogeneous educational, occupational, cultural, and religious characteristics. Community-level evidence is important because national and regional averages may conceal local patterns of knowledge, acceptance, communication, and service barriers. Evidence specific to Sapele can help nurses and other health professionals design interventions that respond to the concerns actually reported by women in the community.

Accordingly, this study assessed knowledge and awareness of contraception, attitudes and beliefs, acceptance and utilization, communication patterns, and perceived barriers among women of childbearing age in Sapele Community. The study also considers the implications of the findings for nursing practice, reproductive-health counseling, community engagement, and future family-planning research.

1.1. Study objectives

The specific objectives were to: (i) determine the level of knowledge and awareness of contraceptive practices; (ii) assess acceptance and utilization of contraceptive methods; (iii) examine attitudes and beliefs regarding contraception; (iv) identify perceived factors contributing to acceptance and non-acceptance; and (v) propose evidence-informed strategies for improving informed contraceptive decision-making and reducing the risk of unintended pregnancy. The publication version organizes these objectives within a knowledge-attitude-practice, communication, and barriers framework while retaining the underlying study data.

2. Methods

2.1. Study design and setting

A descriptive cross-sectional survey design was used. The study was conducted in Sapele Community, Sapele Local Government Area, Delta State, Nigeria. The community comprises urban and semi-urban settlements and is served by public and private health facilities that provide reproductive and obstetric care.

2.2. Study population and sampling

The target population was women of childbearing age (15–49 years) resident in Sapele. The source project estimated this population at 73,401. A multistage sampling approach was used: three wards were selected, communities within selected wards were sampled, and eligible women were subsequently recruited using probability-based procedures. Although an initial conventional sample-size computation produced a larger target, field constraints resulted in a final analytic sample of 109 respondents. This smaller sample should be considered when interpreting precision and generalizability.

2.3. Instrument and data collection

Data were collected with a structured, pre-tested questionnaire covering socio-demographic characteristics, knowledge of contraceptive practices, attitudes toward contraception, contraceptive practice, and reasons for non-acceptance or non-use. Content validity was assessed by reproductive-health experts. A pilot test was undertaken in a nearby community, and internal consistency was reported as Cronbach's $\alpha = 0.85$. The researcher administered 109 questionnaires over approximately six weeks.

2.4. Variables and statistical analysis

The primary descriptive outcomes were awareness, method-specific knowledge, attitudes toward contraception, ever/current use, frequency of use, and perceived barriers. Categorical data are reported as frequencies and percentages. Because only aggregate questionnaire counts were available for this publication rewrite, multivariable associations between socio-demographic characteristics and contraceptive acceptance could not be independently reconstructed. Consequently, the article emphasizes directly verifiable descriptive findings rather than overstating unsupported associations. Percentages were recalculated from reported frequencies where necessary, and minor inconsistencies in the source tables were resolved in favour of internally consistent frequency totals ($n = 109$).

2.5. Ethical considerations

Participation was voluntary. Respondents were informed about the purpose and procedures of the study, their right to withdraw, and measures for confidentiality and anonymity. No personal identifiers were included in the analytic presentation. The source project states that informed consent and appropriate administrative permissions were obtained before data collection.

3. Results

3.1. Socio-demographic characteristics

All 109 respondents were women of childbearing age. The largest age group was 15–25 years (34.9%), followed by 26–35 years (29.4%), 36–45 years (23.9%), and 46 years or older (11.9%). Secondary education was the most common educational level (49.5%), while 27.5% had primary education and 22.9% had tertiary education. Forty-five respondents (41.3%) were married.

Table 1: Socio-demographic characteristics of respondents ($n = 109$)

Characteristic	Frequency	%
Age (years)		
15–25	38	34.9
26–35	32	29.4
36–45	26	23.9
46 and above	13	11.9
Religion		
Christianity	72	66.1
Islam	25	22.9
Other	12	11.0
Occupation		
Trader	32	29.4
Housewife	30	27.5
Artisan	20	18.3
Civil servant	27	24.8
Education		
Primary	30	27.5
Secondary	54	49.5
Tertiary	25	22.9
Marital status		
Single	30	27.5
Married	45	41.3
Divorced	22	20.2
Separated	12	11.0

3.2. Knowledge and sources of contraceptive information

Sixty-nine respondents (63.3%) reported having heard about contraceptive practices, while 40 (36.7%) reported no awareness. However, method-specific knowledge was much weaker. The project classified 69 respondents (63.3%) as having poor contraceptive knowledge, compared with 25 (22.9%) with fair, 10 (9.2%) with good, and 5 (4.6%) with excellent knowledge. Healthcare providers were reported as a source of information by only 21 respondents (19.3%); smaller proportions cited school, media, or friends/family. This distinction between broad awareness and usable method-specific knowledge is important: having heard of contraception did not necessarily translate into adequate understanding.

Table 2: Selected indicators of contraceptive knowledge and attitudes ($n = 109$)

Indicator	Frequency	%
Heard about contraceptive practices	69	63.3
Poor contraceptive knowledge rating	69	63.3
Healthcare provider as information source	21	19.3
Contraception considered important for women's health	49	45.0
Contraception considered morally acceptable	40	36.7
Believed contraception is effective in preventing pregnancy	39	35.8
Would recommend contraception to friends/family	34	31.2

3.3. Attitudes toward contraceptive practices

Attitudinal responses were predominantly unfavourable. Sixty respondents (55.0%) did not consider contraceptive practices important for women's health. Fifty-five (50.5%) did not regard contraception as morally acceptable and 14 (12.8%) were undecided. Seventy respondents (64.2%) did not believe contraception was effective in preventing pregnancy. Only 34 (31.2%) indicated that they would recommend contraception to friends or family, while 65 (59.6%) would not and 10 (9.2%) were undecided.

3.4. Contraceptive utilization

Fifty-one respondents (46.8%) reported having ever used or currently using a contraceptive method, compared with 58 (53.2%) who reported no use. Consistent use was much lower: 13 (11.9%) reported always using contraception, 12 (11.0%) sometimes, 26 (23.9%) rarely, and 58 (53.2%) never. Condoms were the most frequently reported method in the source data, followed by IUDs, injectables, implants, and oral contraceptive pills.

Table 3: Contraceptive practice among respondents ($n = 109$)

Practice indicator	Frequency	%
Ever/current contraceptive use: Yes	51	46.8
Ever/current contraceptive use: No	58	53.2
Always use contraception	13	11.9
Sometimes use contraception	12	11.0
Rarely use contraception	26	23.9
Never use contraception	58	53.2
Condoms	20	18.3
Intrauterine device	10	9.2
Injectables	9–10	8.3–9.2
Implants	6	5.5
Oral contraceptive pills	5	4.6

The most frequently reported reason for contraceptive use was pregnancy prevention (25.7% of the full sample), followed by prevention of sexually transmitted infections (10.1%), child spacing (6.4%), and delaying childbearing (4.6%).

3.5. Reasons for non-acceptance and communication barriers

Fear of side effects was the most frequently reported barrier (31.2%), followed by lack of contraceptive knowledge (27.5%), partner opposition (22.9%), and religious or cultural beliefs (18.3%). Only 41 respondents (37.6%) reported having discussed contraception with a partner or healthcare provider, whereas 68 (62.4%) had not. Forty-four respondents (40.4%) reported difficulties accessing contraception.

Table 4: Reported barriers and communication indicators ($n = 109$)

Indicator	Frequency	%
Fear of side effects	34	31.2
Lack of contraceptive knowledge	30	27.5
Partner opposition	25	22.9
Religious/cultural beliefs	20	18.3
Never discussed contraception with partner/healthcare provider	68	62.4
Experienced difficulty accessing contraception	44	40.4

3.6. Graphical presentation of key findings

Figures 1–3 summarize the principal descriptive findings. The figures are based strictly on the aggregate frequencies reported in the study and are intended to make the pattern of contraceptive acceptance, barriers, and communication more readily interpretable.

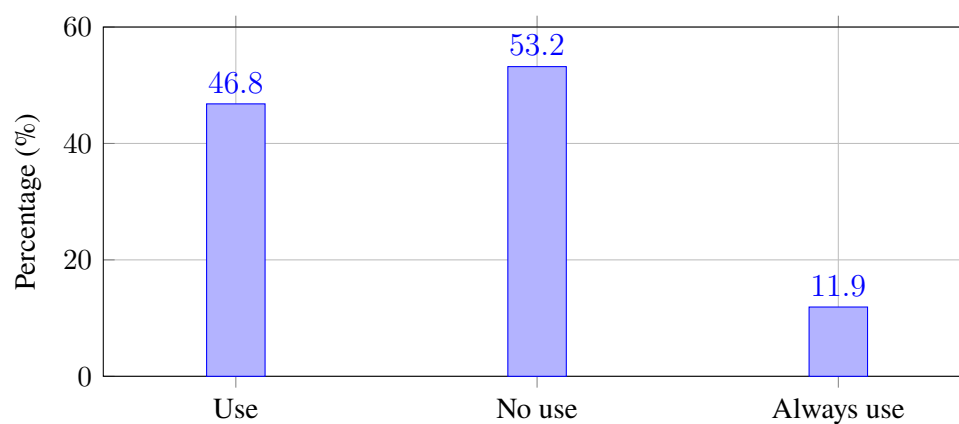


Figure 1: Contraceptive utilization indicators among respondents ($n = 109$). “Use” and “No use” represent the reported ever/current-use classification, while “Always use” represents consistent use.

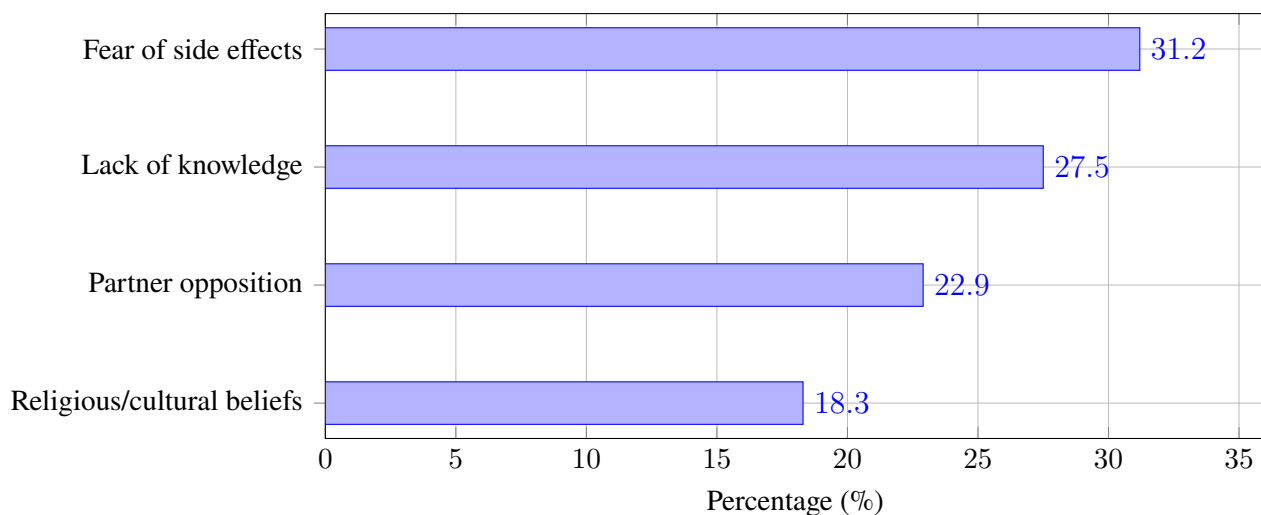


Figure 2: Reported reasons for non-acceptance or non-use of contraception. Fear of side effects was the most frequently reported barrier.

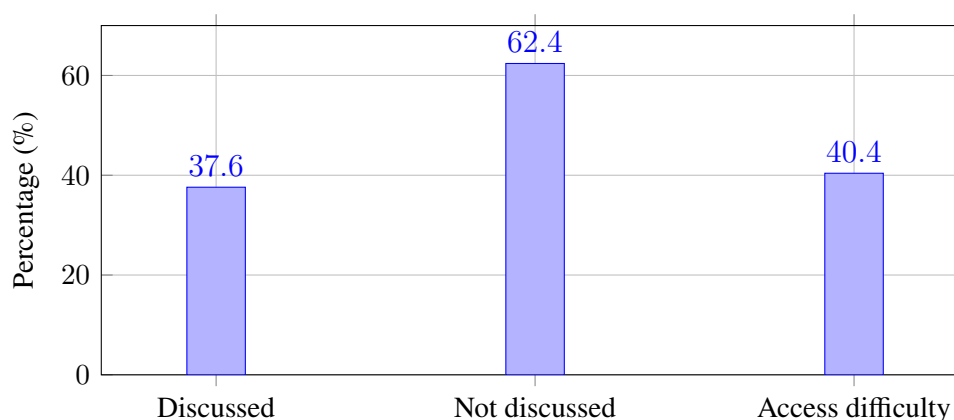


Figure 3: Communication and access indicators. Nearly two-thirds of respondents had not discussed contraception with a partner or healthcare provider.

4. Discussion

This study provides community-level evidence of an important disconnect between contraceptive awareness and informed, consistent use among women of childbearing age in Sapele. Although 63.3% of respondents had heard about contraceptive practices, the same proportion was classified as having poor method-specific knowledge. Awareness should therefore not be interpreted as adequate contraceptive literacy. Knowing that contraception exists is different from understanding available methods, comparative effectiveness, duration of action, expected side effects, eligibility, correct use, and options for switching. This distinction is programmatically important because knowledge that is superficial may have limited influence on behaviour.

4.1. Awareness, knowledge and information sources

The finding that only 19.3% identified healthcare providers as a source of contraceptive information suggests a missed opportunity for professional counseling. Health workers can provide

information that is individualized, clinically appropriate, and responsive to misconceptions in ways that informal sources may not. WHO recommends person-centred contraceptive information and services that support voluntary, informed method choice [14, 15]. The present findings therefore support strengthening nurse-led counseling not only in dedicated family-planning clinics but also during antenatal, postnatal, outpatient, immunization, adolescent-health, and community outreach contacts.

The awareness-knowledge gap also has implications for communication strategy. Generic messages that merely encourage women to “use family planning” may not answer the questions that influence actual decisions. Educational interventions should compare method duration, effectiveness, common side effects, return to fertility, need for repeat visits, and protection against sexually transmitted infections. WHO’s 2025 social and behaviour change guidance supports integrating evidence-based communication interventions into broader family-planning programmes [16]. In Sapele, such interventions should be adapted to literacy level and delivered through trusted community and health-system channels.

4.2. Contraceptive acceptance, utilization and consistency

Fifty-one respondents (46.8%) reported ever/current contraceptive use, but only 11.9% reported always using contraception. This difference is one of the most important findings of the study. The 46.8% indicator cannot be directly compared with national modern contraceptive prevalence because the questionnaire combined ever use and current use and did not restrict the measure to modern methods. Nevertheless, the much lower proportion reporting consistent use suggests that initiation alone is an insufficient marker of successful contraceptive practice.

National Nigerian research has also highlighted challenges with continuation. Analysis of the 2018 NDHS found substantial modern-method discontinuation among sexually active married women who had previously used contraception [3]. Discontinuation may reflect a desire for pregnancy, side effects, access problems, partner influence, or changing preferences. From a service perspective, this means that family-planning quality should be evaluated not only by new acceptors but also by whether users can obtain follow-up, receive reassurance or clinical review when needed, and switch voluntarily to another suitable method.

The method pattern in this study was dominated by condoms, with lower reported use of IUDs, injectables, implants, and oral pills. Method mix can reflect availability, familiarity, perceived reversibility, privacy, partner involvement, cost, and confidence in health services. Condoms have the unique advantage of providing protection against both unintended pregnancy and sexually transmitted infections when used correctly and consistently [13]. However, users who desire longer-term pregnancy prevention should also receive balanced information about long-acting reversible methods and other medically eligible options [15].

4.3. Attitudes, perceived effectiveness and moral acceptability

Attitudinal findings were predominantly unfavourable. More than half did not consider contraception important for women’s health, approximately half did not regard it as morally acceptable, and 64.2% did not believe it was effective in preventing pregnancy. These perceptions are clinically and behaviourally meaningful because perceived benefit is unlikely to motivate use when effectiveness itself is doubted. The findings also suggest that some resistance is value-based rather than purely informational.

Previous African evidence shows that contraceptive decisions are influenced by social norms, religion, misconceptions, perceived side effects, partner dynamics, and women’s autonomy [5, 6]. Interventions should therefore avoid stigmatizing women who decline a method. Culturally

responsive counseling can acknowledge values and concerns while providing accurate information and preserving voluntary choice. Where community or faith leaders are involved in health promotion, their role should be to support accurate information and access rather than to pressure individuals toward or away from contraception.

4.4. Fear of side effects and the need for continuity of counseling

Fear of side effects was the most frequently reported barrier (31.2%). This finding is consistent with the broader evidence that concerns about adverse effects can influence initiation, continuation, and method switching. Nigerian studies of contraceptive continuation have documented discontinuation related to method experience, including bleeding changes and other perceived side effects [3]. The implication is not that concerns should be minimized; rather, counseling should distinguish expected, manageable effects from symptoms that require clinical assessment and should make clear that alternative methods may be available.

A high-quality counseling pathway would include pre-initiation information, opportunity for questions, informed selection, clear follow-up instructions, and a non-judgmental option to discontinue or switch. Such an approach aligns with rights-based family planning and may build trust more effectively than one-time demand-generation messages [14, 11].

4.5. Partner opposition, communication and reproductive autonomy

Partner opposition accounted for 22.9% of reported barriers, while 62.4% of respondents had never discussed contraception with a partner or healthcare provider. Nigerian evidence has repeatedly shown that male-partner attitudes and couple dynamics can influence women's contraceptive behaviour. Ajah et al. reported substantial male involvement in contraceptive decisions among women attending a family-planning clinic in Enugu [1], while national couple-level analysis found associations between male attitudes, decision-making patterns, and contraceptive use [8]. More recent qualitative research likewise emphasizes the importance of partner support and communication [4].

These findings support carefully designed male-engagement and couple-communication interventions, but such strategies require an important safeguard: partner involvement should not become partner control. Women's confidentiality, safety, and autonomous reproductive decision-making must remain central. Couple counseling may be useful where desired by the woman, while confidential individual counseling should remain available.

4.6. Interpretation using the Health Belief Model

The Health Belief Model helps integrate the study findings into a coherent behavioural explanation [9]. Poor method-specific knowledge can weaken perceived benefits and self-efficacy. Doubts about contraceptive effectiveness directly reduce expected benefit. Fear of side effects represents a perceived barrier. Partner opposition and cultural or religious concerns add interpersonal and social barriers, while limited contact with healthcare providers reduces credible cues to action. Difficulty accessing contraception further increases the practical cost of acting on positive intentions.

The model suggests that no single intervention is likely to address all these influences. Information may improve knowledge but may not overcome partner opposition; improved commodity supply may not correct misinformation; and positive attitudes may still fail to produce use when services are difficult to reach. A more effective programme would combine accurate

method-specific education, supportive clinical counseling, accessible commodities, follow-up for side effects, communication interventions, and respect for reproductive autonomy.

4.7. Comparison with the Nigerian family-planning context

The Sapele findings should be interpreted within Nigeria's broader family-planning environment. National evidence indicates low modern contraceptive use and persistent inequalities in access and uptake [7, 2]. UNFPA continues to identify low contraceptive prevalence as a reproductive-health challenge in Nigeria and supports programmes intended to improve both demand and supply of high-quality family-planning services [12]. The present study adds a local perspective by showing that, within Sapele, informational, attitudinal, interpersonal, and access barriers coexist.

This coexistence matters for programme design. For example, increasing stock without improving counseling may leave fear of side effects unchanged, while education without reliable service availability may generate demand that the health system cannot meet. Integrated interventions are therefore more appropriate than isolated awareness campaigns.

4.8. Local significance and contribution of the study

The principal contribution of this study is its focused description of contraceptive acceptance in an under-reported Delta State community. It documents not only whether respondents had heard about contraception, but also the quality of knowledge, reported use, consistency of use, attitudes, communication, and barriers. The combination of 53.2% non-use, only 11.9% consistent use, 62.4% reporting no discussion with a partner or healthcare provider, and 40.4% reporting access difficulty identifies multiple points at which interventions could be targeted.

The findings should not be used to infer causal relationships because the design was cross-sectional and participant-level data were unavailable for adjusted analysis in this publication version. They are nevertheless useful for hypothesis generation, local service planning, and the design of a larger analytic study.

5. Implications for Nursing and Public Health Practice

Nurses are strategically positioned to translate these findings into practice because they interact with women across multiple points of care. First, contraceptive counseling should become a routine component of relevant reproductive-health contacts rather than being restricted to dedicated family-planning visits. Second, counseling should be method-specific and should explicitly address effectiveness, common side effects, duration, return to fertility, follow-up, and switching options. Third, women who initiate a method should have a clear pathway for reassessment if they experience concerns or wish to change methods.

Community-health nursing can complement facility-based services through outreach, small-group education, and referral. Messages should be culturally responsive and should distinguish evidence-based health information from myths without ridiculing religious or cultural beliefs. Because a large proportion of respondents had not discussed contraception with a partner or healthcare professional, interventions should create safe opportunities for confidential questions and, where women desire it, couple communication.

At the health-system level, programme managers should monitor more than the number of contraceptive commodities distributed. Indicators of counseling quality, method choice, follow-up, discontinuation, switching, stock availability, and client satisfaction would provide

a more complete picture of service performance. WHO and UNFPA guidance increasingly emphasizes quality, voluntariness, informed choice, and person-centred care [14, 11].

For public-health planning in Sapele, the results support a combined strategy: strengthen provider counseling skills; improve community contraceptive literacy; ensure reliable access to a broad method mix; provide side-effect management and switching support; involve men in appropriately designed education; and preserve women's confidentiality and autonomy. Such a package directly addresses the barriers observed in the study rather than assuming that lack of awareness is the only problem.

6. Strengths and Limitations

A strength of this study is its focus on an under-reported local population and its simultaneous assessment of knowledge, attitudes, practice, communication, and barriers. The questionnaire also demonstrated good reported internal consistency. Several limitations should be acknowledged. First, the final sample of 109 was substantially smaller than the initially calculated sample, limiting precision and external generalizability. Second, responses were self-reported and may be affected by recall and social-desirability bias. Third, the source dataset available for this publication rewrite consisted of aggregate counts rather than participant-level data; adjusted associations between demographic characteristics and contraceptive acceptance could therefore not be independently verified. Fourth, a few numerical inconsistencies were present across the original narrative and tables. This article uses the internally consistent counts from the principal results tables and explicitly avoids claims that cannot be reconstructed from those data.

7. Conclusion

Women in this Sapele sample demonstrated moderate general awareness of contraception but poor method-specific knowledge, unfavourable attitudes, and low consistent utilization. Fear of side effects, inadequate knowledge, partner opposition, religious or cultural concerns, and limited communication with partners and healthcare providers were prominent barriers. Strengthening nurse-led counseling, community outreach, accurate side-effect education, method-specific information, and respectful partner/community engagement may improve informed contraceptive decision-making and consistent use.

Recommendations

Healthcare providers should integrate contraceptive counseling into routine contacts with women of reproductive age, with particular attention to method effectiveness, side effects, eligibility, and switching options. Community programmes should use culturally responsive messages and involve trusted local stakeholders while preserving voluntariness and reproductive autonomy. Future studies in Sapele should recruit larger samples and retain participant-level data to permit robust multivariable analysis of factors independently associated with contraceptive acceptance and use.

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Authors' Contributions

Obataze J. Akpoyovwere contributed to supervision, conceptual refinement, scholarly revision, and preparation of the manuscript for publication. Aruoriwo Grace Okparavero contributed to the original study conception, field data collection, and initial project report. Both authors reviewed and approved the final manuscript.

Conflict of Interest

The authors declare no conflict of interest.

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Data Availability

The findings reported in this article are based on the aggregate data contained in the underlying study report. Availability of participant-level data is subject to the authors' and institution's data-governance requirements.

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