Barriers to Family Planning Continuation among Married Women in Abuja, Nigeria

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ABSTRACT

Background

Contraceptive discontinuation and switching are major challenges in the maintenance of reproductive health outcomes in Nigeria. Although awareness and the use of modern contraceptive methods are improving, the discontinuation rate of married women remains high. In Abuja, socio-cultural factors, side effects, and service factors are important determinants of contraceptive use. This study aimed to explore the barriers to family planning continuation and determine the predictors of contraceptive discontinuation among married women in Abuja, Nigeria, guided by Andersen's Behavioural Model of Health Services Utilization.

Methodology

A cross-sectional survey design was used, and the sample of 512 respondents was selected through the multistage sampling technique, with the survey conducted in three Area Councils of the Federal Capital Territory, namely, AMAC, Bwari, and Gwagwalada. The target respondents were married women between the ages of 15 and 49 years who had ever used modern contraceptive methods and men between the ages of 15 and 59 years who had been living in the FCT for the last 12 months or more. Descriptive statistics and logistic regression analysis were used, and the analysis was carried out at 5% significance. The analysis was done with the aid of SPSS version 25 software.

Results

The results showed that 65% of the ever-users had discontinued the use of a modern family planning method, while 29% had also switched the method. Fear of side effects was the most common reason cited (42.8%), which was significantly associated with the outcome of discontinuation (aOR = 2.4; 95% CI: 1.3–4.6; p = 0.006). Religious objection was also significantly associated with the outcome (aOR = 2.1; 95% CI: 1.0–4.2; p = 0.042). Support for family planning if services were free also showed a protective effect against the outcome of discontinuation (aOR = 0.4; 95% CI: 0.2–0.9; p = 0.028). Cultural objection was positively associated with the outcome, but did not reach the level of significance. Switching was more common among the women living in the cities and those with higher levels of education.

Conclusion

Contraceptive discontinuation among married women in Abuja is largely affected by side effects, religion, and financial constraints. Therefore, it is important to improve counseling, affordability, and socio-religious concerns to enhance the sustainability of contraceptive use and reinforce reproductive health in Abuja, the FCT.

Keywords: Contraceptive discontinuation, Married women, Healthcare accessibility, Family planning continuity

BACKGROUND

Contraceptive practices in modern times remain pivotal in the control and maintenance of fertility, the betterment of maternal health, and women's reproductive freedom in Nigeria's context. The problem of method discontinuation and switching, however, emerges as one of the critical challenges to the adoption and utilization of modern contraceptives by married women of childbearing age. Available evidence at the national level suggests that "a substantial percentage of sexually active married women experience method discontinuation within their own short periods of use" (Kupoluyi et al., 2023; Agbana et al., 2023).

Further evidence has recently emerged affirming the prevalence and contextual determinants of discontinuation. Specifically, Kupoluyi et al. (2023) identified age, parity, education level, and exposure to information on family planning policies as significant determinants. More recently, Agbana et al. (2023), relying on data from the 2018 DHS survey carried out in Nigeria, affirmed method dissatisfaction, dissatisfaction due to side effects, and lack of access as determinants. In a different context, Mohammed-Durosinlorun et al. (2024) investigated discontinuation among clients attending health facilities in Northern Nigeria and quickly identified dissatisfaction with service quality and inadequate counselling among hospital clients. In Lafia, similar facility-client encounter determinants were found for switching, including significant prevalence among clients (Edugbe et al., 2023).

The issue of healthcare service accessibility is still a core concept in the discussion of contraceptive continuity. It, thus, cannot be taken as an issue of proximity; it involves the availability of preferred services, affordability, counseling, and attentiveness of service providers. The literature indicates that the decision on women's contraceptive continuity cannot be disassociated from the health service environment provided in the delivery of family planning services (Kupoluyi, 2025). The Abuja case has specific service and population attributes. On postnatal contraceptive behavior, research carried out in the populations of Karonmaji and Lugbe has emphasized the importance of service exposure and socio-cultural factors on decisions to use modern contraceptive methods (Jennifer et al., 2025). Another specific population attribute identified is the role of fertility intentions and spousal communication among postpartum women in Abuja on the use and continuation of modern methods (Iluno et al., 2026).

Social and relational factors also interplay with healthcare accessibility. Adebola et al. (2025) have shown that significant others, including spouses and family members, are influential in family planning decisions among ever-married women. Women's empowerment and reproductive decision-making autonomy have similarly been linked with delayed childbearing and contraceptive behavior in Ayodeji & Adekunle (2025). In contexts where levels of empowerment are low, discontinuation may be indicative not just of service-related barriers but more so of limited agency. Additionally, discontinuation has broader fertility implications. Abdulfathi et al. (2025) document measurable fertility consequences of contraceptive discontinuation among women in Kano State, emphasizing the demographic significance of sustained contraceptive use. Long-acting reversible contraceptive trends among married women also suggest that method choice and accessibility are important predictors of continuation (Kupoluyi, 2025).

Theoretical consideration

There is a theoretical underpinning for examining the reasons for the discontinuation and switching associated with contraceptive use. One approach to providing an explanation for the utilisation of health services is the application of Andersen's Behavioural Model of Health Services Utilisation. In summary, this model explains that health service utilisation is affected by predisposing factors (e.g., age, education level, fertility preferences), enabling factors (e.g., accessibility, cost, and availability), and need factors (e.g., perceived risks of pregnancies, side effects). In the context of the research, accessibility was identified as an essential facilitating factor that had the potential to either encourage the consistent use of contraceptives or cause discontinuation and switching.

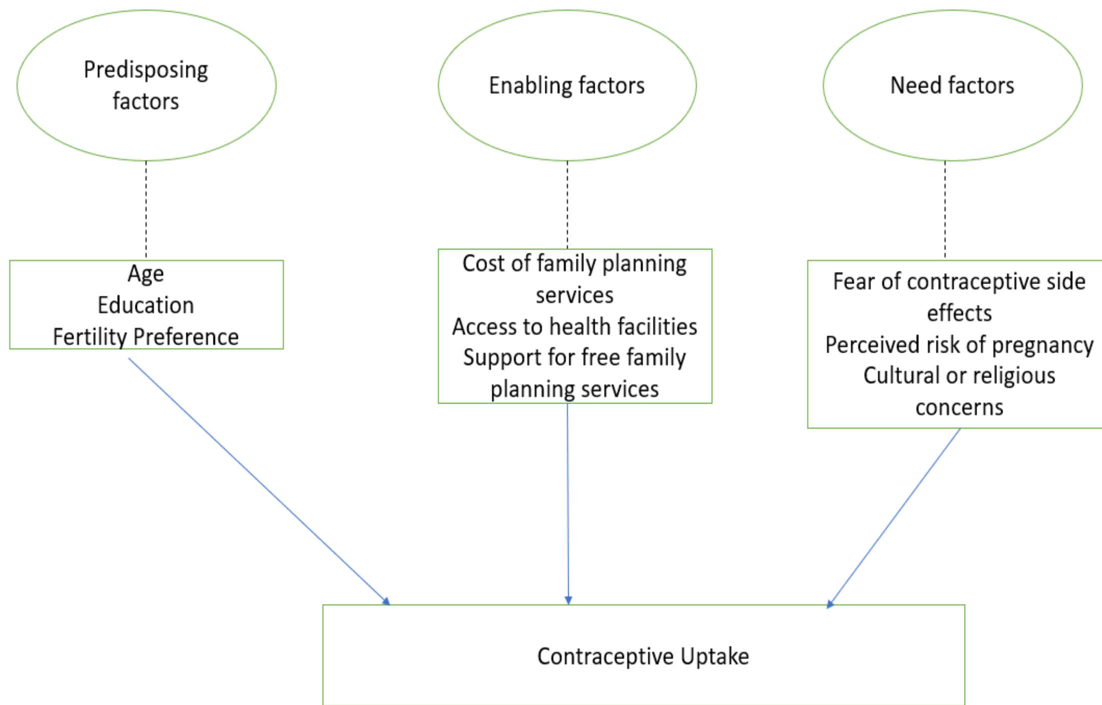

Figure 1: Andersen behavioural model of Contraceptive Uptake. Adapted from "Re-visiting Andersen's Behavioural Model of Health Services Use: A Systematic Review of Studies from 1998-2011, " by B. Babitsch, D. Gohl, and T von Lengerke, 2012, GMS Pyschosoc Med, 9, p. 9.

In spite of existing research in the area, limited primary empirical research exists that focuses on the relationship between the multidimensional accessibility of healthcare and rates of discontinuation and switching amongst married women using primary data within Abuja. We fill this research niche.

METHODOLOGY

Measurement of Key Variables

Contraceptive Discontinuation (Outcome Variable)

Contraceptive discontinuation was defined as stopping the use of a modern contraceptive method within the study reference period after previously initiating its use.

Fear of Side Effects

Fear of side effects was measured using a binary variable derived from responses to the question:

"Did concerns about possible side effects influence your decision to stop using a contraceptive method?"

Responses were coded 1 = Yes and 0 = No.

Religious Objection

Religious objection was assessed using a self-reported item asking respondents whether their religious beliefs discouraged contraceptive use. Responses were dichotomized as:

1 = Religious objection present

0 = No religious objection

Support for Free Family Planning Services

Participants were asked whether they would support continued use of family planning methods if services were provided free of charge. Responses were coded as 1 = Yes and 0 = No.

Cultural Objection

Cultural objection referred to perceived cultural norms discouraging contraceptive use and was measured as a binary variable (Yes/No).

Study Area

The study was conducted in the Federal Capital Territory (FCT), Abuja, located in the North-Central Region of Nigeria. The FCT covers an area of about 7,315 square kilometres. Its geographical location is between latitude 6°47′ and 9°25′ north of the equator and between longitude 6°47′ and 7°40′ east of the Greenwich meridian. The FCT was created in 1976 by excising an area from the old Kwara, Niger, Kaduna, and Plateau States. The main part of this area was taken from Niger State. Unlike the 36 States in Nigeria, each headed by an elected Governor, the FCT is headed by the Federal Capital Territory Administration (FCTA), nominated by the President (Oyetunji A. et al, 2021).

Research Design

This study used a cross-sectional survey design to examine the association between healthcare service accessibility and the discontinuation and switching of contraceptive use among married women in Abuja, Nigeria. A cross-sectional study design is appropriate for assessing associations between variables measuring healthcare service accessibility and contraceptive outcomes at a given point.

Population and Sample Size

The target population under study consists of married women aged 15-49 years who have ever used any modern method of contraception in a given year and residing in FCT for at least 12 months. By using a Cochran formula to compute the sample size, the total number of respondents to be interviewed for this study was determined to be 512. Although men aged 15–59 years were included in the broader household sampling frame to capture contextual household dynamics in the larger study, the present analysis focuses exclusively on married women with prior contraceptive experience.

Sampling Techniques

For the research in question, the sampling design used in arriving at the sample of eligible research participants was a multi-stage sampling. The aim of the sampling design was to sample the pool of eligible research participants whose intended sample represents the sample of individuals from the three (3) local government areas of the six (6) local government councils. The identified area council of the sampled cluster by the NPC 2006 has an EA identified with 50 listed households with 30 eligible female research participants aged between 15-49 years identified to have already used contraceptive methods before, including the male counterpart. To achieve a multi-stage sampling design, EA in FCT is stratified on the basis of rural and urban local government councils.

In conducting facility-based interviews, a random sample of family planning facilities in the cluster was chosen as recruitment sites for eligible respondents for the client exit and family planning counsellor evaluation study. In public health facilities within the EAs, a recruitment site was qualified if they offered family planning services and have a trained provider. The ten recruitment sites will be strategically located throughout facilities within the study area in urban and rural zones. Interviewed respondents were women of reproductive age who had prior experience with contraceptive use. The number of clients that can be interviewed from each facility can be estimated as a result of dividing the final sample size for evaluation by the total number of recruitment sites, which sums up to 20; nonetheless, client flow into each site was taken into consideration for such distribution. The total number of interviewed clients within each facility, as needed, was allotted proportionately according

to client flow volumes. For the research, the client data of selected health facilities was evaluated through the District Health Information System 2 (DHIS2). Evaluation for the compilation of on-site client data will be considered for the retrospective analysis of client data for the selected facility, which may not be on the DHIS2.

Method of Data Analysis

The quantitative data were analyzed using SPSS software. The analysis was based on univariate, where the socio-demographic factors, factors that facilitate and hinder uninterrupted contraceptive switching for women would be done using a frequency distribution table and charts for certain indicators. Logistic regression was used at the multivariate stage of analysis to establish the relationship between the response and explanatory variables.

Ethical Consideration

Ethical clearance was obtained from the FCT Ethics Review Committee for the research process to cover the three LGAs of the FCT region. It covers the rules stipulated by the IRB for the process of obtaining informed consent, the issues of maintaining the confidential nature of the research findings, and the risks/benefits of conducting the research for the respondent. Moreover, the informed consent was obtained from the respondents willingly after the explanation of the need for conducting the research was provided. For the married girls who were below the age of 18 years, an assent form is available for the respondent category, and the research was conducted in the absence of the guardian/spouse for the respondent, for the purpose of maintaining the confidential nature of the research findings. Researchers were sought for the research due to the increased number of female researchers, due to the influence of the opposite gender, and for not conducting the research due to the nature of females were not conducting the research.

Data Management

Since the data collected was semi-structured and had been transcribed using Microsoft Word software, the entire process of coding, indexing, and theme development was carried out by one individual to avoid any possible errors. Contrary to this, the quantitative data collected using the Kobo Collect method was saved in Microsoft Excel software in csv format.

RESULTS

This paper focuses on married women, and the socio-demographic profile of the respondents is presented in Table 1. From the data obtained, it is clear that most of the respondents belonged to the 25-34 years age group, which comprised 42.1%, followed by the 35-49 years age group, which comprised 39.5%, and then the 15-24 years age group, which comprised 18.5% of the sample participants. This indicates that most of the participants were within their productive years, meaning they were part of the target population, which was expected for a contraceptive uptake and discontinuation study in Nigeria. As far as their educational attainment was concerned, 63.3% of the respondents reported having achieved at least post-primary education, while 36.7% reported having only achieved basic education. It would seem here that the vast preponderance of women who were queried were relatively well-educated, and this would seem to be positive in promoting awareness, choice, and attitudes in relation to family planning and contraceptive usage. Nevertheless, the high percentage reporting only basic education would seem to confirm the necessity for community-based education about reproductive health, as access to formal educational systems may be limited.

Out of these, 59.1% of the participants were from rural areas, and 40.9% were from urban areas. The dominant share of rural participants is pertinent, considering the factors of an effective family planning program, such as those facing hurdles in terms of access, misconceptions, and low male participation, which is relatively higher in rural compared to urban areas. This high share of rural participants can be explained by the use of the stratified sampling method, where the selection was done in a manner that the sample population best represents the urban and rural socio-economic setting of FCT. By Area Council, AMAC accounted for 46.2%, Bwari accounted for 30.4%, and Gwagwalada accounted for 23.4%. The division represents the difference in population density and accessibility between each of the Areas. AMAC represents an urban community, which could be more densely populated in terms of health facilities as well as family planning service points, but Bwari and Gwagwalada do

represent a semi-urban and a rural community, respectively, and as such may have differing socio-cultural influences on contraceptive usage.

Table 1: Socio-Demographic Characteristics of Household Survey Sample (N=512)

Variable	Category	Frequency (512)	Percent (%)
Age	15–24	95	18.5
	25–34	216	42.1
	35–49	201	39.5
Education	Basic	188	36.7
	Post-primary	324	63.3
Residence	Urban	209	40.9
	Rural	303	59.1
Area Council	AMAC	237	46.2
	Bwari	156	30.4
	Gwagwalada	119	23.4

Source: Field survey, 2025

Table 2 shows the distribution of the reported barriers to the continuity of family planning services among women. The results show that the most reported barrier is the fear of side effects, with 94 women (42.8%). The high number of women reporting the fear of side effects as a barrier to the continuity of family planning services indicates that the fear of actual or perceived health complications is a major deterrent to the sustained use of family planning services. Financial barriers were the second most frequently reported barrier to the continuity of family planning services, with 72 women (32.6%) reporting them. The high number of women reporting financial barriers as a deterrent to sustained use of family planning services indicates that the cost of services, or associated costs of seeking family planning services, is a major deterrent to sustained use. Beliefs regarding religion were identified by 62 respondents, which accounts for 28.1%. This shows that religion plays a crucial role in guiding individuals on matters of reproduction. Where there is a perceived incompatibility between religion and contraception, some women may stop using contraception despite their desires.

Cultural expectations were identified by 52 respondents, which accounts for 23.4%. This shows that cultural values regarding fertility, childbearing, and gender play a crucial role in guiding individuals on matters of reproduction. Where there are cultural expectations regarding large family size, some women may avoid continuity. The desire to bear more children was identified by 44 respondents, which accounts for 19.7%. This shows that some women may avoid continuity because they want to bear more children. Family/community influence was identified by 25 women (11.2%), indicating that community influence plays a part, albeit a small one, in decision-making about contraception. The least identified factor was lack of access, with 21 women (9.4%) reporting this as a barrier. This implies that access to contraceptive services may not be a major problem in this community, as opposed to other barriers.

Table 2: Barriers to Family Planning Services Continuity among Women

Barrier to FP support	**n (%)**
Fear of side effects	94 (42.8)
Financial constraints	72 (32.6)

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Religious beliefs	62 (28.1)
Cultural expectations	52 (23.4)
Desire for more children	44 (19.7)
Family/community influence	25 (11.2)
Lack of access	21 (9.4)

Source: Field survey, 2025

Table 3 shows the results of logistic regression analysis for the predictors of family planning discontinuation. The adjusted odds ratio (aOR), 95% confidence interval (CI), and p-values indicate the relationship of each predictor with family planning discontinuation after controlling for all other variables included in the model. Fear of side effects was found to be a predictor of family planning discontinuation, as it was associated with a statistically significant relationship (aOR = 2.4, 95% CI: 1.3-4.6, p = 0.006). The results indicate that women who reported fear of side effects were 2.4 times more likely to discontinue family planning compared with women who did not report fear of side effects. The confidence interval does not include 1, and the p-value is less than 0.05, confirming a statistically significant relationship. This implies that fear of side effects greatly increases the probability of discontinuing family planning.

However, support for family planning is also found to be statistically significant (aOR = 0.4; 95% CI: 0.2–0.9; p = 0.028). The odds ratio is less than 1, which implies a protective effect. The chances of discontinuation were 60% less likely in the group of women who showed support for family planning if it were free compared to those who showed no support. The confidence interval is not equal to 1, and the p-value is less than 0.05, which implies a statistically significant effect. The effect of religious objection on the discontinuation of family planning is found to be statistically significant (aOR = 2.1; 95% CI: 1.0–4.2; p = 0.042). The chances of discontinuation were twice as likely in the group of women who showed religious objections compared to those who showed no objections. The lower confidence limit is close to 1, but the p-value is less than 0.05, which implies a statistically significant effect.

The cultural objection has an adjusted odds ratio of 1.7 (95% CI: 0.8–3.5; p = 0.091). Although this suggests that cultural objections are associated with a greater likelihood of discontinuation, as indicated by the odds ratio, this value is not significantly different from 1, and the p-value is greater than 0.05. Thus, this factor is not significant in this model.

Women living in urban areas had nearly three times the odds of current modern contraceptive use compared to rural peers (aOR 2.89, 95% CI 1.98–4.21).

Post-primary education and urban residence have an adjusted odds ratio of 2.54 (95% CI: 1.68–3.84; p = <0.001) and 2.89 (95% CI: 1.98-4.21; p = <0.001), respectively, which suggests that having a higher education and living in an urban area is statistically significant to uptake of family planning as the p-value is less than 0.001.

Table 3: Logistic Regression showing the Relationship between predictors and Family planning discontinuity

Predictor	**Category**	**aOR**	**95% CI**	**p-value**
Fear of side effects	Discouraged FP use	2.4	1.3–4.6	0.006
Religious objection	Discouraged FP use	2.1	1.0–4.2	0.042
Cultural objection	Discouraged FP use	1.7	0.8–3.5	0.091

Support if FP is free	Discouraged FP use	0.4	0.2–0.9	0.028
Post-primary education	Support FP use	2.5	1.68–3.84	<0.001
Urban residence	Support FP use	2.9	1.98–4.21	<0.001

Source: Field survey, 2025

Model Fit

Logistic and multinomial regression models were assessed for fit using the Hosmer-Lemeshow goodness-of-fit test (for logistic), likelihood ratio tests, and pseudo-R^2 statistics. For the current use model, the Hosmer-Lemeshow test returned $p = 0.63$, indicating a satisfactory fit. The multinomial model yielded a McFadden pseudo-R^2 of 0.18, appropriate for behavioral models of contraceptive practice.

DISCUSSION OF FINDINGS

The study's findings reveal that the rate of contraceptive discontinuation remains high among married women in Abuja, and the fear of side effects has been identified as the most prominent barrier and a strong predictor of contraceptive discontinuation. The study found that married women who experienced fear of side effects were more likely to discontinue the use of contraceptives. This finding is in line with the research of Kupoluyi et al. (2023), which found that side effects and method dissatisfaction were the major determinants of contraceptive discontinuation among sexually active married women in Nigeria. Agbana et al. (2023) found that side effects and method dissatisfaction were the key contributors to the discontinuation of contraceptives based on the 2018 Nigeria DHS data. The study's findings support the continued influence of perceived health risks on the behavior of married women.

Religious objection was also a significant contributor to discontinuation. In fact, it was found that women who had expressed religious objection to contraceptive use were twice as likely to stop using it. This is consistent with the study by Adebola et al. (2025), which showed the significant role played by significant others, such as spouses and religion, in family planning decision-making. In fact, contraceptive use in many places is not just a personal choice but is often influenced by the dominant religion and its expectations. If there is a perceived incompatibility between religion and contraception, it could lead to discontinuation, even if the benefits of the method are recognized.

Financial factors were equally important. Those who reported they would support family planning if it were free of charge were significantly less likely to discontinue. Although access was not commonly described as a problem, the protection offered by the affordability of the method suggests that it may still be a factor. Kupoluyi (2025) noted the importance of accessibility, availability of chosen methods, and cost as important factors in the continuation of contraceptive use, especially for long-acting reversible contraceptives. Financial constraints may be a hindrance even in urban areas like Abuja. Although cultural objection was positively linked to discontinuation, it was not found to be statistically significant after adjustment. This implies the potential indirect effect of cultural factors on discontinuation through other factors, such as religion, spousal influence, or fertility intentions. Fertility preference has been identified as a reason for discontinuation in this study. Iluno et al. (2026) established the effect of fertility intentions and spousal communication on the use of contraceptives by postpartum women in Abuja. Women may want more children and thus intentionally discontinue the method, which is a fertility preference rather than a problem of service delivery.

The study also revealed that women living in urban areas had nearly three times the odds of current modern contraceptive use compared to rural peers (aOR 2.89, 95% CI 1.98–4.21). Higher education was strongly associated with uptake (aOR 2.54, 95% CI 1.68–3.84). Kupoluyi et al. (2023) identified education as a key factor in influencing contraceptive practice, and Ayodeji and Adekunle (2025) related it to women's empowerment and reproductive decision-making. Educated women might be more likely to explore alternative methods rather than stopping the method due to side effects. The high rate of discontinuation reported in the study is similar to the national rate reported by Kupoluyi et al. (2023) and Agbana et al. (2023). The implication is that the problem of

maintaining use persists despite the advances made in awareness and service availability. The implications of the study are far-reaching. Abdulfathi et al. (2025) reported the fertility implications of the high rate of discontinuation of contraceptives.

From the perspective of Andersen's Behavioural Model, the study findings reveal the influence of predisposing factors like educational level and fertility intentions, enabling factors like affordability, and perceived barriers like side effects and religious opposition in the context of contraceptive use. These factors interact in a complex manner rather than in isolation from each other.

As of 2024, NDHS conducted by the National Population Commission in collaboration with ICF indicates that approximately 37% of contraceptive users discontinue a method within 12 months of initiation. The discontinuation rate of 65% observed in this study conducted in Abuja suggests that family planning stopping remains a challenge, particularly pronounced in Abuja. While Abuja benefits from relatively better health infrastructure compared to many regions of Nigeria, socio-cultural and perception-based barriers such as fear of side effects and religious concerns appear to play a stronger role in shaping contraceptive behaviour.

CONCLUSION

Contraceptive discontinuation among married women in Abuja was mainly driven by the fear of side effects, religious, and economic factors. Although cultural factors were also present, they did not independently predict discontinuation after adjusting for other variables. Education and urban residence were related to better contraceptive continuation and change behaviors, indicating the value of informed decision-making and empowerment as positive factors. The study findings suggest that contraceptive discontinuation among married women in Abuja cannot be explained by physical access factors alone. Instead, it is influenced by the interplay of health concerns, socio-religious, economic, and reproductive factors. These factors are all interconnected and should be taken into consideration if the goal is to improve the rate of contraceptive continuation and strengthen reproductive health in Abuja.

The findings from this research have implications for policy development for reproductive health programming within the Federal Capital Territory Administration (FCTA). Improving client-centered family planning counselling services within health care facilities could improve women's knowledge of potential side effects and how to manage them when they occur. Additionally, expanding subsidized or free family planning services (including the cost of consumables) within FCTA health facilities may contribute to increasing continuation contraceptive rates among women and men with resource constraints. Collaboration with religious and community leaders may also help address socio-cultural misconceptions that discourage sustained contraceptive use.

RECOMMENDATIONS

Based on the findings from this study, the following recommendations are made:

i. Programs should be continued in their promotion of male involvement and spousal communication, as significant others play a role in decisions about contraception. Promoting communication may help eliminate barriers and enhance continuation.

ii. Financial barriers may also be addressed. This could be achieved by increasing the provision of free or subsidized contraceptives, which may enhance continuation rates, especially among those willing to use family planning but are limited by financial constraints.

iii. Religious and community leaders play a key role in clarifying misconceptions and building support for family planning. The major predictor of discontinuation was religious objection, so discussions with community leaders may help reconcile reproductive health objectives with religious beliefs.

iv. There is a need to enhance counseling within family planning programs. Counseling should be such that it gives detailed information about side effects, their management, and alternatives. Women who are well-informed may be more inclined to switch rather than stop.

v. Finally, educational programs aimed at increasing women's autonomy and decision-making power should be reinforced, particularly in rural areas. Empowered women are likely to make conscious reproductive decisions and adjust their methods if they do not work, rather than stopping altogether.

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