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Experiences, Perceptions and Decision-Making Regarding Contraceptive Use among Women of Reproductive Age in Rural and Urban Communities in Anambra State, Nigeria: A Qualitative Study

Dike Christiana Ebele[1], Digor Faith[2], Ojule Inumanye N.[3]

[1, 2, 3] Africa Centre of Excellence for Public Health and Toxicological Research (ACE-PUTOR), University of Port Harcourt, Nigeria

Abstract:- **Background:** Modern contraceptives prevent unintended pregnancy, unsafe abortion and maternal and infant deaths, yet contraceptive use in Nigeria remains low and uneven. In Anambra State, the 2024 Nigeria Demographic and Health Survey (NDHS) found that 58.7% of sampled women used no method. Such statistics cannot explain why women who know about and accept contraception still do not use it.

Objectives: To explore (1) perceived barriers to contraceptive use, (2) women's experiences of contraceptive use, including perceived effectiveness, side effects and interactions with healthcare workers, (3) how women make decisions about contraceptive use, and (4) the advice women offer to other women, comparing rural and urban communities in Anambra State.

Methods: A phenomenological qualitative design, guided by the Health Belief Model, was used as the qualitative strand of a parallel convergent mixed-methods study. Twelve women leaders (executive members of town women's associations), one from each of 12 Local Government Areas (six urban, six rural) across the three senatorial zones, were purposively selected. In-depth interviews of about 45 minutes were held in English or Igbo during the women's annual August meetings, using a semi-structured guide. Interviews were audio-recorded, transcribed verbatim and thematically analysed with NVivo, and continued until thematic saturation.

Results: Eight themes emerged. For barriers: (1) partner approval, authority and secrecy; (2) uneven access to services; (3) fear of side effects and bodily change; (4) misinformation and community narratives; and (5) context-dependent religious and cultural influence. For experiences: (6) perceived effectiveness and method experience; (7) health worker counselling and service encounters; and (8) contraception as family wellbeing. Decision-making ran along a continuum from joint agreement, through husband-led decisions, to covert individual use. Women's advice was consistent across settings: seek counselling, obtain methods from health facilities, discuss with the partner where possible, and ignore rumours. Rural accounts described stronger partner control, fear of marital violence, privacy concerns, distance, transport costs, staff shortages and stock-outs, whereas urban accounts centred on side effects, provider competence and work schedules.

Conclusion: Women in Anambra State generally regard contraceptives as effective and beneficial, but use is constrained by partner authority, fear of bodily harm, misinformation, uneven service quality and religious or cultural norms, with rural women facing the heaviest combination of barriers. Programmes should combine client-centred counselling, couple and male engagement, confidential services, community-based correction of myths, and improved rural service delivery.

Keywords*: Contraceptive use; women of reproductive age; experiences; decision-making; barriers; rural–urban; qualitative study; Anambra State; Nigeria.*

1. Introduction

Contraception is one of the most cost-effective public health interventions. By helping women prevent unintended pregnancy and space births, it reduces unsafe abortion, pregnancy-related complications and maternal and child mortality, and it supports women's education, employment and autonomy (World Health Organization [WHO], 2025; Yeboah et al., 2023). Access to contraception is also a rights issue. Since the 1994 International Conference on Population and Development in Cairo, family planning has been framed as part of sexual and reproductive health and rights, and Sustainable Development Goal target 3.7 commits countries to universal access to family planning services by 2030 (United Nations, 2019).

Despite this, the gap between women's reproductive intentions and their ability to act on them remains wide. Globally, an estimated 164 million women of reproductive age who want to avoid pregnancy have an unmet need for contraception (WHO, 2023). Sub-Saharan Africa has some of the lowest levels of met need for modern methods and some of the highest fertility rates, partly because of low contraceptive use and high fertility preferences (Dasgupta et al., 2022). The consequences are serious. About 260,000 women died of pregnancy-related causes in 2023, and most of these deaths occurred in low- and lower-middle-income countries and were preventable (WHO, 2025). Many are linked to unintended, closely spaced or unsafe pregnancies.

Nigeria shows both progress and persistent gaps. The 2024 Nigeria Demographic and Health Survey (NDHS) reported that 20% of currently married women aged 15–49 used a contraceptive method, 15% a modern method, and that modern use was higher in urban areas (22%) than rural areas (10%) (National Population Commission [NPC] & ICF, 2025). In Anambra State, the same survey indicated that 58.7% of sampled women used no method (NPC & ICF, 2025), and an estimated 174,200 women of reproductive age had unmet family planning needs (Anambra Fact Sheet, 2019). The state has high literacy and a dense network of health facilities, so low use cannot be explained by lack of schooling or services alone.

Studies in Nigeria and elsewhere show that barriers to contraceptive use go beyond knowledge. They include fear of side effects, misconceptions, partner opposition, religious and cultural beliefs, cost, distance and provider attitudes (Ahuru & Nzoputam, 2020; Ezugwu et al., 2021; Kasso & Abam, 2023; Fasanu et al., 2025). In Port Harcourt, fear of side effects was the leading barrier, and women described rumours that implants are derived from pigs, cause cancer or lead to infertility, as well as partner disapproval that could lead to conflict or expulsion from the home (Kasso & Abam, 2023). In Osun State, health concerns, spousal disapproval, religious and sociocultural norms and health-system factors such as staff shortages and unofficial fees were the main barriers (Fasanu et al., 2025). In rural Tanzania, young married women feared heavy bleeding and infertility, and some husbands opposed use because they valued large families (Lee, 2021).

Most Nigerian evidence of this kind comes from facility-based samples, such as antenatal or family planning clinic attendees. These women have already reached services and may differ from women in the wider community. Few studies have explored, in women's own words, how barriers and experiences differ between rural and urban settings in the south-east. Survey statistics show how many women use contraceptives. Qualitative accounts are needed to show why women accept, delay, hide or abandon use, and how these decisions are negotiated within marriages and communities. This matters for programme design: if the obstacles are mainly interpersonal and social, then information campaigns alone will not close the gap.

The study was guided by the Health Belief Model (HBM). The model proposes that health actions depend on perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy, moderated by demographic and social factors (Alyafei & Easton-Carr, 2024; Baker et al., 2015). Applied to contraception, women are more likely to use a method when they perceive a risk of unintended pregnancy and believe the benefits (birth spacing, health, family finances) outweigh the barriers (cost, side effects, partner or religious disapproval), and when cues such as counselling or a partner's encouragement prompt action. The qualitative strand examined chiefly perceived barriers, perceived benefits and cues to action.

1.1 Objectives of the Study

1. To explore perceived barriers to contraceptive use among women of reproductive age in rural and urban communities in Anambra State.
2. To explore women's experiences of contraceptive use, including perceived effectiveness, side effects and interactions with healthcare workers, in rural and urban communities in Anambra State.
3. To examine how women of reproductive age make decisions about contraceptive use in rural and urban communities in Anambra State.
4. To explore the advice women of reproductive age offer to other women regarding contraceptive use, and how these perspectives compare between rural and urban communities in Anambra State.

2.1 Research Questions

1. What do women of reproductive age in rural and urban communities in Anambra State perceive as barriers to contraceptive use?
2. What are women's experiences of contraceptive use, including perceived effectiveness, side effects and interactions with healthcare workers, in rural and urban communities in Anambra State?
3. How do women of reproductive age make decisions about contraceptive use in rural and urban communities in Anambra State?
4. What advice do women of reproductive age offer to other women regarding contraceptive use, and how do these perspectives compare between rural and urban communities in Anambra State?

2. Methods

2.2 Design and Philosophical Stance

This was the qualitative strand of a parallel convergent mixed-methods study. The quantitative and qualitative strands were conducted concurrently, analysed separately and integrated at interpretation (Creswell & Plano Clark, 2018). The qualitative strand used a phenomenological approach, which aims to understand individuals' experiences and the meanings they attach to a phenomenon. Here the phenomenon was contraceptive use and non-use as lived within marriage and community. The study took an interpretive stance, treating women's accounts as situated, socially constructed meanings rather than fixed facts. Reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ).

2.3 Setting

Anambra State is in south-eastern Nigeria, with its capital at Awka. It has three senatorial zones (Anambra North, Central and South) and 21 Local Government Areas (LGAs). The population is predominantly Igbo and Christian, with a minority practising traditional religion. The state has commercial and industrial hubs (Onitsha, Nnewi, Awka) and rural farming communities. It has 575 primary health centres, 37 secondary and two tertiary facilities.

Many Igbo women belong to town or village women's associations whose annual "August meeting" brings married women home to their towns of origin. These gatherings gave access to a large number of women and to their elected leaders, and they are the setting in which community norms about family life are discussed.

2.4 Participants and Sampling

Purposive sampling was used. Four LGAs (two urban, two rural) were chosen from each senatorial zone, giving 12 LGAs. In each LGA, one executive member of the women's association, in a town selected for its rural or urban character, was invited to take part. Executives were chosen for their leadership role, knowledge of women's affairs in their community, and active involvement in organising the August meeting. The aim was depth rather than statistical representation, consistent with qualitative principles on data saturation (Boddy, 2016; Creswell & Poth, 2018).

Inclusion criteria: women aged 15–49 years resident in the community, willing to participate. *Exclusion criteria:* women with severe mental illness impairing communication, women unable to communicate in English or the local language without a translator, and women who did not consent.

Twelve interviews were conducted, six in urban and six in rural communities, and interviewing stopped when no new themes emerged. Where recorded in the transcripts, participants were aged 35–49 years, married, Christian (Anglican or Catholic), mostly tertiary-educated, and mostly civil servants with three to five children. Participant characteristics are in Table 1.

Table 1: Characteristics of the interview participants (n = 12), as recorded in the interview transcripts

ID	Setting	Age (years)	Education	Occupation	Children	Denomination	Contraceptive experience reported
P01	Urban	49	Not recorded	Civil servant	5	Christian	Condom
P03	Urban	Not recorded	Not recorded	Civil servant	3	Anglican	Condom; IUD considered
P04	Urban	43	Not recorded	Civil servant	4	Christian	Jadelle implant
P07	Urban	39	Tertiary	Civil servant	3	Christian	Condom
P08	Urban	Not recorded	Not recorded	Not recorded	Not recorded	Not recorded	Jadelle implant
P09	Urban	Not recorded	Not recorded	Not recorded	Not recorded	Catholic	Implant, then pills
P02	Rural	35	Tertiary	Civil servant	3	Catholic	Natural method
P05	Rural	39	Tertiary	Civil servant	3	Anglican	Condom
P06	Rural	35	Not recorded	Not recorded	Not recorded	Christian	Pills
P10	Rural	Not recorded	Not recorded	Not recorded	Not recorded	Not recorded	Injectables
P11	Rural	Not recorded	Not recorded	Not recorded	Not recorded	Catholic	Pills
P12	Rural	39	Tertiary	Civil servant	3	Christian	Ovulation method; pills earlier

All participants were married.

2.5 Data Collection

A semi-structured interview guide was prepared in English and translated into Igbo where needed. It had two parts. The first covered perceived barriers: partner approval, cost, distance and availability, reasons for non-use, community information and misinformation, and religious or cultural influence. The second covered experiences: effectiveness of methods used, encounters with health workers, concerns or fears, how decisions are made and who influences them, benefits for family wellbeing, and advice to other women (Table 2). The guide was reviewed by the project supervisors and a research analyst for clarity and relevance.

Table 2: Interview guide domains

Domain	Illustrative question
Partner influence	How does your partner's approval or disapproval influence your decision to use contraceptives?
Access	Do cost, distance to health facilities, or availability of services affect your use? If yes, how?
Reasons for non-use	What reasons, if any, have prevented you from using contraceptives in the past or currently?
Information	What information or misinformation about contraceptives have you heard within your community?
Religion and culture	In what ways do religious beliefs or cultural practices influence your decisions?
Effectiveness	Can you share your experience with the effectiveness of any method you have tried?
Providers	Describe your experience with health care providers when seeking contraceptive advice or services.
Decision-making	How do you decide whether or not to use contraceptives, and who influences your decision?
Wellbeing	How does contraceptive use contribute to the wellbeing and financial planning of your family?
Advice	What advice would you give other women concerning using contraceptives?

Interviews were arranged by appointment and held during the August meetings by the first author, with four trained research assistants supporting logistics. Interviews lasted about 45 minutes, were conducted in English or Igbo according to preference, and were recorded on audio tape with written notes. The interviewer introduced herself as a doctoral student, explained that the information was for academic purposes only, and obtained verbal consent before every interview. Participants were encouraged to tell their stories in detail without hesitation.

2.6 Data Analysis

Recordings were transcribed verbatim, and Igbo passages were translated into English. Analysis followed the steps of thematic analysis. The first author read each transcript repeatedly, coded the data inductively with NVivo, and grouped codes with similar meaning into categories and then candidate themes. Candidate themes were checked against the full data set, refined, named and organised under the research objectives. Rural and urban transcripts were compared for similarities and differences. Contrasting (deviant) cases, such as participants who concealed contraceptive use or whose husbands refused entirely, were purposely examined to avoid over-stating consensus. Quotations are lightly edited for punctuation only, and ellipses mark omitted text.

2.7 Rigour and Reflexivity

Credibility was supported by face and content review of the guide, prolonged engagement during the meetings, and discussion of coding and themes with the supervisors. Dependability and confirmability were supported by an audit trail of transcripts, codes and theme development. Thick description of the setting and participants supports transferability. The researcher is a midwife and an Igbo woman from the region. This probably helped rapport and understanding of idiom, but it may also have shaped the questions asked and her interpretation, for example when she probed participants about hiding contraceptive use from husbands. This was managed through supervision and by returning to the transcripts when themes were refined.

2.8 Data Management and Presentation of Findings

Audio files and transcripts were stored on a password-protected computer accessible only to the research team, and participants were identified by code throughout. Where participants used Igbo expressions, the translation

was checked against the recording by a second Igbo-speaking member of the team. In the Results, each quotation is attributed to a participant code and setting, so readers can see whether a view came from an urban or a rural woman. Quotations were selected because they illustrated the range of views within a theme, and not because they were the most dramatic. Where only one woman held a view, this is stated, so that single accounts are not mistaken for general patterns.

2.9 Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee of the University of Port Harcourt ([**Ethical Approval Code:** UPH/CEREMAD/REC/MM111/030 **Date:** 1st July, 2025) and from the Planning, Research and Statistics Department of the Anambra State Ministry of Health ([**Reference:** MH/PRS/424/VOL.226 **Date:** 25TH NOVEMBER, 2025). Copies of the approvals and the introductory letter were presented to community leaders and women's executives, who permitted data collection during the meetings. Participants were informed of the study's purpose and gave consent. They were assured of anonymity and confidentiality, that they would not be exposed to any hazard, and that participation was voluntary with the right to withdraw at any time. Participants are identified only by code.

3. Results

Eight themes were identified and mapped to the objectives (Table 3). Participants are identified by code (P01–P12) and setting.

Table 3: Summary of themes by objective

Objective	Theme	Sub-themes
1. Barriers	1. Partner approval, authority and secrecy	Spousal support; husband's authority; fear of conflict or violence; concealed use
	2. Uneven access to services	Free and nearby services; distance and transport costs; stock-outs; shortage of providers; work schedules; privacy
	3. Fear of side effects and bodily change	Weight gain or loss; bleeding; hormonal imbalance; future infertility; dizziness and headache
	4. Misinformation and community narratives	Cancer, infertility, hypertension, reduced sexual satisfaction; stories from friends; confusion over methods
	5. Religion and culture as context-dependent	Catholic doctrine; Igbo pro-natalism; elders' views; supportive interpretations
2. Experiences	6. Perceived effectiveness and method experience	Condoms, implants, injectables effective; adherence with pills; natural methods
	7. Health worker counselling and service encounters	Friendly, knowledgeable providers; rushed or incomplete counselling; fear of poor insertion
	8. Contraception as family wellbeing	Spacing; caring for children; saving money; maternal health
3. Decision-making	Cross-cutting theme: from joint agreement to covert autonomy	Joint agreement; husband-led decisions; covert individual use
4. Advice and comparison	Cross-cutting theme: women's advice and rural–urban contrasts	Seek counselling; discuss with partner; ignore rumours; rural–urban differences

Objective 1: Perceived Barriers to Contraceptive Utilization

Theme 1: Partner Approval, Authority and Secrecy

Partner influence was the strongest and most contrasting theme. It acted as a facilitator where husbands were supportive and as a barrier where they were not. Five of the six urban participants described husbands who approved of contraception, and some husbands encouraged it for the sake of the family.

"My husband approves of my use of contraceptive. He doesn't have any problem with that." (P03, urban)

"My partner gave his approval to the use of contraceptives. When I told him after our last baby, he said I should go on." (P04, urban)

"They play supportive role in ensuring that our women engage in the use of contraceptives." (P01, urban)

One urban participant (P09) was the exception. She concealed use because she expected refusal:

"I don't tell him about my contraceptive, how I use it… He will not agree." (P09, urban)

In rural accounts, partner opposition was more frequent and more forceful. Husbands objected because of beliefs that children are given by God, or that contraceptives would impair a couple's ability to conceive when they wanted another child.

"My partner doesn't approve using contraceptive because he believes that when we are ready for another, to have another child, stories might come in. So, that's why he disapproves of using it." (P02, rural)

"My partner refuses completely because his decision is that he knows that God is the provider of children and He's the one that gives children." (P10, rural)

Fear of marital conflict and violence led some women to avoid contraception altogether:

"For now, I don't use it because I fear my husband. I cannot disobey him because of his decision." (P10, rural)

"My husband doesn't like it. So, to avoid having conflict in my marriage or sometimes leading to quarrels and all that or beating me, I try to avoid it. That is why I don't use it anymore." (P11, rural)

Others used contraception covertly and went to great lengths to avoid detection. For P02, the problem was not only the husband but the community's capacity to report back to him:

"I normally don't use the facility close to me for the fear of him seeing me or anybody that knows him, that knows me, might go and report me to him. So, I normally don't use facility that is close to me. I prefer using the ones that is very far away from where we stay." (P02, rural)

A more negotiated form of male influence appeared in P06's account. Her husband initially did not agree, but changed his mind after attending health education sessions, and she still located the final decision in his role as head of the family.

"He said he had some health workers talking about that and he now put interest on that. At least for the health of the wife and the children." (P06, rural)

Taken together, these accounts show that a husband's position often settled the question before any health consideration arose. They also show that men can be persuaded. Exposure to health workers' messages moved one husband from refusal to support, which is consistent with the idea of health education as a cue to action.

Theme 2: Uneven Access to Services

Access was experienced very differently across participants. Several urban women described services as free, close and reliable.

"In fact, it's cost effective. It is free. In all our health centers. And the health centers are everywhere in our community." (P01, urban)

"No, the centre is close to our place so, nearness is not a problem and then is always available." (P04, urban)

Condoms were also easily obtained from pharmacies: “It doesn’t affect because is affordable. The condom we get is always available, distance and cost is not a barrier” (P03, urban). Another participant observed that family planning “is not costly” and “is available whenever they go there” (P12, rural).

For other women, access was a real barrier, and rural accounts were most affected. Distance and the cost of transport were named, as was the absence of the preferred method:

“Yes, because of transportation. And that makes my clinic visits difficult. And the health facility is not close to where I am living… And these are too costly now. The transportation from my place to the place where I used to go for health counseling.” (P10, rural)

“The availability of a particular one that I needed in the health center wasn’t there. So, I have no option than to stop it.” (P11, rural)

Shortages of trained providers were reported. One participant said health workers “are not always available… You may go there, you will not see them,” adding: “The one that is there is always working alone. He has many things to do. That makes it hard not to attend to clients” (P06, rural). P02 reported that the method she wanted, such as an IUD or implant, “will not be available” at times. An urban participant also reported distance, stock-outs and cost:

“The health center sometimes is very far and even on getting there sometimes, they will not tell you that it’s not there. So, in such of that is what affects me most. So, it’s not all available all the time.” (P09, urban)

Time was an additional barrier for working women. A participant who wanted an IUD explained that “due to the work, the tight schedule of my work, I didn’t have time to go, so I opted for the second option,” which was condoms (P03, urban).

Theme 3: Fear of Side Effects and Bodily Change

Concerns about the body were among the most widespread barriers in both settings. Women worried about weight gain or loss, bleeding, hormonal imbalance, dizziness, headache and future infertility. Weight was a particular concern.

“In fact, I’m big. And from the information I heard before, from people who use IUD, they complain that it makes someone to get bigger, get fatter. And I don’t need to be fat.” (P01, urban)

“I am of the impression that it’s hormonal imbalance. And because I am on the big side, I don’t want anything that will come and add to the already existing fat in my body.” (P02, rural)

For some women, fear was based on personal experience. A participant who used Jadelle explained: “The only reason is that the one I used, I started gaining weight, so weight is the problem I am having… that is why me and my husband thought of stopping for now and watch the weight” (P04, urban). She had used the method for more than three years, and the weight gain began in the fourth year. Another, who had used pills, reported: “Sometimes, I feel somehow dizzy. Sometimes, I feel weak or there seems some headache” (P09, urban).

Fears about fertility were especially strong among rural women. One said: “I’m worried about hormonal imbalance so that it won’t fail me next time I want to get pregnant. Then also, obesity” (P06, rural). Another had stopped pills because “I feared that I might not get pregnant by the time I will remove it” (P12, rural). Fear also shaped method choice, not only general uptake. One participant avoided implants and other hormonal methods in favour of condoms: “I wouldn’t want the one that would have any issue on my hormone” (P05, rural). An urban condom user, meanwhile, worried about a different problem: “sometimes it breaks and I react to the latex” (P01, urban).

Theme 4: Misinformation and Community Narratives

All participants had heard negative claims about contraceptives in their communities. These included cancer, permanent infertility, continuous bleeding, hypertension, weight gain or loss, and reduced sexual satisfaction.

"They said with contraception, you will not give birth again, that with contraception, you will even develop cancer, with contraception, bleeding every time." (P04, urban)

"They said it causes cancer because it stayed in the body for a long period of time. Then some said that it reduces their sexual satisfaction." (P06, rural)

Rural women tended to ground their fears in specific stories about friends and neighbours, which made them more persuasive:

"I have a friend that did implants… when she's not ready to have a child, no baby was forthcoming for over 10 years now. And I also have a friend that after doing implants, she started having high blood pressure and the rest." (P02, rural)

This participant could recall only negative information: "None, none, honestly" when asked about positive information. Another reported "so many stories within the community about the people that have used it," with some becoming bloated or infertile (P11, rural). A participant who had stopped pills because of cancer and bleeding rumours also acknowledged a positive view, "family planning is good in the sense that it will help you to space your children" (P12, rural).

In contrast, urban women often evaluated rumours against their own experience. P04 said that of everything she had heard, "I didn't take any of them serious, just the weight that I am gaining." The rumour about weight gain was the one that matched her lived experience, so she did not dismiss it. There was also confusion about methods. One participant noted: "I heard of artificial, I heard of natural method of family planning. So, for me to make a suitable one, it becomes a confusion" (P06, rural).

Theme 5: Religion and Culture as Context-Dependent Influences

Religion and culture did not influence participants uniformly. Some described them as barriers, and others as neutral or even supportive.

Catholic participants described doctrinal disapproval: "From the religious aspect, as a staunch Catholic, we are against the use of contraceptive, because it's a sin" (P02, rural). "As a Catholic member, I know we are fanatic with our religion. The church disapproved it. So, it is a sin if we go ahead of it according to our own belief" (P09, urban).

Culture was discussed mainly in terms of Igbo pro-natalism and the role of elders:

"We are Igbos and Igbos believe in children. Their culture, they believe in having more children. So many children. So, it affects the way people use it sometimes. Even in my own marriage, it affects it." (P11, rural)

"Our elders there, in my community, they discourage the use of contraceptives. They don't like it. Because they believe that children is what comes naturally." (P10, rural)

Other participants reported no cultural or religious opposition and offered a supportive reading. An Anglican woman said: "My religion doesn't affect my decision on the use of contraceptives, they only tell you to have the number of children that you are able to cater for" (P03, urban). Another reported: "Both cultural and religion, they don't have a strong opposition concerning the contraception. You are free to use any one you like" (P06, rural). One participant said her church encouraged the ovulation method specifically (P12, rural). The pattern suggests that denomination, local interpretation and the husband's religious convictions all mattered, and that religion can open as well as close the door to family planning.

Objective 2: Women's Experiences of Contraceptive Use

Theme 6: Perceived Effectiveness and Method Experience

Women who had used methods generally judged them effective at preventing pregnancy, whether condoms, implants, injectables or natural methods.

"For the past three years now, it has not failed me, so the experience has been okay and we don't have any complaint. My husband does not complain, I don't complain about it, we are okay with that." (P03, urban)

"When I used the Jadelle, I am very very okay with it. I don't even feel any pain… Nothing like pregnancy." (P04, urban)

"Use of injections or injectables… for two years now, there's no sign of pregnancy… It's effective." (P10, rural)

A participant who had used an implant said it was "very effective… I enjoyed my marriage. I enjoyed having sex with my partner" (P09, urban), which shows that effectiveness was tied to the quality of marital and sexual life as well as to pregnancy prevention.

Effectiveness was also linked to correct use. Two women who used pills became pregnant after missing doses, but still considered the method effective when used correctly. "I tried using pills, but when I missed one… because of that, I got pregnant… If I use it very well, it should be effective" (P06, rural). Another said: "You have to monitor it. You have to use it as at when due" (P11, rural). One woman using natural methods reported that "it has been working for me to some extent, because my last baby is two years plus" (P02, rural), while another using the ovulation method observed that it "is effective only that it fails when one wants to use it for sex selection" (P12, rural).

Positive experiences coexisted with side effects. One Jadelle user described initially heavy and fluctuating menses, which stopped after treatment from the family planning matron, and then weight gain in the fourth year (P04, urban). Husbands' views on method also mattered. A condom user said her husband "is not comfortable with it" because of breakage and her own latex reaction (P01, urban), while a rural participant noted that some women and her own husband felt condoms reduced sexual satisfaction (P06, rural).

Theme 7: Health Worker Counselling and Service Encounters

Most urban participants and some rural participants described health workers as friendly, knowledgeable and supportive, and their counselling as central to choosing a method.

"My experience with healthcare providers have been good, yes. They give proper counselling for me to make choice of the suitable one for me and they also encourage me to come for it as a means of family planning." (P03, urban)

"I met the matron they said is in charge of family planning unit, she counseled me, she talked to me and told me the types, how they work and then after every explanation, I now decided I should go for that of my choice. I don't have issue with them. They were friendly." (P04, urban)

"They were so nice. They gave me a listening ear. They directed me… and they have knowledge on that." (P09, urban)

Rural accounts were mixed. Some praised providers: "They explain things to me the way I would understand it" (P10, rural), and "they are very caring. They will teach you everything, every method. Is left for you to choose the one you want" (P12, rural). Others described rushed consultations because of heavy client loads and staff shortages:

"Because of the influx of a lot of patients, they don't normally have the time to counsel you well. They will be kind of rushing you to speak up so that they will attend to other patients waiting for them." (P02, rural)

"They will rush things. Even when you are asking them some questions, they will be like, let me do it. I have somewhere an important workshop to attend." (P06, rural)

Others said explanations were correct but not detailed enough: "The explanation will be correct. They will not just give you the explanation fully… it will not be that in detail" (P11, rural). Trust also depended on technical skill. One urban participant feared insertion of an implant after a friend's reported injury: "Maybe the nurse didn't put it well or insert it well. So, from there she started developing some pains and some other injuries. So, I'm having fear on how to get a reliable source of professionalism" (P09, urban).

Theme 8: Contraception as Family Wellbeing

Participants valued contraception for more than preventing pregnancy. They linked it to child spacing, caring for children, household finances and maternal health.

"It has helped me to prevent unwanted pregnancies, thereby helping me to enjoy motherhood. Being able to train the ones I already have and prepare myself for another pregnancy when I'm ready." (P01, urban)

"In my family, it helps us to save money. Economically, it helps us to train up our children. Get time to gather, get time to work in order to provide for the family." (P01, urban)

"Considering the economic situation of this country, honestly I don't think I will continue encouraging people to go for contraceptive. Is good, is good." (P04, urban)

Rural participants stressed spacing and health. "It helps in spacing of children… it will help me to space the number of children that I want to have" (P10, rural). A participant who had spaced her three children by about two years each through the ovulation method said "family planning is good in the sense that it will help you to space your children" (P12, rural). One husband accepted contraception "at least for the health of the wife and the children" (P06, rural).

Objective 3: How Women Make Decisions about Contraceptive Use

Cross-cutting Theme: From Joint Agreement to Covert Autonomy

Decision-making accounts fell along a continuum. At one end were couples who agreed on family size and method together. One woman explained: "Before we started giving birth, we agreed that we will have three children… after that, we both agreed to stop at that number and it was the two of us that agreed on the current contraceptive we are using" (P03, urban). Another said: "Nobody, except my husband. Is just the decision of me and my husband" (P04, urban). P12, whose husband disliked contraceptives, said that "if we must use it, it will be a joint decision."

In the middle were husband-led decisions, in which the woman received counselling but the husband made the final choice. "My husband decides because he's the head of the family. But that should be done after counselling" (P06, rural). "My husband discourages it. So, practically, he's the one that decides" (P02, rural). "It is my partner that normally affects the decision" (P11, rural).

At the other end were women who decided alone and in secret. They justified this as an exercise of agency, and often voiced both resolve and fear:

"My decision alone is without my husband's knowledge… I'm a woman, I know what I want. And I'm the one that will bear the pains and the burdens of this." (P10, rural)

"It's only me that decides on it… I don't have the authority to stand that." (P09, urban)

Even covert users worried about discovery. P10 feared that "by adventure" her husband would find out and "I fear the outcome," because she might want to confide in his relatives about what she was passing through. These accounts show that covert contraceptive use is an act of self-protection but one carried with anxiety.

Objective 4: Advice to Other Women and Rural–urban Comparison

Women's Advice

Advice was consistent across settings. Women urged others to seek counselling before choosing a method, to obtain methods from health facilities, to discuss with partners where possible, and not to rely on rumours.

"You need to be counseled on the one that will be suitable for you and your partner… discuss with your husband and seek his consent before you choose anyone." (P03, urban)

"I will tell them not to always listen to rumours. Let them get the correct information from the health centre. Instead of hearing more and more rumours from the village." (P06, rural)

"Once you confide with your health worker, health provider, they will help you, they will assist you, they will guide you. So, at the end, you know that you follow the right step." (P10, rural)

Another woman proposed inviting the family planning matron to address her association, "because it is very vital," and said she would tell the main leader to do so (P04, urban). One rural participant cautioned that women with fears should not be forced: "if you have any fear of using any of the methods, please don't go for it" (P02, rural). A participant who first advised joint decision-making noted that "your partner might have another reason, you might have another reason" (P11, rural), so decisions should be coordinated.

Rural–urban Contrasts

Table 4 summarises how accounts differed by setting. Partner opposition, violence, privacy, distance, transport costs and staff shortages were mostly rural concerns. Urban women emphasised counselling quality, provider competence, side effects and work schedules. Fears about side effects and misinformation were shared, but rural women more often grounded them in specific local stories.

Table 4: Contrasts between rural and urban accounts

Domain	Urban accounts	Rural accounts
Partner role	Mostly supportive or joint; one concealed use	Frequent opposition; husband as final authority; fear of conflict or beating; covert use
Access	Free or nearby services, pharmacies; occasional stock-outs and cost	Distance, transport costs, stock-outs, absent or overstretched providers
Privacy	Not raised	Avoiding nearby facilities for fear of being reported to husband
Side effects	Weight gain, menstrual change, dizziness	Weight, bleeding, fertility, hypertension, drawn from local stories
Religion/culture	Mostly neutral; Catholic disapproval in some	Catholic doctrine, Igbo pro-natalism and elders' views more prominent
Provider experience	Largely positive; concern over insertion competence	Mixed: supportive, but rushed and incomplete counselling

4. Discussion

This study explored, in women's own words, the barriers to and experiences of contraceptive use in rural and urban Anambra State. Women generally believed that contraceptives work and benefit their families, but use was shaped by partner authority, fear of bodily harm, misinformation, uneven services and religious or cultural beliefs. These accounts support a view of contraceptive use as a negotiated social practice rather than only an individual health choice. This helps to explain a finding from the quantitative strand of the same study, in which moderate knowledge and acceptability were not associated with utilization.

Partner Influence: Partner approval emerged as both the strongest facilitator and barrier. The finding that husband disapproval limits use is consistent with reports from Delta, Enugu and Osun States (Ahuru & Nzoputam, 2020; Ezugwu et al., 2021; Fasanu et al., 2025) and with qualitative evidence from Enugu that patriarchal beliefs lead many married women to use methods without their husband's knowledge (Okonkwo et al., 2024). Our data add detail on how male authority operates. Opposition was grounded in religious reasoning and fertility fears, women described fear of conflict and physical violence, and some used methods covertly and travelled to distant facilities to avoid being seen. Covert use has also been described among women with rheumatic heart disease in Uganda (Kamalembo et al., 2025) and in Port Harcourt, where disapproval could lead to conflict or expulsion (Kasso & Abam, 2023). Women whose husbands supported contraception, or who were persuaded by health education (P06), described stable use. This supports male involvement strategies, as other studies have also found that husband support increases use (Shiferaw et al., 2023). Yet P09 and P10 show that services which require

partner consent will exclude women with unsupportive husbands, so confidential options must be preserved. The ethical tension is real: promoting couple counselling is sensible, but it must not expose women to violence.

Access: Cost and distance were not universal barriers; for many women services were free or near. This pattern echoes survey findings from the quantitative strand, where about nine in ten women found contraceptives accessible. But rural women faced transport costs, stock-outs, absent or overstretched providers and the need to travel to avoid being seen. These health-system barriers agree with reports from Osun and Tanzania (Fasanu et al., 2025; Lee, 2021) and with evidence that proximity and a wide choice of methods increase use (Kraft et al., 2022). The unmet demand for a preferred method, leading one woman to stop altogether, shows how stock-outs interrupt use. Access is therefore not only a question of whether a facility exists. It also concerns whether the right method, a trained provider and an affordable journey are available on the day, and whether the woman can attend without being seen.

Side Effects and Misinformation: Fear of side effects was the most consistent barrier across settings and matches earlier Nigerian and international studies (Kasso & Abam, 2023; Ahuru & Nzoputam, 2020; Raga et al., 2023). Our data show that some of these fears were real experiences (weight gain on Jadelle; dizziness on pills), not only rumours. This supports the call to distinguish myths from genuine adverse effects in counselling, and to offer method switching and follow-up, since irregular bleeding is a leading reason for discontinuation in Nigerian clinic data (Inuwa et al., 2024). In rural accounts, rumours were anchored in named friends, which makes them more credible than abstract claims. Health Belief Model language fits well: perceived barriers (weight gain, infertility, cancer) were weighed against perceived benefits (spacing, family finances), and, for those who persisted, cues to action such as counselling and spousal agreement tipped the balance (Alyafei & Easton-Carr, 2024). The woman who accepted the rumours about cancer and infertility but not the weight-gain rumour that she herself experienced shows that women test community information against their own bodies.

Religion and Culture: Religious and cultural influence varied. Catholic doctrine and Igbo valuation of children were barriers for some, whereas Anglican and other participants interpreted their faith as supporting responsible family size. This agrees with studies that found religion a leading barrier in Enugu (Ezugwu et al., 2021) and with findings that it can be both barrier and facilitator depending on interpretation (Lemu et al., 2024). Working with religious leaders and elders, who were described as gatekeepers, should therefore be context-specific rather than assuming a single position. Church-based support for natural methods, as one participant described, may be an entry point for counselling on fertility awareness-based methods, although these are less effective than modern methods when used imperfectly.

Rural–urban Patterns in Context: The contrast between settings was one of degree and not of kind. Urban and rural women both feared side effects, heard rumours and weighed religious teaching. What differed was how many barriers accumulated on the same woman. A rural woman who must travel far, pay for transport, risk finding her method out of stock, hide the visit from her husband and face an elder's disapproval carries a combination of obstacles that an urban woman with a nearby free clinic and a supportive husband rarely meets. This accumulation is consistent with national figures showing that modern method use among married women is less than half as high in rural areas as in urban areas (NPC & ICF, 2025), and it suggests that single-component interventions, such as stocking more commodities or running a radio campaign, will help only where the other barriers are already low. Packages that address supply, counselling and social support together are more likely to reach rural women.

Experiences with Providers: Women valued counselling and friendly providers, and the positive urban accounts contrast with studies reporting inadequate counselling (Kamalembo et al., 2025). Rural women, however, described rushed and incomplete consultations resulting from staff shortages. Counselling quality matters because multiple counselling sessions have been shown to increase acceptance (Makins et al., 2018), and because counselling about a method strongly increased its acceptance in Ethiopia (Shiferaw et al., 2023). Fear about the technical competence of insertion is an under-reported dimension of trust and suggests that provider training and visible quality assurance for long-acting methods would help.

Advice as a Resource: Women's advice to others was consistent across settings and practical: seek counselling, use facilities, involve the partner where possible and distrust rumours. That rural and urban women gave the same

core advice, despite facing different obstacles, suggests a shared view of what good practice looks like, even where women cannot follow it themselves. Advice offered from experience also carries credibility that formal messages may lack, which is why peer networks such as women's associations are promising channels for health education.

Decision-making and Advice: The continuum from joint agreement to covert use is the study's central finding on autonomy. It shows that the Health Belief Model's individual-level constructs need to be read within relationships: a woman's perceived benefits and barriers are weighed alongside her husband's. Women's own advice (get counselled, get methods from facilities, talk to your partner, ignore rumours) is a ready-made community education message that programmes can adopt directly, and the proposal to invite the matron to address the women's association is a practical delivery channel that costs little. Because women's associations already meet every year, using them for health education requires no new structures, only the willingness of providers and leaders to take part.

Integration with the Quantitative Strand: In the survey strand, women had moderate knowledge and acceptability, but neither was associated with use, and few were comfortable discussing contraceptives with a partner or willing to recommend them. The interviews give the mechanism. Women know about and accept contraceptives in principle, but use depends on whether the husband agrees, whether the woman fears bodily harm, whether the preferred method and a competent provider are available, and what the church and elders say. The two strands therefore converge: closing the gap between knowledge and use requires more than awareness.

Strengths and Limitations: Strengths include coverage of all three senatorial zones, balanced rural and urban sampling, comparison across settings, and attention to deviant cases. Limitations should be considered. First, participants were 12 women leaders of town associations. They were all married, Christian, and mostly educated civil servants, so their views may not represent less educated, non-Christian, unmarried or adolescent women, and leaders may also have given socially desirable answers on a topic that is sensitive in their communities. Second, interviews were held at public gatherings, which could limit privacy, although they were done separately by appointment. Third, some transcripts had missing demographic details and transcription errors, which required verification against the recordings. Fourth, one interview per LGA limits within-LGA variation. Fifth, the interviewer's identity as a midwife may have influenced responses on provider experience. Findings are not meant to be statistically generalisable, but they offer transferable insight into settings with similar patriarchal and religious contexts.

Relevance to the Health Belief Model: The accounts add three points to the model. First, perceived barriers were not only personal beliefs about the method but also beliefs about what other people would do: a husband's reaction, a neighbour's gossip, a church's teaching. Second, cues to action were as often social as clinical. A husband who listened to health workers, a friend's story of an implant gone wrong, and a matron's explanation all acted as cues, in opposite directions. Third, self-efficacy, the confidence to carry out a behaviour, depended on whether a woman could act without her husband's permission. Women who described deciding alone did so with confidence but also with fear, which suggests that self-efficacy in this setting is bounded by relational risk. Models that treat the woman as the sole decision-maker will therefore under-estimate the obstacles she faces.

Roles of Stakeholders: The findings point to distinct responsibilities. Health workers need time and training to counsel well and to explain side effects honestly, including the fact that some, such as weight change, are real. Facility managers and the State Ministry of Health need to secure commodities and staffing in rural centres. Women's associations, which hosted this study, are natural partners for community education because participants trusted them and one proposed inviting a family planning matron to address the members. Church leaders and elders could be engaged on birth spacing and maternal health, building on the supportive interpretations some participants described. Husbands should be reached through couple-oriented sessions that frame contraception as protection of the wife's and children's health, the framing that moved one participant's husband from refusal to support.

Implications: Programmes should (1) provide client-centred counselling that addresses real side effects and myths, and ensure method switching and follow-up; (2) engage men, religious leaders and elders through couple

counselling and community dialogue; (3) protect confidentiality for women whose partners disapprove; (4) address rural stock-outs, staffing and outreach; (5) use women's associations and trusted providers as channels for accurate information, as participants themselves proposed; and (6) strengthen provider skills and visible quality for long-acting methods. Future research should include women who are not association leaders, unmarried and adolescent women, and husbands, and should test interventions that combine counselling, male engagement and confidential services.

5. Conclusion

Women of reproductive age in rural and urban Anambra State recognise contraceptives as effective and beneficial for spacing births and family welfare. Utilization is constrained by partner disapproval and male authority, fear of side effects, community misinformation, uneven service access and quality, and religious and cultural norms, with rural women facing the heaviest combination of barriers. Improving contraceptive uptake requires interventions that go beyond information: client-centred counselling, male and community engagement, confidential options, and better rural service delivery. Women themselves offered a simple agenda: be counselled by a trained provider, obtain methods from facilities rather than rumour, talk with your partner where it is safe to do so, and let community associations carry accurate messages. Programmes that listen to these voices and act on them are more likely to turn acceptance into safe and sustained use.

Declarations

Ethics Approval: Obtained from the University of Port Harcourt Research Ethics Committee and the Anambra State Ministry of Health Planning, Research and Statistics Department.

Consent to Participate: Informed consent was obtained from all participants.

Data Availability: De-identified transcripts are available from the corresponding author on reasonable request.

Competing Interests: None declared.

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