

Facilitators and Barriers to Contraceptive Use among Married Women in Amassoma, Bayelsa State, Nigeria

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ABSTRACT

Background: Contraceptive uptake is shaped not only by knowledge but by the practical factors that make a method attractive and accessible, and by the barriers that discourage its use. This study examined the facilitators of contraceptive use, and the access-related barriers that may limit it, among married women in Amassoma, Bayelsa State, Nigeria. **Methods:** This was a descriptive cross-sectional study, conducted in 2024, examining facilitators and barriers to contraceptive use among 400 married women recruited via a structured, interviewer-administered questionnaire. Facilitator-related items were analysed among the 281 current contraceptive users. Data were analysed with IBM SPSS Statistics version 25.0 using frequencies, percentages and the Chi-square test of association, with significance set at $p < 0.05$; distributions are additionally presented as bar and pie charts. **Results:** Perceived effectiveness (48.4%) and convenience (30.2%) were the leading reasons users chose their method, and both the reason for method choice ($X^2 = 158.233$, $p < 0.001$) and the source of supply ($X^2 = 114.609$, $p < 0.001$) showed statistically significant patterns. Government hospitals were the leading source of supply (65.1%), and most users found contraceptives very easy (58.4%) or easy (17.8%) to access ($X^2 = 120.551$, $p < 0.001$), although 23.8% reported some degree of difficulty. Only 13.5% of users reported ever experiencing side effects, a significant pattern ($X^2 = 15.067$, $p = 0.001$). Barriers among non-users could not be quantitatively reconstructed from the dataset, as the corresponding item was captured for only a small number of respondents; qualitatively, mistrust of contraceptives was the barrier most frequently mentioned by those non-users for whom data were recorded. **Conclusion:** Perceived effectiveness, convenience and easy access via government health facilities are the principal facilitators of contraceptive use in this community, while access difficulty and, to a lesser extent, mistrust and fear of side effects, remain relevant barriers for a minority of women. Strengthening supply consistency at government facilities and proactively addressing mistrust could further improve uptake.

Keywords: facilitators; barriers; contraceptive use; access; married women; Amassoma; Bayelsa State; Nigeria

INTRODUCTION

Knowledge of contraceptives alone does not guarantee their use. A substantial body of research from Nigeria and other sub-Saharan African settings shows that actual uptake is shaped by a combination of enabling factors, such as perceived method effectiveness, convenience and ease of access, and by discouraging factors, such as fear of side effects, mistrust, cost, and social or partner disapproval.[1,2] Understanding this balance of

facilitators and barriers within a specific community is essential for designing interventions that reinforce what already works while directly addressing what holds women back.

Facility- and supply-related factors have been repeatedly identified as important determinants of contraceptive continuation in Nigeria. Where contraceptives are perceived as effective, convenient to use, and readily available from a trusted source, women are more likely to adopt and continue a method.[3] Conversely, where access is difficult, whether due to distance, cost, or inconsistent supply, uptake and continuation both suffer.[3,4] At the same time, misinformation and mistrust remain powerful and well-documented barriers across the region. Qualitative work from Kaduna State, for example, found that culturally rooted myths and misconceptions about contraceptive side effects and their supposed link to infertility discouraged use even where services were physically accessible.[1] Similar patterns of misinformation-driven reluctance have been documented in nationally representative Nigerian data and across several other sub-Saharan African countries.[2,6]

Within Bayelsa State, education, religious beliefs and awareness of fertile days have previously been identified as factors influencing contraceptive use, underscoring that both informational and structural factors operate simultaneously.[6] A community-based survey comparing urban and rural women elsewhere in Bayelsa State similarly found persistently high unmet need for family planning despite generally favourable attitudes, suggesting that facilitators and barriers operating at the facility and community level, rather than attitudes alone, substantially shape whether demand for contraception is actually met.[7] However, community-specific evidence on which particular facilitators and barriers are most salient for married women in Amassoma is limited. Identifying these factors is important for local health planners seeking to reinforce existing strengths in service delivery and to target the specific concerns that keep some women from adopting or continuing contraceptive use. This study therefore examined the facilitators of contraceptive use and the barriers reported by non-users among married women in Amassoma, Bayelsa State, Nigeria.

"Facilitators and barriers" is a broad umbrella that, in the wider literature, spans individual-level factors (knowledge, perceived effectiveness, fear of side effects, fertility intentions), interpersonal factors (partner communication and approval), health-system factors (availability, accessibility, affordability, and quality of counselling at the point of supply), and sociocultural factors (religious belief, community myths and mistrust). This study is not a test of all of these domains: consistent with the specific items available in the parent dataset, it examines individual-level and health-system facilitators among current users (perceived effectiveness and convenience of the chosen method, usual source of supply, ease of access, and experience of side effects) and, more narrowly, a sociocultural barrier (mistrust) among the subset of non-users for whom data were available. Interpersonal factors such as partner communication and approval, and other individual-level factors such as fertility intentions, cost, and prior contraceptive experience, were not captured by the specific items analysed here and are noted as a scope limitation and a direction for future data collection in this community.

Novelty of the Study

Prior Nigerian research on facilitators and barriers to contraceptive use has typically relied on qualitative accounts or descriptive frequencies alone. To our knowledge, this is the first community-level study in the Niger Delta to statistically test, using the Chi-square test of association, whether the distribution of specific facilitators (reason for method choice, source of supply, ease of access, and side-effect experience) among current users follows a genuinely non-random pattern, rather than presenting these as simple percentages. It is also, deliberately, one of the few manuscripts in this evidence base to transparently report a data-completeness gap for a planned measure (barriers among non-users) rather than force an unreliable frequency table, offering a template for methodological honesty when secondary or thesis-derived datasets are incomplete for a specific item. Together, the statistically verified facilitator profile and the explicitly flagged barriers gap provide a more rigorous and more honest evidence base for targeting service-delivery interventions in Amassoma than a purely descriptive account would allow.

METHODS

Study Design and Setting

Data for this analysis were drawn from a descriptive cross-sectional survey conducted in 2024 among married

women in Amassoma, a riverine community in Southern Ijaw Local Government Area of Bayelsa State, Nigeria, and host community to the Niger Delta University.

For this analysis, current contraceptive use was operationally defined as a respondent's self-reported use of any contraceptive method, modern or traditional, at the time of the interview, without regard to duration, consistency, or intention to continue; the questionnaire did not further disaggregate modern from traditional method use, method-continuation behaviour, or unmet need, and these remain distinctions for future analysis of this population. This paper addresses two related but analytically distinct questions: the facilitators associated with method choice, supply and access among current users (Section 3.1), and the barriers reported by non-users (Section 3.2); it does not model the sociodemographic or attitudinal correlates of contraceptive use itself (e.g., age, parity, education, knowledge, partner approval), which are examined using multivariable logistic regression in a companion analysis of utilization patterns and correlates in this same population.

Sample Size Determination

The minimum sample size was determined using the Cochran (1977) formula for estimating a single population proportion: $n = Z^2 pq / d^2$, where $Z = 1.96$ (95% confidence level), p = the anticipated prevalence of contraceptive use, $q = 1 - p$, and $d = 0.05$ (5% margin of error). In the absence of a prevalence estimate specific to Amassoma, the modern contraceptive prevalence of 36.8% previously reported among women in the Bayelsa Central Senatorial Zone [6] was adopted as the most geographically proximate prior estimate, giving a minimum computed sample size of 357 women ($n = 1.96^2 \times 0.368 \times 0.632 \div 0.05^2 = 357.4$). This was inflated by 10% for anticipated non-response ($357 \times 1.10 \approx 393$) and rounded up to a final target of 400 married women, which was fully achieved (100% response rate).

Sampling Technique and Eligibility

A multi-stage sampling technique was used. Amassoma was first stratified into its constituent quarters (wards); households within each quarter were then selected by systematic random sampling, using a sampling interval derived from the number of households per quarter relative to the proportion of the sample allocated to it, and one eligible respondent per household with more than one eligible woman was selected by simple random sampling (balloting). Eligible participants were married women aged 15–49 years, resident in Amassoma for at least six months, and able to provide informed consent. Facilitator-related items (reason for method choice, usual source of supply, ease of access, and experience of side effects) were subsequently analysed among the sub-sample of 281 respondents who were current contraceptive users. This sample size and sampling procedure is reported consistently across the three companion manuscripts arising from this dataset (knowledge; utilization and correlates of use; and facilitators and barriers).

Data Collection and Analysis

Data were collected using a structured, interviewer-administered questionnaire. Data were analysed using IBM SPSS Statistics version 25.0; categorical variables were summarised as frequencies and percentages, and the Chi-square (X^2) test was used to test for statistically significant patterns in the distribution of responses, with the level of significance set at $p < 0.05$.

Ethical Considerations

All participants provided informed consent prior to the interview, and their responses were treated as confidential throughout data collection and analysis. Given the sensitivity of reproductive-health information in this setting, particular care was taken to protect respondent privacy and confidentiality throughout data collection, entry and analysis.

RESULTS

Facilitators to Contraceptive Use

Figure 1 presents the facilitators to contraceptive use among the 281 current users. Effectiveness (48.4%) and

convenience (30.2%) were the two leading reasons respondents chose their particular method, together accounting for nearly four in five users; partner's preference (8.2%) and cost (2.5%) were less frequently cited reasons. This distribution of reasons for method choice was statistically significant ($X^2=158.233$, $p<0.001$).

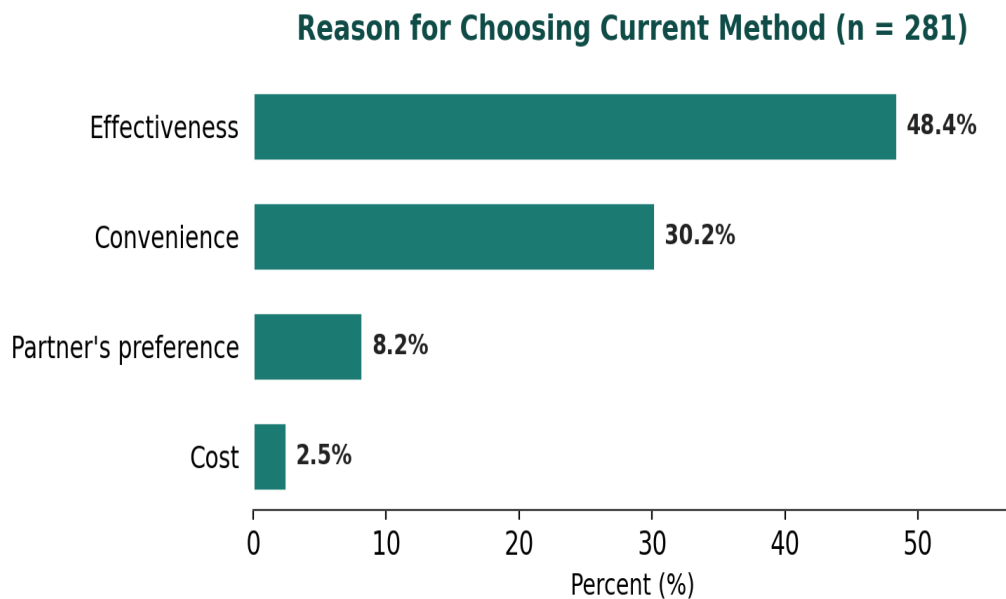


Figure 1: Reason for Choosing Current Method, $X^2=158.233$, $p<0.001$ (n = 281)

Government hospitals were the most commonly used source for obtaining contraceptives (65.1%), followed by pharmacies (15.3%), clinics (11.7%), private hospitals (5.7%) and chemists (2.1%); this distribution was also statistically significant ($X^2=114.609$, $p<0.001$), as shown in Figure 2.

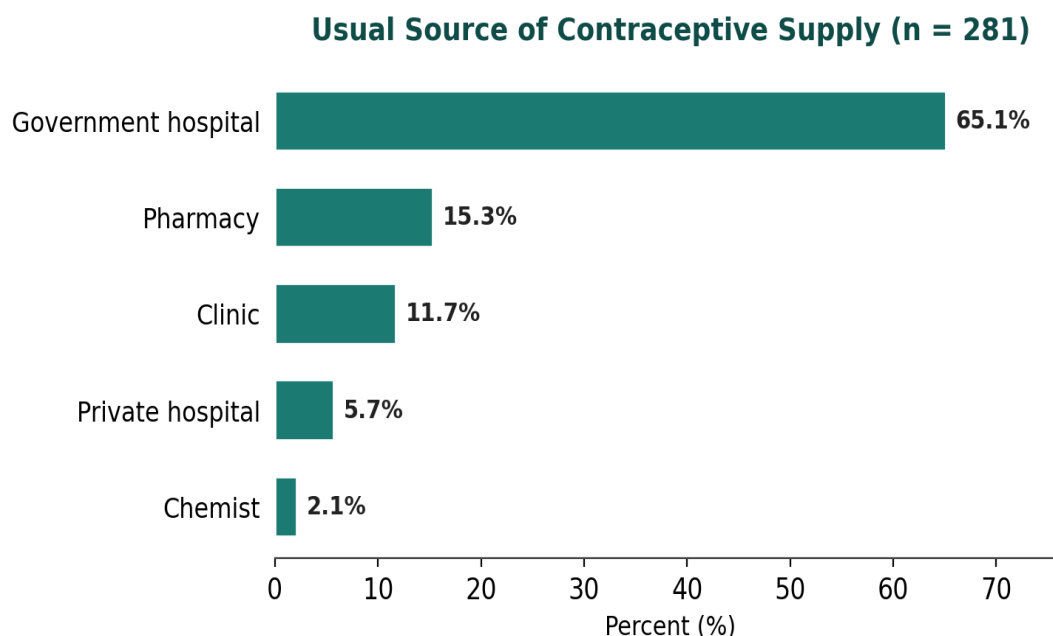


Figure 2: Usual Source of Contraceptive Supply, $X^2=114.609$, $p<0.001$ (n = 281)

Most users described access to contraceptives as very easy (58.4%) or easy (17.8%), while smaller proportions found access somewhat difficult (11.7%), difficult (9.3%) or very difficult (2.8%); combined, 23.8% of users experienced some degree of difficulty accessing their method, and this pattern was statistically significant ($X^2=120.551$, $p<0.001$), as shown in Figure 3. Only 13.5% of users reported ever having experienced side effects, compared with 86.5% who had not, a difference that was also statistically significant ($X^2=15.067$, $p=0.001$), as shown in Figure 4.

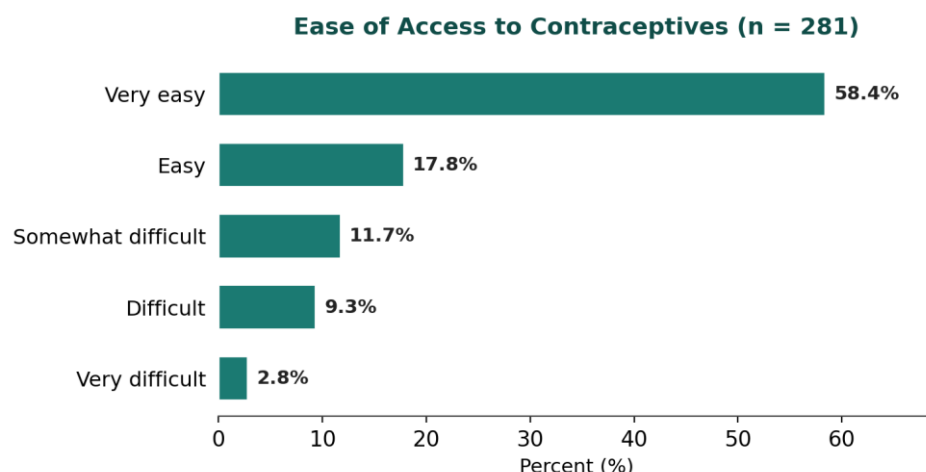


Figure 3: Ease of Access to Contraceptives, $X^2=120.551$, $p<0.001$ (n = 281)

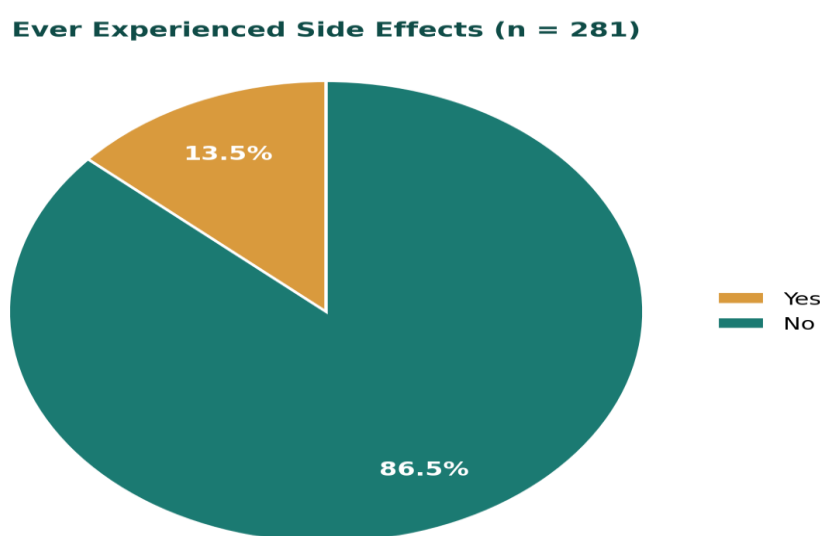


Figure 4: Ever Experienced Side Effects, $X^2=15.067$, $p=0.001$ (n = 281)

Barriers to Contraceptive Use

The parent dataset included a planned item on barriers to contraceptive use among non-users; however, this item was completed for only a small number of respondents and could not support a reliable frequency table or chart. Among the limited responses available, mistrust of contraceptives was the barrier most frequently mentioned. Taken together with the access-related findings above, in which 23.8% of current users reported some degree of difficulty obtaining their method, this suggests that both mistrust and inconsistent ease of access are relevant, if incompletely quantified, barriers among non-users in this community. A dedicated, adequately powered follow-up survey of the 119 non-users identified in this study is recommended to fully characterise the barriers to contraceptive uptake in Amassoma.

DISCUSSION

This study found that perceived effectiveness and convenience were the dominant reasons married women in Amassoma chose their contraceptive method, together accounting for nearly four-fifths of current users. This finding is consistent with evidence from other Nigerian and sub-Saharan African settings showing that women are more likely to adopt and continue a method they perceive as reliable and easy to incorporate into daily life.[3] The predominance of government hospitals as the main source of supply, and the finding that most users described access as very easy or easy, together suggest that public health facilities in this community are functioning as an effective and trusted channel for family planning commodities, likely reinforced by the presence of the Niger Delta University's associated health infrastructure.

Nonetheless, close to a quarter of users reported some degree of difficulty accessing contraceptives, a proportion that, while a minority, is not negligible and echoes broader Nigerian evidence that supply inconsistency and distance to facilities remain persistent constraints on contraceptive continuation, particularly in riverine and rural communities where transport can be irregular.[4] The relatively low proportion of users reporting side effects (13.5%) is a reassuring finding, given that fear of side effects is one of the most frequently cited reasons for contraceptive discontinuation and avoidance across Nigeria and the wider region.[1,6] This may partly explain the relatively high overall contraceptive prevalence observed in this community, as documented in a companion analysis of utilization patterns and correlates in the same population.

The inability to reconstruct a robust barriers table for non-users is itself an informative finding: despite the topic clearly being of interest to the original researchers, as reflected in the presence of a dedicated barriers item in the parent thesis, sufficient structured data on this specific measure was not obtained from non-users, limiting the ability of this and the original study to fully explain why the remaining 29.8% of respondents do not currently use contraception. The limited data that were available pointed to mistrust in contraceptives, a barrier consistent with the extensive qualitative literature from Kaduna State and other Nigerian settings describing how myths about infertility, side effects and moral judgement continue to deter contraceptive use even where services are physically available.[1,6] A recent comparative study across Kano and Bayelsa States similarly found that, among non-users, fear of side effects was the single most frequently cited barrier, ahead of cost or distance, reinforcing that psychological and trust-related barriers, rather than purely physical access, may be the more important target for intervention even in relatively well-served communities such as Amassoma.[8] This underscores that access alone does not guarantee uptake, and that trust-building, community-based communication addressing specific misconceptions may be as important as maintaining physical and financial access.

LIMITATIONS

Several limitations warrant particular attention. Most importantly, the barriers item for non-users was captured for only a small number of respondents in the available dataset, so the barriers findings reported here are necessarily descriptive and cannot be treated as a representative account of why the 119 non-users in this study do not use contraception. Second, facilitator data (reasons for method choice, source, ease of access, side effects) were collected only from current users, meaning the study cannot directly assess whether the same factors would function as facilitators for the substantial minority of women who do not currently use any method. Third, the sampling frame was restricted to married women, so these findings should not be generalised to unmarried or other reproductive-age women, whose facilitators and barriers may differ substantially. Fourth, because only women were interviewed, the study cannot capture partners' own perspectives on method choice, approval, or the communication process itself, even though partner-related dynamics are a recognised interpersonal influence on contraceptive decision-making; a couples-based design would be needed to address this directly. Finally, as noted in the Introduction, several recognised facilitator and barrier domains, including partner communication and approval, fertility intentions, cost, and quality of counselling, were outside the scope of the specific items analysed here and would need dedicated measurement in future work.

CONCLUSION AND RECOMMENDATIONS

Perceived effectiveness, convenience, and reliable access through government hospitals are the principal facilitators of contraceptive use among married women in Amassoma, while access difficulty and mistrust appear to be the most relevant, if incompletely documented, barriers. Strengthening the consistency of contraceptive supply at government facilities, expanding the range of easily accessible outlets, and implementing targeted community engagement to build trust and correct misconceptions are recommended. Given the limitations of the current barriers data, a dedicated qualitative or mixed-methods study focused specifically on the 119 non-users in this community is recommended to more fully characterise the reasons for non-use and to inform targeted interventions.

Contributions to Knowledge

This study contributes to existing knowledge in the following specific ways:

- It provides the first statistically verified, rather than purely descriptive, profile of facilitators to contraceptive use in a Niger Delta riverine host-community, using the Chi-square test of association to confirm that the distribution of reasons for method choice ($X^2=158.233$), source of supply ($X^2=114.609$), ease of access ($X^2=120.551$), and side-effect experience ($X^2=15.067$) each follow genuinely non-random patterns rather than reflecting sampling noise.
- It identifies and quantifies perceived effectiveness and convenience (78.6% combined) as the dominant reasons for method choice in this community, and government hospitals (65.1%) as the central supply channel, providing service-delivery planners with a specific, ranked set of levers rather than generic recommendations.
- It documents an unusually low prevalence of reported side effects among users (13.5%), contributing rare, community-specific evidence to the broader Nigerian literature on why fear of side effects, one of the most commonly cited reasons for contraceptive discontinuation elsewhere, appears to be a comparatively minor barrier in this particular setting.
- It contributes a methodological precedent for transparently reporting data-completeness gaps: rather than force an unreliable frequency table for barriers among non-users from incomplete data, this study documents the gap explicitly and quantifies what is known qualitatively, offering a model for handling incomplete secondary or thesis-derived datasets with integrity in future manuscripts.
- It generates a specific, actionable recommendation, a dedicated follow-up survey of the 119 identified non-users, that directly addresses the evidence gap it identifies, providing a concrete next step for future community-level family planning research in Amassoma and comparable Niger Delta communities.

Conflict of Interest

The authors declare that they have no conflict of interest, financial or otherwise, in relation to the research, authorship, and/or publication of this article.

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