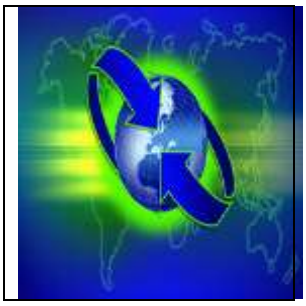

Planned Parenthood and Healthy Lifestyle: A Survey of Contraception in the Southeastern Region of Nigeria.

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Receive February, 2026, accepted and published April, 2026

Abstract

This study investigated contraceptive praxeology in three Southeastern States, Nigeria. Specifically, this study adopted the knowledge, attitude, and practices (KAP) survey to describe how knowledge of, attitude towards and practices of contraceptives explain contraceptive behavior. Using the purposive and convenience sampling techniques, a sample of 422 females (aged 15 – 49 years) and males (aged 15 – 64 years) was selected using the survey method. However, after checking for response completeness and usability, data from a final sample size of 344 respondents were used in this study. The quantitative data was obtained from a structured questionnaire personally administered by the researchers and their assistants, the research objectives were analyzed using descriptive statistics such as tables, frequencies, percentages, and maps. The findings of this study showed that knowledge of contraceptives was generally widespread, and attitude towards contraceptive tended to be positive, with a high contraceptive prevalence, although, this high rate was largely attributed to the use of traditional methods. Based on these findings, it was concluded that, high knowledge of, and positive attitudes towards contraceptives may not necessarily translate to practical use of modern contraceptives, and this may, among other reasons, be attributed to socio-cultural factors and misinformation from social media platforms, which appears to be the commonest source of contraceptive information. It was recommended that usage of modern contraception might be enhanced by mounting evidence-based re-education programmes beyond the so-called facts presented by social media platforms.

Keywords: Contraception, Knowledge, attitude and practices survey (KAP), Fertility, Population

Introduction

In a world where the human population is constantly on the rise, so also is the modification of the environment and the redistribution of the spatial patterns of human population. Inordinate population growth arising from high birth rates and low mortality are a problem for any country (Eni, 2025). From straining the country's infrastructure, such as health and medical facilities, to a shortage of food supply, malnutrition, and a rising cost of commodities and depletion of the general well-being of the people, the consequences of overpopulation cannot be emphasize enough (Cherie *et al*., 2025; Bradshaw, 2025; Mane *et al*.,

2023). Three broad factors (fertility, mortality and migration) contribute towards population dynamics in the world. Of the three factors outlined above, concerns about fertility have aroused great interest for government policymakers, demographers and academics alike (Atoyebi *et al*., 2025; Anson *et al*., 2019; Oluwaseun *et al*., 2014).

Fertility is the medium through which human being replaces themselves in order to continue their lineage on earth (Chandiok *et al*., 2016). High fertility rate is a major contributor to population growth in any country. The 2014 United Nations World Fertility Report defined high fertility as more than three children per woman over her reproductive career. A society's fertility level is directly impacted by the ratio of women and men using contraception to limit births and the effectiveness of the method they employ (Eni 2023). Use of contraceptive allows the individual or couples to effectively plan and space pregnancies, which is crucial for maternal and child health outcomes as well as economic growth (Eni, 2025; Hailegebreal *et al*., 2023).

The utilization of contraceptives plays a vital role in public health by significantly lowering the incidence of unintended pregnancies and, consequently maternal mortality, thus acting as a catalyst in alleviating poverty, empowering women and helping in the advancement of gender equality (Bass & Okuwa, 2026; Jyotsana *et al*., 2026; Guillen-Calle *et al*., 2025). Unintended pregnancy (defined as a mistimed or unwanted/undesired pregnancy) is a proxy indicator of humans not using contraceptives optimally, and it is prevalent among women across all ages of their reproductive cycle who engage in unprotected intercourse (Seruwagi *et al*., 2025; Hailegebreal *et al*., 2023; Lamina, 2015). Access to sexual reproductive health information among individuals of all reproductive ages and contraceptive autonomy are necessary for all individuals in the society to minimize the number of unintended pregnancies which is nearly half of the 121 million pregnancies recorded yearly and globally (Boakye *et al*., 2025; Oyinlola *et al*., 2024; Mane *et al*., 2023; United Nations Population Fund (UNFPA), 2022; Engelbert *et al*., 2021).

A healthy lifestyle is everybody's dream, and one way to achieve this is Planned Parenthood. The use of contraceptives is not only integral to healthy living but valuable for the fulfilment of the Sustainable Development Goals. Knowledge and use of contraceptive methods influences the efficient and continuous use of contraceptive which in turn is shaped by a host of drivers including people's educational level, positive attitudes and feedbacks from friends and families, lifestyle choices, and preference for large families or specific genders, (Hossain & Akter, 2025; Khan *et al*., 2025; Simiyu *et al*., 2025). Attitude towards contraception influences peoples choices and use of contraceptives. Despite this, understanding of contraceptive behavior, attitudes, and practice remains limited in certain regions, and this knowledge is imperative for enhancing and predicting reproductive health outcomes. Furthermore, there is a paucity of evidence in understanding contraceptive knowledge and behavior in Nigeria.

Although studies have reported increase in global contraceptive use, Nigeria contraceptive prevalence rates is still one of the lowest in the world (Bass & Okuwa, 2026; Hailegebreal *et al*., 2023; Etokidem *et al*., 2017). Moreover, contraceptive prevalence exhibits notable variation across regions and populations, with substantial unmet needs persisting in Nigeria. Therefore, the objectives of this study are to: i. examine the sources of contraceptive information in the study area, ii. analyse and map the respondents' attitudes towards contraceptives, iii. examine the residents level of knowledge of contraceptives and iv. evaluate the contraceptive prevalence rates. It is hoped that this study will shed light on the contraceptive patterns and behaviour in the South-Eastern region of Nigeria, thus contributing to studies on, and practice of Planned Parenthood.

Sources of contraceptive information

Contraceptive information and services are essential to the health and human rights of both males and females (World Health Organization (WHO), 2025). A strong relationship exist between contraceptive information (through mass media and advertisement) and contraceptive use. People who recall hearing or seeing contraceptive messages regularly, often end up using

one form of contraceptive or the other. With this in mind, great attention must be paid to the sources through which contraceptive messages gets to the target audience as even the correct information about contraceptives can be lost when using the wrong channel to disseminate that information, more so, negative information can also easily be spread about contraceptives using various sources (Kedida *et al*., 2025). Therefore, using the right channel to promote contraceptive messages cannot be over emphasized, because contraceptive behaviours to a large extent depend on how individuals obtain one or more information on contraceptives (Zakaria, 2025). Furthermore, it must also be noted that what works for one location may not necessarily work in another area, and adopting a wrong strategy may not guarantee a good result.

Attitudes towards the utilization of contraceptives

Attitudes towards usage of contraceptive are influenced by demographic factors including gender and partner support, age, educational level, among several factors. Findings on gender influence are mixed. While some studies report that women have the upper hand in contraceptive decision (Beyene *et al*., 2024), other reports suggest that men have the final say, while others report a jointly-made contraceptive decision (NDHS, 2018). Support especially by the husbands/men also greatly influenced contraceptive choices used by their partners (Kisaakye *et al*., 2025; Agyekum *et al*., 2022). With respect to age and education, younger women (aged 15 – 24 years) and those less educated (37.5% of the respondents with secondary school qualification) (Iluno *et al*., 2025) and no education (Gebremariam *et al*., 2025) tend to exhibit more negative or ambivalent attitudes towards contraceptive use.

In contrast, a study conducted in Ethiopia, showed that older women (aged 40-49 years) were less likely to use contraceptive compared to younger women aged (15 – 29 years) Hailegebreal *et al*., (2023). While women aged 30-39 years were also been cited as having negative attitudes towards the use of contraceptives in Southeastern Ethiopia (Gebremariam *et al*., 2025).

Knowledge, Attitude and Practices Survey (KAP) Model

The KAP is an acronym for Knowledge (K) (referring to the state of awareness of the various methods, types and source of contraceptive), attitudes (A) (the believe, feelings or disposition an individual have towards the use of contraceptives; acceptability, social norms and religious belief shapes an individual's attitude) and Practices (P) (the actual behaviour or the observable actions taken by an individual in the consistent and frequent use or discontinuation of or adherence to the use) of contraception (Nsubuga *et al*., 2016; Gumucio, 2011).

Sufficient contraceptive knowledge helps in shaping an individual's perceptions and decisions about family planning (Ajong *et al*., 2016). Researchers have found that highly educated women were more aware of contraceptive methods and family planning practices, which further increased contraceptives use amongst them (Eni, 2023; Shah *et al*., 2021). Contraceptive knowledge about the various methods available helps the individual make informed choices about the best and effective contraceptives to use (Pazol *et al*., 2015). Therefore, a lack of knowledge about the benefits and availability of modern contraceptive methods may pose a threat to contraceptive use (Eni & Essien, 2022; Mather *et al*., 2021; Shah *et al*., 2021).

Knowledge of contraceptives, no matter how beneficial one may consider it to be, does not automatically mean that a contraceptive may be used by all. However, the level of knowledge may directly influence an individual's level of use, as informed individuals are more likely to engage in contraceptive use (Ahmed *et al*., 2025). A study by Bekele *et al*., (2020) aimed at assessing Ethiopian women's level of knowledge and attitude towards contraceptives use found that 82.8% of the participants knew about contraceptives/family planning, although this knowledge varied from region to region. Furthermore, a cross-sectional study by Zakaria, (2025) in Tanzania, reported average knowledge of contraceptives with (59.7%) of the respondents knowing at least one method of contraceptive and the remaining 40.3% participants having no

knowledge of any contraceptive method. The researcher cited insufficient reproductive health education as the reason for the low level of contraceptive knowledge among the participants.

In summary, it can be seen that though most couples have some knowledge on contraceptives *per se* (Ahmed *et al*., 2025; Debel *et al*., 2025; Ukoji *et al*., 2022; Etokidem *et al*., 2017; Lamina, 2015; Monjok *et al*., 2010), the practical use of the knowledge of contraceptive for family planning amongst couple is largely limited (Kumakech *et al*., 2025; Abubakar & Abubakar, 2024; Eni, 2023). Moreover, not all the study that measured knowledge and use of contraceptives paid attention to couples attitude towards contraceptives, and how these attitudes or predispositions will explain the practice or use of contraceptives by males and females in different context.

Types of contraceptive methods

Mim *et al*., (2025) and the World Health Organisation (WHO) (2022) defined contraception as using different mechanical devices, compound, drugs, surgical techniques, or behavioural strategies to prevent conception intentionally. This is accomplished using contraceptives. Contraceptives or birth control are family planning technique used in the prevention of unintended pregnancy (for non-married people), prevention of pregnancy (for the married couples), promotion of healthy child spacing, limiting of one's family size, prevention of the spread of HIV and reduction of the risk of sexual transmitted infections (STIs), empowers individual level reproductive choices, reduction of infant and child mortality, reduction of maternal mortality and morbidity, and reduction of unsafe abortion (Kunene *et al*., 2025; Seruwagi *et al*., 2025; WHO, 2025; Ukoji *et al*., 2022). Contraceptive use also have financial benefit. For example, using birth control will lead to having the number of children that one's economic status can accommodate, and guarantees a healthy and relatively higher standard of living (Kunene *et al*., 2025; Monjok *et al*., 2010). This is because more children will require more resources to take care of and these resources have competing needs and are relatively scare (Eni & Essien, 2022).

Contraceptive methods can be grouped into the following: i) Permanent methods: this modern form of contraceptive is a non-hormonal method and the various types include the male and female sterilization. As the name implies, it is a permanent method that cannot be reversed; ii) Hormonal methods are reversible methods which includes injectable, oral contraceptive pills, emergency contraception, and implants; iii) Barrier methods: are non-hormonal methods and they include: intrauterine devices (IUDs), diaphragms and condoms; iv) fertility awareness-based methods (FABMs): is also a non-hormonal methods and are referred to as natural family planning. It include the standard days methods which is done using the calendar and the billing method; and v) the traditional methods include: long-term abstinence, withdrawal, periodic abstinence, prolong breast-feeding (www.globalhealthlearning.org; Kunene *et al*., 2025; WHO, 2025; Abubakar & Abubakar, 2024; Monjok *et al*., 2010).

Contraceptive Prevalence Rate (CPR): Global and Regional Perspectives

Contraceptive Prevalence Rate (CPR) is a health indicator for measuring contraceptive use in a particular environment with the aim of determining those with unmet needs for family planning. The United Nations World Contraceptive Use 2024 defined the Contraceptive Prevalence (CPR) as the proportion of women currently using, or whose partners are currently using, at least one method of contraception, irrespective of the method being used.

It is applied as: $$CPR = \frac{U_m + U_t}{P} \times 100$$

Where U = Number of women of a given marital status and age-group using a modern method of contraception (m) or a traditional method of contraception (t) and, P = total number of women of a given marital status and age-group.

The introduction of modern contraceptives has significantly increased the contraceptive prevalence rate globally. For instance, in 1960, the contraceptive prevalence rate in many developing countries was 9% and grew to 60% in 1997 leading to the reduction of fertility rates in many developing countries down from 6.0 children per woman in 1960 to 3.1 children in 1997

(Monjok *et al*., 2010). Globally, the contraceptive prevalence stands at 44%, with 29% in sub-Saharan African and 23% in Nigeria as of 2020 (Fehintola *et al*., 2022; United Nations (UN), 2019).

Socio-demographic and personal factors such as age, educational attainment, marital status, religion, parity, knowledge, acceptance and attitude have been implicated as predictors of higher usage or non-usage of contraception among men and women of reproductive ages in Nigeria (Eni, 2025; Fehintola *et al*., 2022; Bekele *et al*., 2021). In the same vein, an Ethiopian study which illustrates an increasing contraceptive prevalence of 41.4%, still reported challenges associated with socio-cultural factors and acceptability (Bekele *et al*., 2021). These regional disparities underscore the complexity of contraceptive behavior and the need for investigating the behavioural strategies linked to contraceptive use.

Despite the importance of using contraception, the contraceptive prevalence rate is very low for Nigeria, with modern contraceptive prevalence rate of 12%, and a 19% unmet needs for contraception amongst women of reproductive ages (Fehintola *et al*., 2022; National Population Commission (NPC), 2019; NDHS, 2018). Furthermore, the 2018 Nigeria Demographic and Health Survey report indicates that Nigeria's fertility rate was 6.6 children per woman in the North West, 6.1 in the North East and 5.0 in the North Central, compared with only 4.7 in the South East, 4.0 in the South-South and 3.9 in the South West. This analysis shows that there is still a significant unmet need for contraceptive use in Nigeria (NDHS, 2018). The survey further showed that the contraceptive prevalence rate (CPR) among currently married women between the ages of 15 to 49 years was 17%, only recording a 2% marginal increase since 2015; with 12% using modern methods and 5% using traditional methods (Iluno *et al*., 2025).

Research design and methods

Research Design

A cross-sectional quantitative survey research design was adopted for this study. The design makes it possible for the researchers to administer a structured questionnaire to identified

participants at a point in time. The primary data used in this study was sourced directly from individuals who form the target population of this study using a well-structured questionnaire which was administered to the target participants directly by the researchers and six trained research assistants. The population of the study included all women within the reproductive ages of 15 to 49 years and men between the ages of 15 to 64 years as used in a previous study by Tragaki & Bagavo, (2014) who have knowledge of at least one method and type of contraceptive and are residents in the study area for at least one year. It is important to know that there are no published data showing the total number of people in the research area within the age bracket being studied. Therefore, the study population is unknown.

Sample size determination

To get the appropriate sample size required for this study, the Cochran (1963) formula was applied thus:

$$n_0 = \frac{Z^2pq}{e^2} = \text{where } \frac{(1.96)^2(.5)(.5)}{(.05)^2} = 384$$

However, to account for a possible non-retrieval, the sample size was further increased by 10% (Debel *et al*., 2025; Kogoziga *et al*., 2025; Kumakech *et al*., 2025). Therefore, 384 x 0.1 = 38.4. Hence, the questionnaire was administered to 422 respondents, (that is: N = 384 + 38 = 422). This questionnaire was proportionally divided amongst the three States based on the result of a study published by the Nigerian Demographic and Health Survey (NDHS, 2018 – p.142), which indicated that the probability of residents in Abia, Enugu and Imo States using one form of contraceptive is 0.12, 0.309, and 0.37, respectively. This probability values served as the basis for apportioning the questionnaire among the three states under study.

Instrumentation

The instrument for data collection was a well-structured questionnaire comprising of three sections. Section A contained items related to the demographic profile of the participants. Section B contains relating to the respondents use of contraceptives, means or channels of

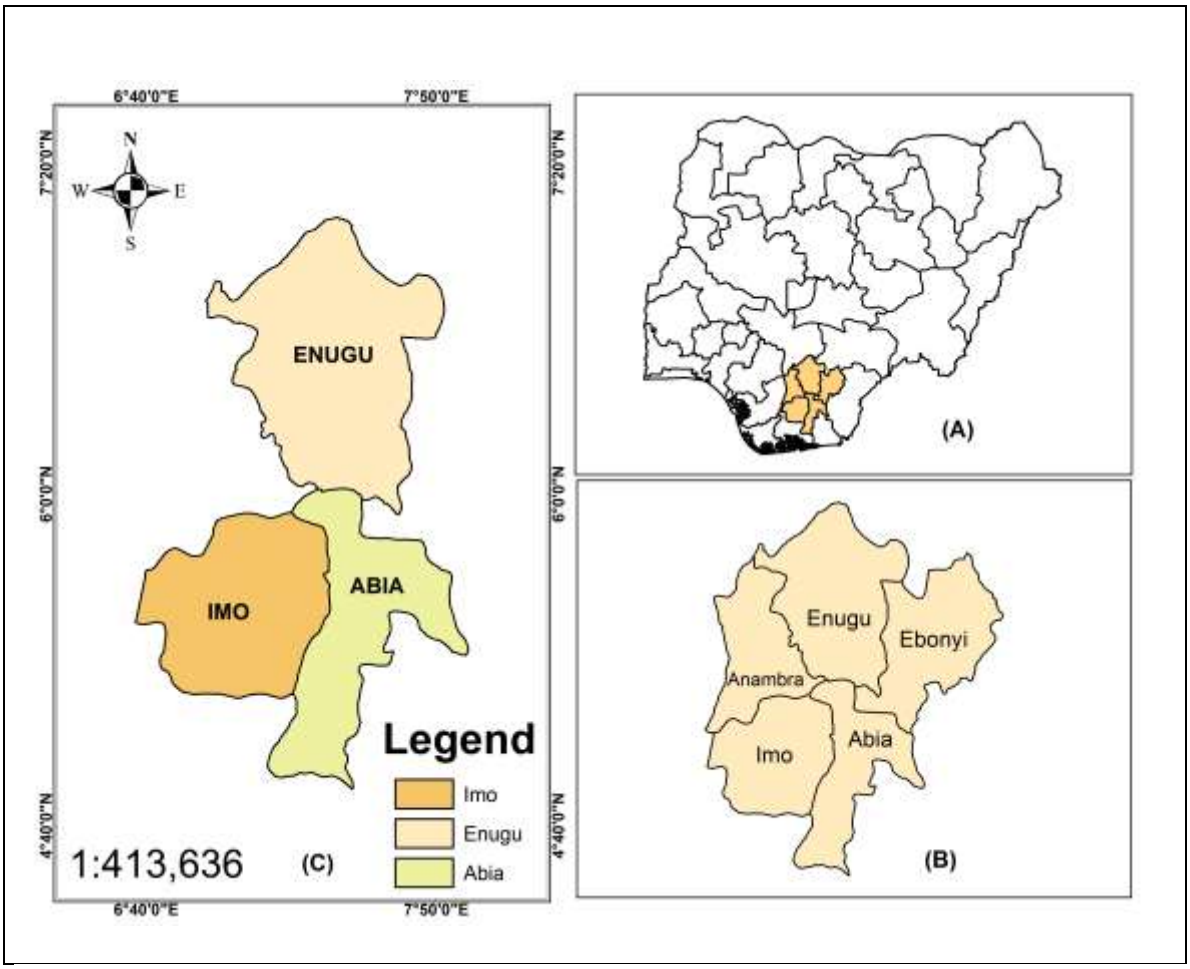
accessing information on contraceptives and how often the respondents heard about contraceptive. In section C, the respondents were asked to indicate their level of agreement or disagreement to three statements meant to measure the respondents' attitude towards contraceptives. The items include: being opened to the idea of using contraceptive; having no reservations in discussing contraceptive with medical personnel; and contraceptives should be a woman business measured on a 9-points Likert scale (where 1 = Very Strongly Disagree, 2 = Strongly Disagree, 3 = Disagree, 4 = Slightly Disagree, 5 = Neither Agree nor Disagree, 6 = Slightly Agree, 7 = Agree, 8 = Strong Agree, and 9 = Very Strongly Agree).. The data collection was carried out by the researchers and six assistants, between March to June, 2025.

Sampling techniques

Firstly, out of the five states in the Southeastern region of Nigeria, three states (Abia, Enugu and Imo) were purposively selected for inclusion this study. The choice of these states were informed by findings by the NDHS (2018), which showed that these states had the highest and lower contraceptive prevalence rates (CPRs) in the southeastern region of Nigeria. Convenience sampling technique was used to administer the questionnaire to the potential participants.

Study Area

The South-Eastern Region of Nigeria is the study area (see figure 1). The region is made up of five Igbo-speaking States that is Abia, Anambra, Ebonyi, Enugu, and Imo States and nighty-five (95) administrative units of unequal size called Local Government Areas (LGAs), reflecting their cultural diversity and ethnicity (Alabi & Badru, 2024; Chibueze, 2023; Joe-Ikechebelu *et al*., 2020). This region constitutes 29,388km^2 of Nigeria's total land mass. There are a total of ninety-five Local Government Areas (LGAs) in this region. Within these LGAs are found many social groups with distinct but similar cultural traits, which are reflected in the diverse behaviour of the people.



Source: Researchers' design, (2025). (ArcMap 10.7.1).

Figure 1: The Study Area (where A = Nigeria, B = Southeastern States and C = Sample Locations).

Ethical consideration

Firstly, an approval letter was gotten from the Head of Department of Geography and Environmental Science, Faculty of Environmental Sciences, University of Calabar, Nigeria for the research instrument to be deployed in the study area. Furthermore, a verbal informed consent was gotten from eligible participants before the actual questionnaire was administered to them. Prospective respondents were informed that withdrawal at any stage of the survey was guaranteed for them without any adverse effect. Participation in this study was entirely voluntary and all information gotten from the field was handled with strict confidentiality.

Data collection methods

Although 422 respondents participated in the survey, only 376 questionnaires were retrieved representing a retrieval rate of 89% and 11% non-retrieval rate. Of the 376

questionnaire retrieved, thirty-two (32) respondents were dropped from this analysis because of incomplete responses. After coding and data cleansings, descriptive analysis was done using 344 complete responses. The high return rate was achieved by the timely reminder the participants got from the researchers and assistants. All responses obtained were first transferred into a Microsoft Excel sheet. This served as a preliminary data assessment of the retrieved questionnaire and helped in the coding of the responses obtained from the respondents. The raw data sheet was then imported into the Statistical Package for Social Scientists *(SPSS) version 27* for data analysis. The result of data analysis was further imported into ArcMap *version 10.7.1* for analysis and data visualization.

Results and discussion

Description of participants

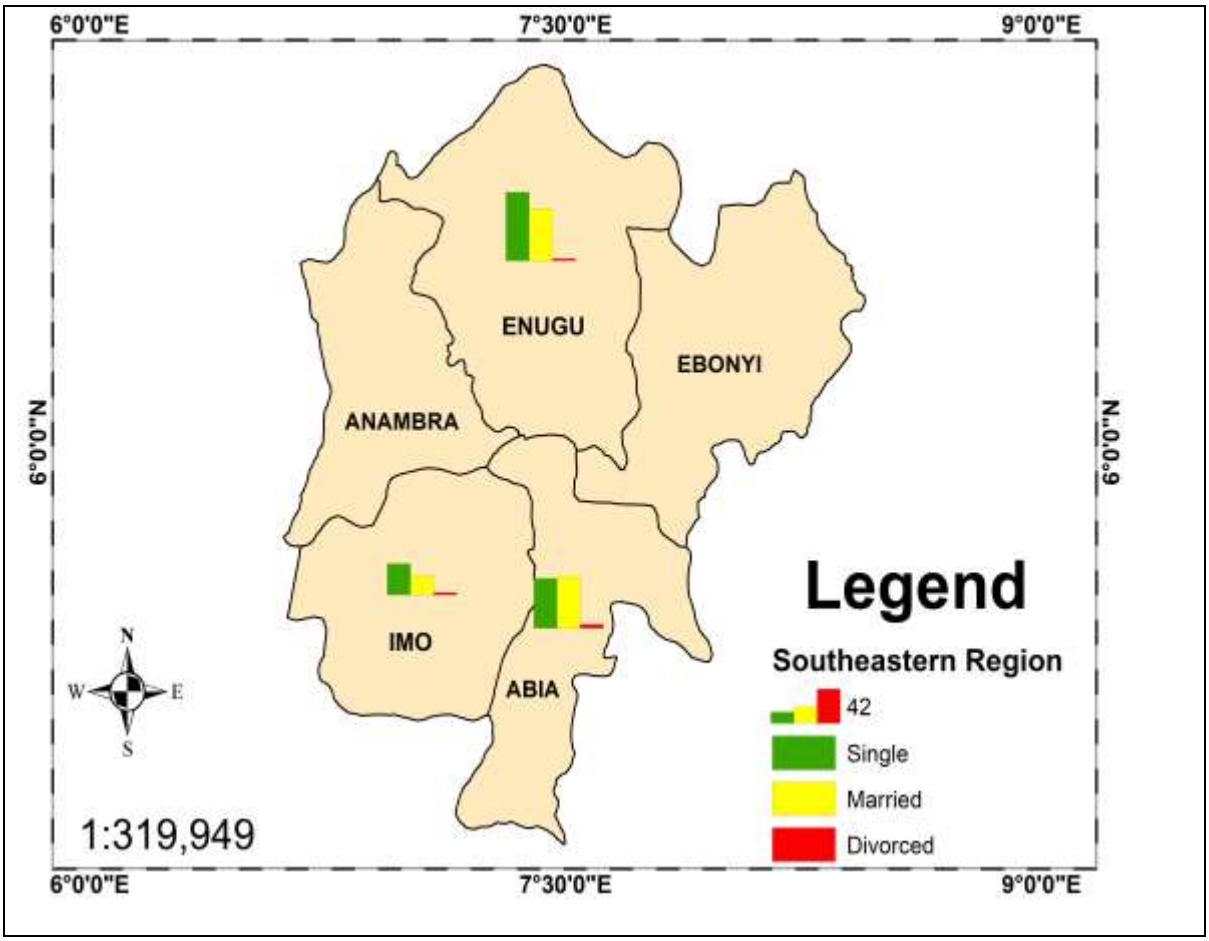
The data presented in this study is a part of a broader study conducted by the researchers. Although 422 questionnaires was administered, only a total of 344 complete responses were used for this analysis and the result presented in table 1. Majority of the participants (51.2%) were males compared to 48.8% of females (see table 1i). 17.1% of the respondents were within the childbearing ages of 15 to 24 years, 22.7% were between 25 - 29 years, while 46.2% fell between the ages of 20 – 24 and 30 - 44 years, respectively, while 8.4% fell under the age bracket of 45 - 49 years and the least participants (5.6%) were between the ages of 50 - 64 years. Concerning their place of residence, table 1 (iii) shows that 18.6% of the respondents were residents of Abia State, 37.5% Imo State, and 43.9% were residents of Enugu State.

With respect to respondents marital status which was presented visually in figure 2**,** slightly more than half (53.2%) of the respondents were single, 43.6% were currently married or living with their partners while 3.2% of the respondents were divorced or separated at the time of this survey. Given that the majority of the respondents are single, this data may be reflective of the current trend in the world where adolescents delay marriage to pursue other personal goals.

Table 1: Participants Demographic Profile

	Characteristics	Frequency	Per cent %
	i) Gender		
	Males	176	51.2%
	Females	168	48.8%
A	**ii) Age group**		
bi	15-24	59	17.1%
a	25-29	78	22.7%
St	30-34	53	15.4%
at	35-39	53	15.4%
e	40-44	53	15.4%
	45-49	29	8.4%
	50-64	19	5.6%
64	iii) **Place of residence**		
	18.6%		
	Enugu State	151	43.9%
	Imo State	129	37.5%
	Total	**344**	**100%**

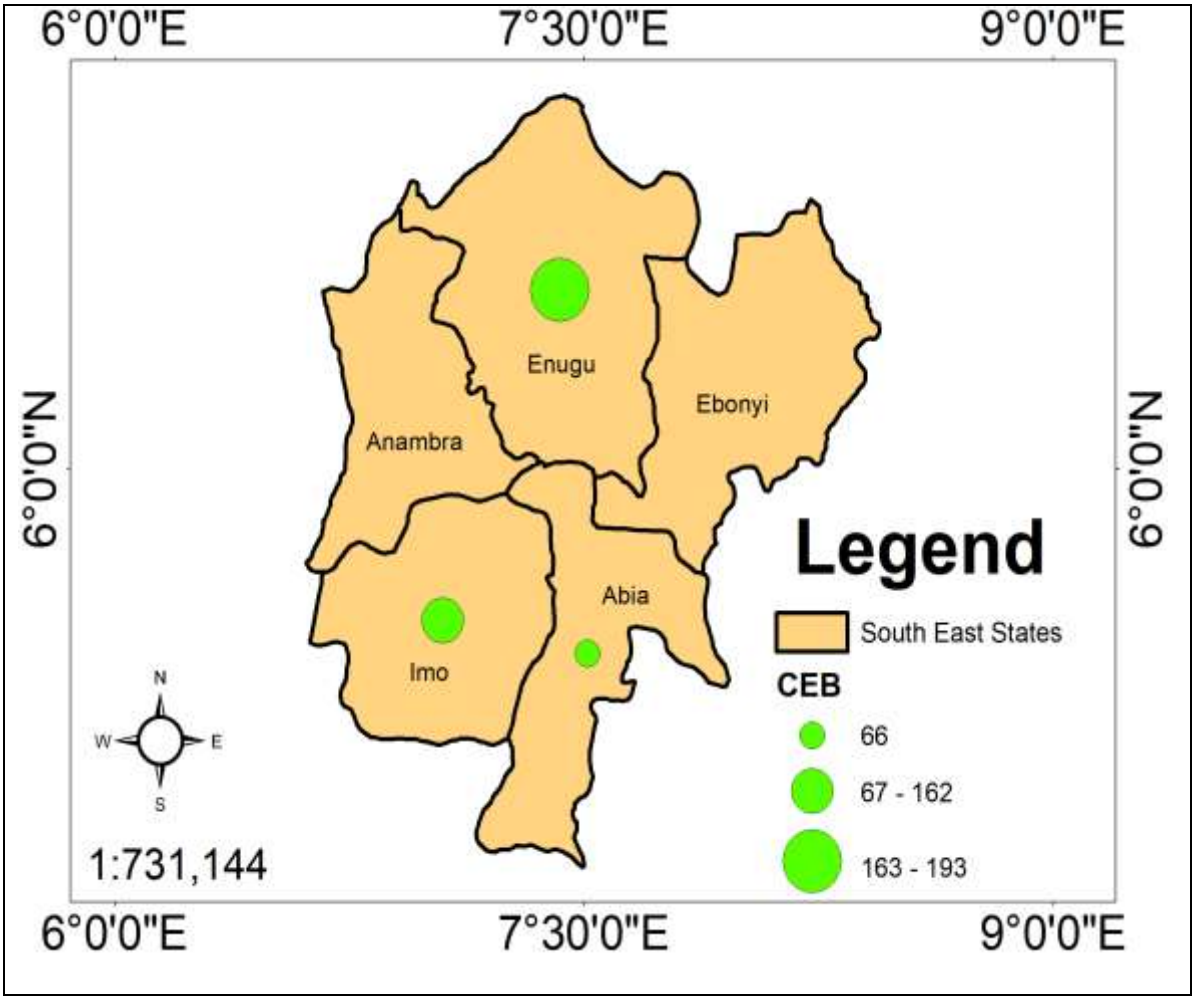
Source: Researchers' Data Analysis, (2025).



Source: Researchers' design, (2025). (ArcMap 10.7.1).

Figure 2: Distribution of respondents by marital status

Parity was investigated using the number of children ever born to the participants and results displayed in figure 3. The result of the data analysis showed that Enugu States had the highest number of children born to the participants with a total of 193 births, Imo State was next with 162 births and Abia States with 66 births**.** Similarly, respondents who had not given births at the time of this survey were more in Enugu and lowest in Abia States.



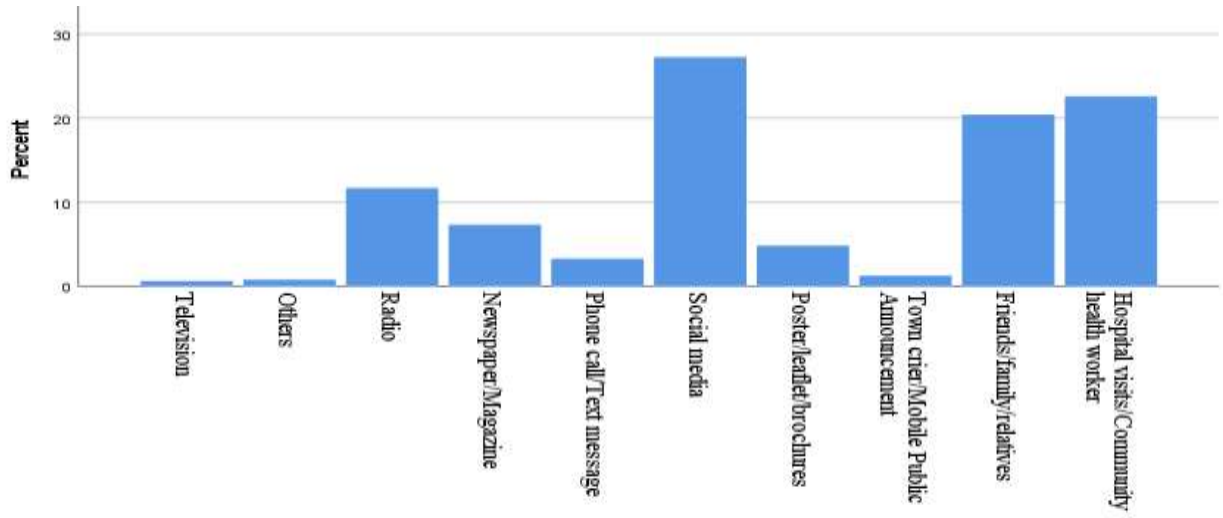
Source: Researchers' design, (2025). (ArcMap 10.7.1).

Figure 3: Distribution of fertility across study locations

Sources of Contraceptive Information

The sampled respondents reported hearing messages about contraceptive methods in the past five months preceding this study and the result is displayed in figure 4. The most common sources of contraceptive information in this study area is the social media (27.3%), followed by

the hospitals and community health workers (22.6%), friends and relatives (20.4%), the radio (11.7%) and newspaper/magazine (7.3%). Only few participants reported the poster/leaftet/brochures (4.8%), phone call/text message (3.3%), television (0.6%), and town crier/mobile public announcement (1.2%) as information sources. This shows that modern method of socialization, that is to say, social media, health institutions and family relations/friends constitute a vital source of information dissemination on contraception.



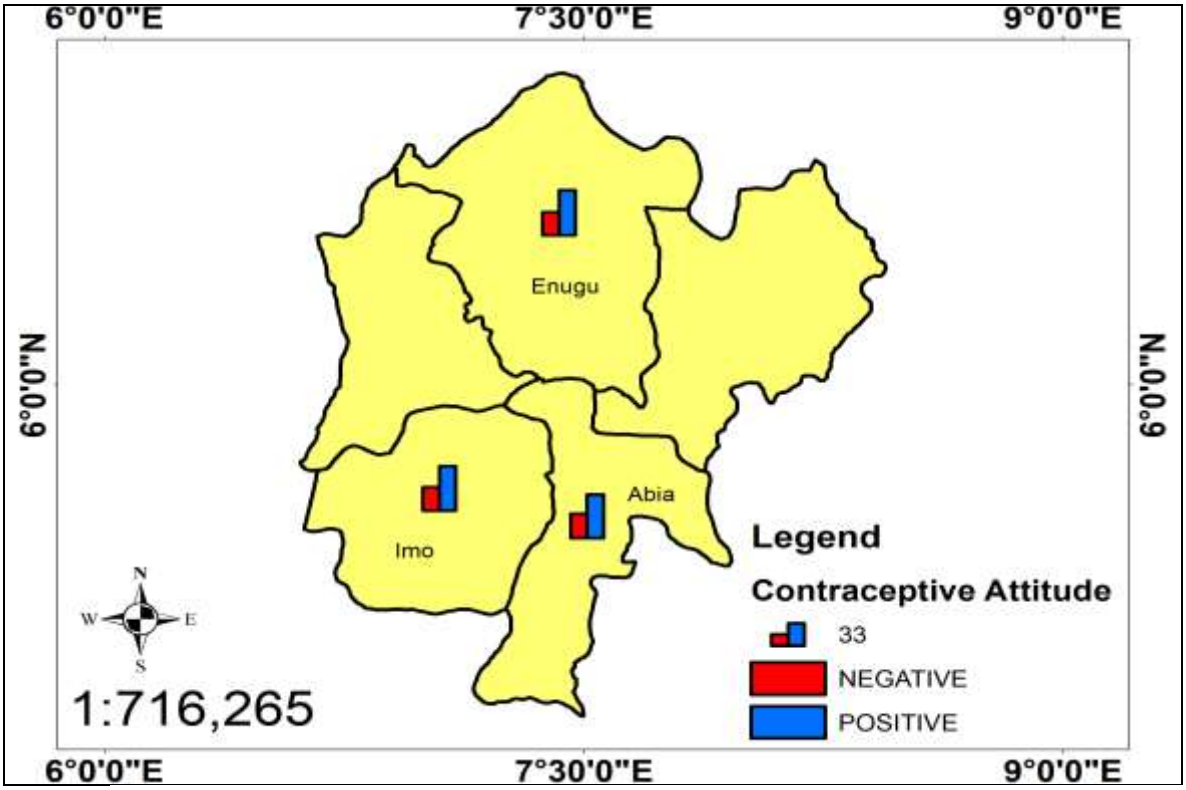
Source: Researchers' Data Analysis, (2025).

Figure 4: Sources of contraceptive information.

Attitudes towards the use of contraceptives

Analysis of the respondents' attitudes towards contraceptives which was one of the objectives of this study, showed that the mean score for Abia State was 17.91, Enugu State, 16.85 and Imo State, 16.49. Those who scored below the mid-point were considered exhibiting a negative attitude and those with the higher mean score were positively predispose to use of contraceptive (see figure 5). The result showed a relatively similar and positive attitudes across the study locations with Abia State displaying a slightly higher mean attitude score than the others. Although, this finding generally showed a positive attitude towards contraceptive, there

were still people in the various sub-locations (34.5% in Abia, 33.7% in Enugu and 35.9% in Imo States, respectively) who are largely averse to the use of contraceptives.



Source: Researchers' design, (2025). (ArcMap 10.7.1).

Figure 5: Attitudes towards contraceptive use by place of residence.

Level of knowledge of contraceptives

The question on knowledge of contraceptive was analysed and presented in figure 6. The pie chart diagram shows that all the respondents (100%) were knowledgeable about contraceptives indicating a high knowledge rate of contraception at the time of this study. This findings was consistent with similar studies conducted in Osun State, Nigeria (79.4%) and Dodoma, Tanzania (96%) (Fehintola *et al*., 2022; Kara *et al*., 2019). The high knowledge would suggest that, the participants are aware of some form of contraceptives methods be it traditional or modern. Whether or not they belief these methods to be effective, or whether they even consciously employ any, is a different matter.

Figure 7 indicated that the pills and male condom were the most popular methods (n = 261, or 14.5 per cent, respectively) followed by withdrawal (n = 209, or 11.6 per cent) and

female condom (n = 172, or 9.5 per cent) and implants (n = 163, or 9.0 per cent) and injectable (n = 130, or 7.2 per cent) and periodic abstinence (n = 107, or 5.9 per cent), and the calendar method (n = 104, 5.8 per cent) with intrauterine devices (n = 86, or 4.8 per cent), male sterilization (n = 83, or 4.6 per cent), emergency contraception (n = 74, or 4.1 per cent), prolong breast-feeding (n = 58, or 3.2 per cent), diaphragm (n = 50, or 2.8 per cent) and female sterilization (n = 46, or 2.5 per cent) being the least popular.

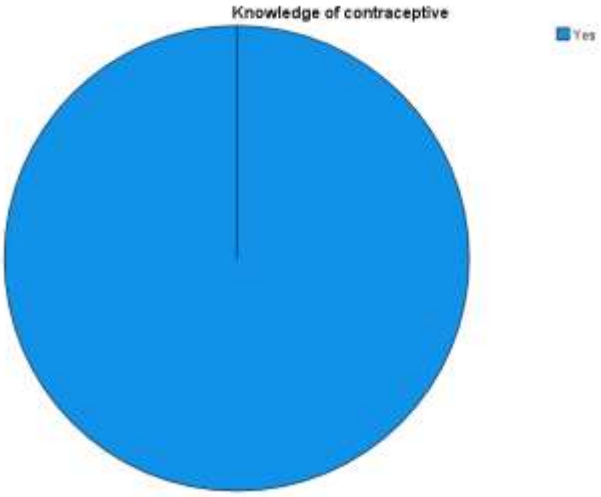
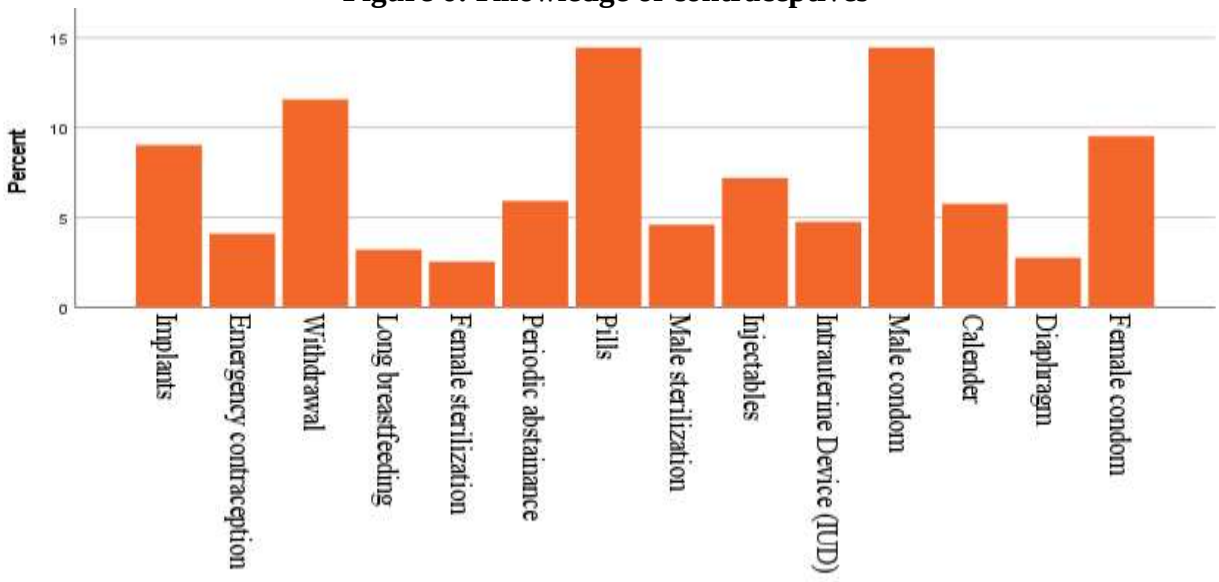


Figure 6: Knowledge of contraceptives



Source: Researchers' Data Analysis, (2025).

Figure 7: Respondents' knowledge of contraceptive methods.

Computation of contraceptive Prevalent Rates for the study area

This study as part of its objective was interested in examining the contraceptive prevalence rates (CPRs) in the sub-regions investigated in the study. To obtain the CPRs, the respondents who answered "*YES*" and "*UNSURE*" to the question "*Have you ever used contraceptives?*" were analysed. Those who responded "*unsure*" were included in the computation because individuals who used traditional contraceptives methods including withdrawal, calendar, prolong breast-feeding, and periodic abstinence methods often do not consider these methods as contraceptives. The computation is shown below:

$$\text{CPR} = \frac{95+2}{151} \times 100 = 64.2\% \text{ (Enugu State)}$$

$$\text{CPR} = \frac{75+5}{129} \times 100 = 62\% \text{ (Imo State)}$$

$$\text{CPR} = \frac{41+1}{64} \times 100 = 65.6\% \text{ (Abia State)}$$

Discussion of findings

The first research objective sought to examine the various sources of contraceptive information available in the study area. The findings of this study showed that the most common sources of contraceptive information in this study area is the social media (27.3 per cent), followed by the hospitals and community health workers (22.6 per cent), and friends and relatives (20.4 per cent). It is important to note that social media platforms, though very accessible to most people, could also serve as channels for misinformation largely because of its uncensored and faceless nature. In other word, it may be contributing to the misconceptions about contraceptives among the adolescent population who largely use it as source of information. This may partly explain why there is much knowledge on contraceptives but less-than corresponding practical application of contraceptives by participants examined in this study.

The implication of these findings shows that, the adoption of a community-based approach, such as training community health workers to provide extensive and adequate family planning information to users and non-users whenever the need arises through various platforms including social media should not be neglected, as this approach may yield a significant result in the use of contraceptive in the study area.

The second objective of this study was to analyse and map the respondents' attitudes towards contraceptives. This finding on the positive attitude exhibited by the respondents aligns with the Theory of Planned Behaviour, which holds that attitudes, amongst other factors, influence the development of behavioural intentions. This is also supported in the literature by Hardika & Sundari, (2025). Good attitudes towards contraceptives are shaped by an individuals' knowledge of the existing methods available, social support from healthcare providers, family members, friends, their partners and even previous positive personal experiences. Positive attitudes towards contraceptives use can increase the possible intention to use contraceptives thus supporting the theory of planned behaviour.

On the aspect of knowledge of contraceptives which was the third objective of this study, although all respondents had knowledge of contraceptives, analysis of figure 7 indicates that, the pills and male condom were the most known modern method of contraceptives to the participants, with the withdrawal method also appearing as the highest known traditional method of contraception, with only fewer than 15 per cent of the study population reporting knowledge of long-acting methods like intrauterine devices (IUDs) or implants. This implies that knowledge of contraceptive does not translate to usage and although this study did not probe further as to why their usage rate may be low in the study area, misconception on the side effects found on social media which was also cited as the go-to channel for contraceptive information, as well as spread of misinformation and myths from friends/family/relatives may be the reasons for their low usage rates in the study area. Although, this is only speculative as the current data for this study does not show this information. Therefore, further study may investigate the reason why

this might be in the study area. Be that as it may, this finding aligns with that of Kedida *et al*., (2025) whose qualitative study found that the respondents reported receiving negative information from their partners, mother-in-laws, relatives and family members during any discussions on contraceptives.

In line with extant literature, this study also sought to investigate the contraceptive prevalence rate of the participants. From our analysis and computation, all three States had a high adoption rate of contraceptives with Abia State having the highest (65.6 per cent), followed by Enugu State (64.2 per cent) and Imo State (62 per cent), respectively. This result for the three states further shows how closely-ralated the States are in terms of their culture, values, perceptions and their way of life. The findings of this study highlight a comparative disparity in CPRs across regions, ranging from two per cent in Northwestern States (Yobe and Sokoto States) to 29 per cent in Southeastern States (Lagos) (NDHS, 2018).

This result also suggests that the knowledge of contraceptive is relatively high among the study participants. It will appear that, most people either use traditional/withdrawal method (which has been generally found to be ineffective) and are averse to the use of modern/sophisticated methods. This explanation is based on part of our findings that showed that only a few respondents were opened to the use of such modern methods as vasectomy and implants. Seeing that majority of the respondents were single, this result may be an indication that the participants do not consider the use of modern contraceptives necessary when not in a marital relationship. On the whole, although there is a significant knowledge of contraceptives and their benefits, people still preferred the traditional and ineffective methods of contraception, probably because of a variety of factors that may include cultural belief, and religious factors.

Conclusion

This research set out to describe how contraceptive knowledge, attitudes, and practices explain contraceptive behaviour among residents of South-Eastern Nigeria. The findings of this study shows that, while knowledge of contraceptives was pervasive and attitudes towards use

largely positive, the practical use of modern contraceptive was insignificant compared to the use of traditional methods, therefore, this study concludes that, adequate knowledge of contraceptives as well as its benefits may lead to positive attitudes towards contraceptives, but not necessarily to actual use of modern and non-traditional contraceptives.

Recommendations for policy directions

Based on the findings of this study, it is recommended that:

a) Fertility management hinged on contraception should target intensive education aimed at mind-reorientation, and changing socio-cultural beliefs about modern contraceptives.

b) Prevalence of modern contraceptives may be enhanced by removing lingering socio-cultural barriers and misgivings to contraceptive use through concerted and evidence-based campaigns beyond what social media platforms offer as facts.

c) In addition to Government mounting concerted educational campaigns to counteract the potential use of social media for misinformation by scaremongers, community-based sex education programmes should be vigorously pursued.

d) Continuous education on the use and usefulness of contraceptives should be encouraged using all means available. This may help enhance peoples positive disposition to contraception and its advantaged to overall family health and well-being.

e) It is also recommended that health workers, social workers and other relevant medical professional should not relent on educating both men and women on the use of condoms as being a far-safer means of preventing unplanned pregnancy than the traditional withdrawal method. Women respondents have also indicated lack of understanding of the female condom as well as phobia for IUDs and implants; it is therefore recommended that sex educational workshops should be mounted specifically to assure women on the safety of those devices.

f) Furthermore, Government could make its used mandatory for women who have more than four children as a way of managing population growth and improving family health.

g) Beyond educating residents on the type and usefulness of modern contraceptive types, Government should make it a matter of policy that men who birth more than four children must have a vasectomy and women who birth more than four children must have implants. Though controversial, this policy may help in controlling unsustainable population growth.

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