

Barriers to Reproductive Autonomy: Understanding Family Planning Access and Choice Among Women of Reproductive Age in Osun State, Nigeria

Iyanu Adufe

iyanuoluwa.adufe@uniosun.edu.ng

Osun State University

Cassandra Akinde

Women in Global Health

Samson Olagoke Oladoye

Kings University

Research Article

Keywords: Reproductive autonomy, Family planning, Women's health, Contraceptive use, Nigeria, Gender norms

Posted Date: March 11th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-8473968/v1>

License:   This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Background

Despite significant efforts to expand access to family planning services, women still encounter obstacles to practicing reproductive autonomy in Nigeria. The achievement of universal access to reproductive health care requires recognition and comprehensive understanding of the multifaceted factors that undermine women's ability to make informed reproductive decisions.

Methods

This qualitative research investigated the experiences, perceptions and issues of family planning access and choice by the women in Osun state, Nigeria. Focus group discussions and in-depth interviews (IDIs) were used in this study. A sample of 25 women in the reproductive age was chosen in Osogbo, Olorunda and Egbedore Local Government Areas. Audio tapes were made of interviews, transcribed, translated thematically and analyzed. Themes and subthemes were created and they were supplemented with illustrative quotes.

Results

There were five themes, which included - Knowledge of family planning and Autonomy; Attitudes towards family planning; Reproductive Autonomy; Barriers to family planning; and Recommendations for Improving Reproductive Autonomy. Results indicated that the level of awareness regarding family planning was high, but misconceptions and sociocultural constraints were limiting adoption. Dominance by partners, religious and cultural values, and other health system issues also limited the reproductive options. Women realized that they needed community education to be inclusive, spouse support, and quality services.

Conclusion

Intersecting individual, socio-cultural, and systemic factors influence women to have reproductive autonomy in Osun State. The interventions should be aimed at education, male participation, and health system empowerment to make sure that there is an equal access to family planning and reproductive rights.

INTRODUCTION

Reproductive autonomy refers to the ability of individuals to make informed and voluntary choices about their reproductive health; an essential human right and one of the pillars of women's empowerment (1). It covers the right to make responsible decisions about the number, timing, and spacing of their children, to

obtain information and means of implementing their choices without being forced, discriminated, or subjected to violence (2). Reproductive autonomy is necessary to ensure gender equality and better maternal and child health outcomes, but in most low and middle-income countries, it remains largely a facade (3–4).

The issues of reproductive autonomy are even more acute in Nigeria, as the high fertility level, low prevalence rate of contraceptives, and one of the highest maternal mortality ratios in the world of 512 maternal deaths in 100,000 live births. This is still a challenge as the Nigeria Demographic and Health Survey (NDHS) also confirms its existence among the population (5–6). Although the level of awareness of family planning (FP) methods is high among sexually active unmarried [98%] and married [94%] women, contemporary contraceptive use is dismally low [19%] (7). This gap between theory and practice highlights a more profound structural and cultural issue, indicating that these impediments go beyond awareness to actions, social norms, and access.

Despite government initiatives to enhance the maternal and reproductive health outcomes, the adoption of modern FP services is suboptimal (8). Lack of reproductive autonomy, gender inequality, socio-cultural, and economic deprivation are some of the issues that render females unable to gain control over their fertility (9). Sociocultural environment of Nigerian societies is mostly inclined towards the elucidation of the masculine supremacy of the reproductive options, thus, making contraception either morally controversial or unnecessary, particularly in marriage (10).

Women have more challenges in their reproductive choices due to cultural and religious pressures. Religious explanations can influence the position of contraception in most societies, where it is occasionally viewed as tampering with the will of God (11). Similarly, the tradition of having a big family size or emphasis on kids (male) continues to exacerbate the pressure against contraceptive use. These are the forces that limit women in their activities, particularly in patriarchal families where decision-making concerning reproduction is normally dominated by the male partners or significant others. All these are made more difficult by the economic factors where poverty is known to limit access to contraceptives or traveling to healthcare facilities, as well as the healthcare service delivery system constraining access (12).

FP and reproductive autonomy have a high level of interrelation. FP is a public health intervention that is vital and also a significant practice of autonomy and reproductive rights (12). By making reproductive choices, women have a higher chance to pursue education, participate actively in strengthening the economy and national development (13). Evidence indicates that enhanced reproductive autonomy results in a decline in unwanted pregnancies, unsafe abortion, and maternal deaths (14). On the other hand, when women are limited in their autonomy, they may become vulnerable to reproductive coercion, high-risk pregnancy, and poverty cycles.

FP in the world is among the most cost-effective strategies of public health in reducing maternal and infant mortality (15). However, in sub-Saharan Africa, Nigeria, being no exception, the gender norms and structural injustices still inhibit the reproductive freedom of women (16). The prevailing common themes

in the literature have always been socio-cultural resistance, religious constraints, insufficient participation of men, fear of side effects, inaccessible quality services, and bias by the health care providing personnel as some of the major factors that discourage the use of birth control (17–18). All these combine to bring about a scenario where knowledge fails to translate to action, and decision fails to mean independence.

Nigeria has many barriers to reproductive autonomy; these cut across individual, household, community, and institutional levels. On an individual level, the adverse factors to uptake include myths and misconceptions about contraception, fear of infertility, and absence of spousal support. The problem of contraception and fertility has been preconditioned on the community level by patriarchal norms and religious conservatism. At the institutional level, lack of trained staff, inconsistent supply of goods and services, and inadequate counseling services undermine the quality of care (17–18). These intersecting challenges underscore the need to have a local and contextualized research that would unveil how structural and sociocultural determinants affect the reproductive practices of women in specific situations within Nigerian contexts.

This study is therefore located in the broader area of discourse of reproductive rights and gender equality. It argues that improvement of female access and control to family planning services should be one of the priority areas, not only in health outcomes but in the objective of achieving the Sustainable Development Goals (SDGs), in this instance, Goal 3 (Good Health and Well-Being) and Goal 5 (Gender Equality). The objective of the study was to determine reproductive autonomy and explore the FP barriers that hinder women of reproductive age in Osun State, a setting representative of Nigeria's diverse ethnic and socio-economic landscape.

METHODS

Study Design

The study employed a qualitative research design to examine barriers to reproductive autonomy and other factors shaping access to and choice of family planning among women of reproductive age in Osun State, Nigeria. The qualitative approach was appropriate because it allowed for an in-depth exploration and understanding of women's reproductive experiences, perceptions, and the socio-cultural influences that inform reproductive decision-making. Data was collected through in-depth interviews (IDIs) and focus group discussions (FGDs), which provided rich narrative accounts of both individual and collective realities. A thematic analysis was subsequently conducted, offering an appropriate framework for the detailed exploration of participants lived experiences, perceptions, and processes of meaning-making.

Study Setting

The study was conducted within the geopolitical region of the south west in Nigeria known as Osun State. The state shares borders with Oyo State on the western, Ekiti, and Ondo States on the eastern, Ogun State on the southern and Kwara State on the northern sides. It has an estimated land area of 9251km² and 30 Local Government Areas (LGAs), further divided into three senatorial districts. National Census in 2006 has shown that population of Osun State is 3.4 million, the population is predicted to grow to 4.7 million by 2016 with an annual growth rate of 3.3. The Yoruba ethnic group is the dominant and main religion is Christianity and Islam, both of which are very influential in determining cultural and reproductive norms. The study was conducted in two LGAs (Osogbo, Olorunda and Egbedore) chosen to represent the population that had different socio-cultural backgrounds, both in the urban and semi-urban settings.

Study Population and Sampling

The population of the study included 25 women of reproductive age (15–49 years) who live in the chosen LGAs. The selection of this group was due to the fact that they are the main users and the potential beneficiaries of the FP services (1). The non-probability convenience sampling was employed to recruit participants between 29th April and 4th June, 2024. This enabled women who were available, willing to join as well as met the inclusion criteria to be included. Inclusion criteria were: women between 15–49 years old, living in the target LGAs not less than one year and at least had one child. Participation was not permitted in the mentally unwell and women who did not provide consent.

The concept of data saturation was the principle that was applied in the determination of the sample size, meaning that, the interviews conducted until such a time when no new themes or insights were acquired through the data. It was made rich and comprehensive with this strategy to capture the diversity of the views about reproductive autonomy and access to family planning.

Data Collection Procedures and Instruments

Data were collected using IDI and FGD guides. These tools were developed in line with research objectives. Some of the themes that were covered by the guides were the knowledge of women on reproductive autonomy, attitudes towards FP, perceived barriers to access and choice, and the influence of reproductive choices by religion, culture, and gender expectations. A pilot sample of the women in another LGA was used to test the relevance, validity, and clarity of the instruments, before the actual data collection. Feedback was used to revise and improve the language, structure, and flow of questions. The guides were validated through face and content validity assessments involving experts and independent qualitative researchers.

Data collection was conducted through face-to-face interviews and focus group discussions. The FGDs included 6–8 people per group, and IDIs were conducted with separate women who valued individual sessions. The principal investigator would facilitate the discussions with the help of a trained note-taker.

The interviews were conducted in English and Yoruba language, depending on the selection of participants so that they would comprehend and feel comfortable. The meetings lasted 15 to 50 minutes and were held in neutral and convenient locations that did not interfere with the privacy and comfort of the respondents. All the focus group discussions and individual sessions were audio-recorded with permission from participants, and nonverbal cues and contextual details were documented as field notes.

Data Management and Analysis

Audio-recordings were transcribed directly and translated into English when applicable before analysis. The transcripts were checked for completeness and accuracy and then analysed. The analysis of the data was conducted using an inductive approach in thematic analysis to reveal some of the common patterns, meanings, and relationships in the data. The analysis was performed in various phases, including reading of transcripts, coding of meaningful text units with descriptive codes, clustering the codes into larger themes and subthemes, which are based on the research objectives, and synthesizing the themes to obtain an insight into the barriers influencing reproductive autonomy and FP access. A synthesis was also made on the themes in order to gain an understanding of the obstacles affecting reproductive autonomy and FP access, in accordance with the thematic analysis framework, developed by Braun and Clarke (19). Illustrative quotes from participants were selected to support the interpretation of key findings, providing authenticity and grounding the analysis in participants' voices.

Ethical Considerations

The Health Research Ethics Committee (HREC) of the College of Health Sciences, Osun State University granted the study ethical approval (Ref: HREC/2024/PBH/070). The appropriate local authorities also gave permission to carry out the study. The involvement of participants was all voluntary. Before the interviews and discussions, the participants were informed of the study's objectives, the privacy conditions, and the ability to drop out of the process without any penalty. Verbal and written informed consent was received. In order to preserve confidentiality, transcripts lacked identifiers, and all the audio files and notes were stored in folders with passwords and could be accessed only by the research team.

Trustworthiness and Study Limitations

Triangulation of data sources (IDI and FGD) and peer debriefing were used to guarantee credibility during the analysis. Reliability was ensured through the preservation of an audit trail of procedures, decisions, as well as coding processes. Rich contextual descriptions were used to increase transferability, as it was possible to evaluate applicability to other settings by the reader. One of the weaknesses of this research is that the study was qualitative and, therefore, the results cannot be statistically generalized to the population as a whole. Nevertheless, it is a strong point as it gives the context and abundant information

about the lived experiences of women in terms of reproductive autonomy and family planning decisions in the Osun State.

RESULTS

Thematic analysis revealed that five major themes and each one of them had sub-themes and categories (Table 1). These themes showed a dynamic nature of the interaction between knowledge and sociocultural interactions and institutional factors that construct reproductive autonomy in women in Osun State.

Table 1
Extracted themes, sub-themes, and categories.

Themes	Sub-Themes	Categories / Illustrative Ideas
Knowledge of FP and Autonomy	Awareness, Sources of Information	Health center education, antenatal exposure, varying awareness levels
Attitudes towards FP	Positive and Negative Perceptions	Benefits of spacing vs. fear of side effects, religious and cultural influence
Reproductive Autonomy	Personal vs. Joint Decision-Making norms	Spousal influence, secrecy, peer, and elder pressure
Barriers to FP	Fear, Cultural and Spousal Opposition	Misconceptions, religious stigma, misinformation
Recommendations for Improving Reproductive Autonomy	Education, Accessibility, Male Involvement	Community sensitization, affordable services, non-judgmental care

Socio-demographic characteristics/Reproductive profile of the participants

13 IDIs, 2 FGDs were done among women of reproductive age in Osogbo, Egbedore and Olorunda LGAs and 25 participants were sampled. The average age of the sample was 34.6 years old, most of them attended senior secondary school, 10 years and above living in the community, and had two or more children. A majority are Christians and are more than half. Virtually all respondents were married (Table 2).

Table 2
Participants' socio-demographic characteristics (n = 25)

Variables	Sub-variables	Frequency(N)	Percentage (%)
Age	23–30	8	32.0
	31–40	12	48.0
	41–49	5	20.0
Educational status	Primary	4	16.0
	Secondary	14	56.0
	Tertiary	7	28.0
Marital status	Single	6	24.0
	Married	16	64.0
	Divorced	3	12.0
Occupation	Unemployed	4	16.0
	Employed	10	40.0
	Self employed	11	44.0
Religion	Christian	14	56.0
	Muslim	11	44.0
Number of years lived in the community	≤ 10 years	8	32.0
	11–20 years	10	40.0
	> 20 years	7	28.0
Number of children	1	8	32.0
	2–3	12	48.0
	4 above	5	20.0

Theme 1: Knowledge of Family Planning and Reproductive Autonomy

The majority of the respondents (94 per cent) were aware of family planning methods, but the knowledge level was quite different. Although the population was highly informed about the existence of the different forms of contraception like injectable, intrauterine devices (IUDs), implants, pills, and condoms, a considerable portion of the population was not aware of how to use these methods correctly, their effectiveness, and possible side effects. Participants noted that health centers, antenatal clinics and community outreach programs were also their key sources of information, although the quality and the depth of counseling were not always similar. Others knew about modern birth control

techniques such as Copper T, injections, and condoms in maternity sessions, while most of them had little or no knowledge about reproductive autonomy.

"I know about family planning methods such as pills and injections from the local health center." – IDI_P2; *"Health workers during antenatal visits talked about pills and injectables."* – IDI_P6; *"Yes, I have heard about family planning methods such as pills, injections, and condoms..but not reproductive autonomy."* – FGD_P1; *"I know about pills, condoms, and injections as family planning methods."* – FGD_P6

Awareness about condoms was largely attributed to informal peer discussions and outreach sessions.

"I have heard about condoms as a family planning method from community outreach programs." – IDI_P3; *"Friends mentioned condoms during our discussions on family planning."* – IDI_P11

Knowledge of IUDs and implants was primarily derived from clinical and maternity centers.

"I know about the Copper T and IUDs from my visits to the maternity center." – IDI_P4; *"Implants were discussed during health talks at the clinic."* – IDI_P1; *"We were informed about the use of implants and IUDs during our women's group meetings."* – FGD_P8

A few participants recognized natural methods, such as the rhythm and breastfeeding methods:

"I know that there are natural methods like the rhythm method and withdrawal." – FGD_P3; *"I am aware of natural methods like breastfeeding and the rhythm method."* – FGD_P9

Regardless of this knowledge, there was low use of modern methods as most of the participants used traditional or natural approaches because they were afraid of complications and distrusted modern decisions..

Theme 2: Attitudes towards Family Planning

The attitudes of participants towards FP were mixed, which were predetermined by their personal experiences, cultural and religious beliefs, and perceived side effects. On one hand, family planning was appreciated by women as one of the ways to space children and have better maternal health, but on the other hand, some believed in it because of a lack of information and culture.

"I believe family planning is important to control the number of children and space pregnancies." – FGD_P2; *"Using contraceptives helps me manage my health better and plan for my family's future."* – FGD_P5; *"I don't like family planning methods because I've heard they have many side effects."* – FGD_P4; *"In my religion, using contraceptives is not allowed, so I don't use them."* – FGD_P3

Those participants who favored FP considered it as a family wellbeing and health management tool, whereas others linked it to infertility, marital stressfulness, or sin.

"I think family planning is good because it helps in managing the number of children you can take care of." – FGD_P6; "I don't use family planning because I've heard it can cause permanent health issues." – FGD_P8; These differing attitudes highlight the influence of cultural and religious norms, particularly among women in conservative communities.

Theme 3: Reproductive Autonomy and Decision-Making

The theme of reproductive autonomy was also significant, showing certain degrees of autonomy of women in terms of FP decisions. Some of interviewees mentioned that they had full reproductive autonomy; however, others said that spousal or communal pressure was among the key factors.

"My own decision is prioritized when it comes to my reproductive health now because I know what I want, and you cannot decide for me." – FGD_P2; "I started using family planning secretly because my husband does not support it." – FGD_P7; "My husband and I decided together not to use family planning because he wants more children." – FGD_P6

Other respondents even revealed that their husbands or extended families were the decisive factors in using contraceptives or not.

"My husband decided that we should not use family planning because he wants more children." – FGD_P10; "Peer pressure also affects decisions about family planning, as many of my friends do not use it." – FGD_P9; "The opinions of elders in my community make it difficult for women to openly use family planning methods." – FGD_P8

Some participants mentioned that they prefer natural approaches, which is related to their safety and acceptance of cultural aspects.

"I prefer natural methods like breastfeeding and the rhythm method." – IDI_P1; "Modern contraceptives don't appeal to me; I believe in natural family planning methods." – IDI_P6

Along with the fear of side effects and cultural beliefs, reproductive autonomy was limited further:

"Fear of side effects and health risks make me hesitant to use modern contraceptives." – IDI_P7; "Due to my faith, I don't consider using any family planning methods." – IDI_P5

All in all, the results have shown that spousal control, peer pressures, and religious doctrines are significant obstacles to free reproductive choices amongst women.

Theme 4: Barriers to Family Planning

The participants cited various obstacles that prevent them accessing and using FP methods. These were individual likes and dislikes, fear of side effects, cultural and religious resistance, spouse rejection and poor education.

Personal Preferences

"I prefer natural methods and don't feel the need for modern contraceptives." – IDI_P1; "I haven't used any family planning methods because I don't feel the need for it." – IDI_P2

Fear of Side Effects

"Some people think that contraceptives cause infertility, which scares them away from using these methods." – FGD_P3; "I have heard that using family planning methods can lead to cancer." – FGD_P5; "I am afraid of the side effects like weight gain and irregular periods." – FGD_P1

Negative Personal Experience

"I used the injection once, and it caused me to bleed excessively." – FGD_P4; "I once used the pills, and it caused me severe headaches and nausea." – FGD_P9

Cultural and Religious Opposition

"There are beliefs that it's a sin. Even some 'teblik' Muslims believe it is a sin. Some Christians don't believe in it too." – FGD_P4; "In my community, using family planning is seen as something bad, and people talk negatively about those who use it." – FGD_P5

Spousal Opposition

"My husband does not support family planning because he believes it is against our culture." – FGD_P4

Lack of Detailed Knowledge

"I need more information before deciding to use family planning methods." – IDI_P12; "I heard about family planning at the maternity center but have no interest in it because I don't trust it." – FGD_P7

All these obstacles indicate that the greatest impediments to contraceptive uptake are misinformation, fear, social opposition and poor reproductive literacy.

Theme 5: Suggestions for Improving Family Planning Services

The participants suggested some measures that can be taken to increase FP awareness and autonomy. Education and sensitization programs, male involvement, engagement of the community leaders, and affordable and non-judgmental services were the most repeated recommendations.

Education and Awareness Programs

"The government should provide more education and awareness programs about family planning." – IDI_P1; "Sensitization and awareness are key to enabling reproductive autonomy among women." – FGD_P5; "Health workers need to provide detailed information and counseling about family planning options." – FGD_P2

Involvement of Community and Religious Leaders

"Community leaders should be involved in sensitizing people about the benefits of family planning." – IDI_P3; *"Involving religious and community leaders in these programs can help in gaining acceptance."* – FGD_P4

Accessible and Affordable Services

"Family planning services should be made more accessible and affordable." – IDI_P8; *"Family planning services should be more accessible and affordable for all women."* – FGD_P7

Inclusion of Men in Reproductive Health Education

"Men should be included in reproductive health education to support family planning." – IDI_P5; *"When men are educated, they will support their wives in using family planning methods."* – FGD_P6

Non-Judgmental and Supportive Counseling

"Healthcare providers should offer family planning services without judgment or stigma." – IDI_P10; *"There should be no judgment or stigma from healthcare providers when women come for family planning services."* – FGD_P8

The viewpoints highlight the importance of multilevel interventions to encourage informed and independent reproductive decisions in women.

DISCUSSION

This study examined the barriers of women in making decisions regarding their FP in Osun State, Nigeria. The results indicate that the general awareness of FP methods is high, but there are still significant gaps in the level of knowledge, attitudes, and autonomy all of which impact on reproductive choices of women.

Socio-Demographic Characteristics

The socio-demographic characteristics of the sample represent a cross-section of the female population being of reproductive age with the majority of them being 26–35 years of age which is a time frame when most women make active decisions regarding childbearing and FP. This holds true with national results by Ajaero et al. (20), which showed that there was the same pattern of age among Nigerian women within the reproductive age. The level of education was also fairly good at 56 percent of the respondents attended secondary school. It is not a new realization that education is a determinant of reproductive health awareness that affects the ability of women to make informed choices regarding contraception (21). The fact that the majority of women were married (64) emphasizes the importance of the role of spouses and relatives in the reproductive autonomy that is in line with previous results by Feyisetan and Casterline (22). Working conditions among the majority participants also indicate the

necessity of workplace-based reproductive health services because economic autonomy can influence the contraceptive preferences and availability.

Knowledge of Family Planning and Reproductive Autonomy

Most of the respondents (94 percent) were familiar with the use of modern methods of contraceptives including pills, injectables, implants and IUD. This is relative to the 72.4% awareness of OlaOlorun and Hindin (23) in Ibadan meaning that there is gradual increase in the awareness levels in southwestern Nigeria. The study did not reveal in-depth knowledge about long-acting reversible contraceptives and the misunderstanding of side effects, however, the trend has been reported by Blackstone and Iwelunmor (24), who detected the same gap in the knowledge of Nigerian women. The health facilities and antenatal sessions were mentioned as the main sources of information by the majority of participants, which highlights the core of the health system in the FP communication. However, asymmetrical information sharing and inconsistent counselling were also noted, which is why there is a necessity to improve the community outreach and unify the content of FP education. Whereas other people were conversant with the concept of reproductive autonomy, some people had never heard of this term, which points to the fact that autonomy is a poorly discussed facet of reproductive health on a grassroots level.

Attitudes towards Family Planning

The perceptions of FP were ambivalent as they depended on the subjective experience, perceived health risk, cultural expectations and religious doctrines. A majority of the interviewees were positive since they recognized the role of FP in enhancing maternal and child health and family well-being - the same as Okigbo et al. (25). But still negative perceptions were present especially the fear of infertility, hormonal imbalance, and long-term health complication. Such misunderstandings still play roles of creating reluctance, as also cited by Oye-Adeniran et al. (26). The repetitive influences were the culture and religious beliefs. In societies where using contraceptives was viewed as defiant of religion, women would either shun FP altogether or find the secret usage method. This is congruent with the documented findings of Feyisetan and Casterline (22) who wrote that religious opposition has been a consistent hindrance to the acceptance of contraceptives in Nigeria.

Reproductive Autonomy and Decision-Making

The result states that reproduction choices made by women depend on various social strata such as husbands, peers, elders in community, and religious authorities. Even though some ladies made their own choices about the use of FP, many of them reported low autonomy because of patriarchal expectations. The spousal authority in decisions on contraceptives is corroborated with the findings of OlaOlorun and Hindin (23) who assert that the decisions about reproduction in southwestern Nigeria are controllable by men. Women with supportive partners responded better to contraceptives with confidence and those in restrictive relationships would either resort to secrecy or shun FP altogether. The power of the community norm and elder judgment was also high especially in rural or religion-based

context. These results support the point that advocating reproductive freedom in Nigeria needs to empower women, as well as involve men, families and communities in more social transformation.

Barriers to Family Planning

According to the participants, the primary obstacles to the uptake of FP were the fear of side effects, misinformation, and sociocultural opposition. Previous studies have reported fear of side effects, including fear of weight gain, menstrual irregularities, or infertility to be one of the biggest deterrents to using contraceptives in Nigeria (7, 18, 28). Popular myths and misconceptions such as the erroneous assumptions about the safety and efficacy of contraceptives have also been cited as a major obstacle hindering the uptake of family planning strategies by women (2, 7, 18). It has been demonstrated that sociocultural resistance, such as disapproval of partners, societal standards, and beliefs, are very potent in affecting reproductive autonomy and restricting the uptake of FP among women in such environments (3, 10, 17).

The myths regarding infertility, cancer, and moral wrongdoing are quite popular, which is also reported by Oye-Adeniran et al. (26) and Afolabi et al. (27). In addition, the challenges in access such as cost of transport, fluctuating supply of commodities, and bias by the provider were indicated as hindrances. All of these are factors that limit women in their capacity to make free informed choices concerning reproductive matters. The view that FP violates cultural or religious beliefs highlights the good role of contextual health communication techniques. According to Okonkwo et al. (28), it can be observed that myths can be effectively busted as faith-based and community-sensitive education bring more acceptance.

Suggestions for Improving Family Planning Services

They highlighted five important interventions as a result of the discussions, which included lifelong learning and sensitisation, incorporation of community and religious leaders, men inclusion in reproductive health dialogues, better access and affordability of services, and absence of judgmental provider attitudes. These recommendations are consistent with those provided by Sedgh et al. (29), who emphasized the need to have culturally sensitive FP education and involvement. The importance of male involvement was especially highlighted, which confirms the results by Moronkola and Fakeye (30), who attributed the positive attitudes of the partners towards increased contraceptive use. Another theme resonating the motive expressed by the participants is the call to have the approachable and respectful service delivery that Izugbara et al. (31) observed to be a significant benefit in terms of reproductive autonomy. In general, the findings are indicative of a community that is conscious but bound, educated but restricted by the social cultural reality. Awareness coupled with willingness and prevailing systemic barriers offer a challenge and an opportunity to interventions on reproductive health in Osun State.

CONCLUSIONS

The research is helpful in understanding the knowledge, attitudes, and independence of women in Osun State, Nigeria on FP. The results indicate that there is good awareness and overall positive attitudes towards using contraceptives, but there are still barriers that persist in the form of misinformation, cultural and religious resistance, dominance of spouses, and limited accessibility of services that prevent successful use. Marital status and educational attainment proved to be crucial factors, and it implies that the intervention should be gender-sensitive and socio-culturally oriented. Women who had higher education were more autonomous and accurate in their knowledge, whereas married women frequently had to bargain FP decisions in patriarchal frames. The evidence points to the need of multilevel approaches that are focused on individual, relational, and systemic factors at the same time. Enhancement of health learning, promotion of male participation, availability of uniform service delivery and incorporation of community-based advocacy may all enhance reproductive autonomy.

Abbreviations

- FP
Family Planning
- FGD
Focused Group Discussions
- IDI
In-Depth Interviews
- LGA
Local Government Areas

Declarations

Ethics Approval and Consent to Participate

The ethical guidelines of the Declaration of Helsinki, when conducting research with human subjects, were to be observed in the study. The Health Research Ethics Committee (HREC) of the College of Health Sciences, Osun State University, gave the ethical approval (Ref: HREC/2024/PBH/070). Proper authorization was also acquired before data collection to the concerned local authorities.

Consent for Publication

Not applicable

Availability of Data and Materials

The datasets (all transcripts) analyzed during the current study are available from the corresponding author on request.

Competing Interests

No competing interest

Funding

Not applicable

Author Contributions

IA conceptualized the research and wrote the first draft of the manuscript, while all authors (IA, CA & SOO) reviewed, edited, and approved the manuscript.

Acknowledgement

The authors would like to sincerely acknowledge the contributions of Ogundare Bolawale Marvellous for her invaluable assistance in data collection, transcription, and preliminary analysis. Her dedication and support were instrumental to the successful completion of this study.

References

1. United Nations Population Fund (UNFPA). State of World Population 2019: Unfinished business—the pursuit of rights and choices for all. New York: UNFPA; 2019.
2. World Health Organization (WHO). Family planning/Contraception. Geneva: WHO; 2023.
3. Izugbara CO. Socio-cultural barriers to women's reproductive autonomy in sub-Saharan Africa. *Reprod Health Matters*. 2015;23(45):155–62.
4. UNICEF. Adolescent fertility and reproductive health in sub-Saharan Africa. New York: UNICEF; 2022.
5. National Bureau of Statistics (NBS). Demographic and Health Survey 2021. Abuja: NBS; 2021.
6. National Population Commission (Nigeria), ICF. **Nigeria Demographic and Health Survey 2023–24: Key indicators report**. Abuja: National Population Commission; 2025. Available from: <https://www.dhsprogram.com/pubs/pdf/PR157/PR157.pdf>
7. Agbana BE, et al. Modern contraceptive use among women in Nigeria: Determinants and regional variations. *BMC Public Health*. 2023;23:1110.
8. National Population Commission (NPC). Nigeria Demographic and Health Survey 2018. Abuja: NPC; 2019.
9. WHO. Family planning and reproductive rights in sub-Saharan Africa. Geneva: WHO; 2020.
10. Cleland J, Bastin S. The cultural context of fertility control in Africa. *Stud Fam Plann*. 2014;45(2):105–21.
11. Upadhyay UD, et al. Development and validation of a reproductive autonomy scale. *Stud Fam Plann*. 2014;45(1):19–41.
12. Sen A. Gender and cooperative conflicts. In: *Persistent inequalities*. Oxford: Clarendon Press; 2019.
13. World Bank. Investing in women's reproductive health. Washington DC: World Bank; 2018.

14. Guttmacher Institute. Adding it up: Investing in sexual and reproductive health 2020. New York: Guttmacher Institute; 2020.
15. Wambua SM, et al. Determinants of family planning use in sub-Saharan Africa: A systematic review. *Glob Health Sci Pract*. 2018;6(4):748–59.
16. Singh S, Darroch JE. Adding it up: The costs and benefits of contraceptive services. Guttmacher Institute and UNFPA. 2014.
17. Blanc AK, et al. The role of gender norms in shaping reproductive health behaviors in Africa. *Glob Public Health*. 2018;13(4):505–19.
18. Woulibijnen J, et al. Barriers to family planning in Nigeria: a systematic review. *Afr J Reprod Health*. 2018;22(3):123–34.
19. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psych*. 2006;3(2):77–101. <https://doi.org/10.1191/1478088706qp063oa>
20. Ajaero CK, Odimegwu CO, Ajaero ID, Nwachukwu CA. Access to mass media messages, and use of family planning in Nigeria: a spatio-demographic analysis from the 2013 DHS. *BMC Public Health*. 2016;16(1):1–10.
21. Onwujekwe O, Uguru N, Etiaba E, Chikezie I, Uzochukwu B, Adjagba A. The economic burden of abortion in Nigeria: A cost–effectiveness analysis of unsafe abortion prevention. *BMC Health Serv Res*. 2019;19(1):1–12.
22. Feyisetan B, Casterline JB. Fertility preferences and contraceptive change in developing countries. *Int Fam Plan Perspect*. 2019;45(2):67–77.
23. OlaOlorun F, Hindin MJ. Having a say matters: Influence of decision-making power on contraceptive use among Nigerian women ages 35–49 years. *PLoS One*. 2014;9(6):e98702.
24. Blackstone SR, Iwelunmor J. Determinants of contraceptive use among Nigerian couples: evidence from the 2013 Demographic and Health Survey. *Contracept Reprod Med*. 2017;2(1):9.
25. Okigbo CC, Speizer IS, Corroon M, Gueye A. Exposure to family planning messages and modern contraceptive use among men in urban Kenya, Nigeria, and Senegal: a cross-sectional study. *Reprod Health*. 2015;12(1):63.
26. Oye-Adeniran BA, Adewole IF, Umoh AV, Oladokun A, Gbadegesin A, Ekanem EE, et al. Community-based study of contraceptive behaviour in Nigeria. *Afr J Reprod Health*. 2016;20(2):75–85.
27. Afolabi BM, Ezedinachi EN, Wagbatsoma VA, Eze S, Ezeanolue EE. Influence of spousal communication on family planning practices among couples in Nigeria. *J Biosoc Sci*. 2015;47(6):702–716.
28. Okechukwu EF, Akinola OI, Balogun MR, Afolabi OT. Access and barriers to contraceptive use among rural women in Nigeria. *Afr J Prim Health Care Fam Med*. 2017;9(1):e1–e6.
29. Sedgh G, Ashford LS, Hussain R. Unmet need for contraception in developing countries: examining women’s reasons for not using a method. *Guttmacher Institute Report*. 2016;1–36.

30. Moronkola OA, Fakeye OO. Male involvement in family planning decisions and practices among married men in Ibadan, Nigeria. *Afr J Reprod Health*. 2018;22(4):44–54.
31. Izugbara CO, Egesa CP, Kabiru CW. Service availability and readiness for family planning in Nigeria: implications for the Sustainable Development Goals. *BMC Health Serv Res*. 2016;16(1):1–9.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [INTERVIEWIDIFGDGUIDES.docx](#)