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Determinants of Contraceptive Use Patterns Among Women of Reproductive Age in Iwaya Community of Lagos State, Nigeria

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Abstract:

Reproductive health and family planning are essential to women's wellbeing and socioeconomic progress, with contraceptive use serving as a key indicator of healthcare access, reproductive health status, and women's autonomy in decision-making. The study assessed the determinants of contraceptive use patterns among women of reproductive age in Iwaya Community, Yaba LCDA, Lagos State, Nigeria. A quantitative descriptive cross-sectional survey was conducted among 117 women aged 15–49 in Iwaya, Lagos, to assess contraceptive use and influencing factors. Participants were selected using structured sampling, and data were collected via an administered questionnaire covering socio-demographics, contraceptive history, knowledge, and accessibility. The instrument was validated by experts and pilot-tested for reliability. Data were analysed using SPSS v25 with descriptive and Chi-square statistics. The study revealed a high contraceptive use prevalence, with 90.6% of respondents having ever used contraception and 84.6% currently using a method. Most began use between ages 20–24, and 59.4% reported very consistent use. Common methods used in the past year included implants, IUDs, and condoms. Knowledge was generally good (67.5%, mean score 12.67±2.02), with healthcare providers as the main information source. Accessibility was favourable, though 35.9% experienced stock-outs. There was relationship between the respondents level of knowledge and contraceptive use (r=0.41; P=0.001). The study found high contraceptive use and good knowledge among respondents, with implants, IUDs, and condoms most used. Despite favourable access, myths persist, highlighting the need for improved education,

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consistent supply, provider training, and extended clinic hours to enhance informed contraceptive choices.

Keywords: Reproductive health, Contraceptive use, Prevalence, Knowledge, Demographic factors, Accessibility,

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Introduction

Reproductive health and family planning are integral to women's overall well-being, empowerment, and socioeconomic development, with contraceptive use serving as a critical indicator of access to healthcare and reproductive autonomy (WHO, 2022). Despite global improvements, women in urban poor communities like Iwaya in Yaba Local Council Development Area (LCDA), Lagos State, face persistent challenges in contraceptive uptake. These barriers are deeply rooted in cultural beliefs, limited awareness, socioeconomic disparities, and misconceptions about contraceptive methods (Adeyemi et al., 2020). Understanding the specific factors affecting contraceptive use in such communities is essential to formulating effective, context-sensitive interventions aimed at improving reproductive health and reducing unintended pregnancies.

Globally, contraceptive use increased significantly from 1990 to 2019, with 49% of women of reproductive age using some form of contraception in 2019, up from 42% in 1990. Sub-Saharan Africa experienced notable growth during this period, with usage rising from 13% to 29% (Shagaro, Gebabo, & Mulugeta, 2022). Ethiopia, for example, saw an increase from 3% to 26%. Modern contraceptive methods dominate global use, accounting for 91% of all users in 2019. In sub-Saharan Africa and Ethiopia, modern method usage stood at 28% and 26%, respectively (Tessema et al., 2022). However, Nigeria lags behind these regional trends. The 2018 Nigeria Demographic and Health Survey (NDHS) reports a national contraceptive prevalence rate of only 17%, with even lower rates in some semi-urban communities like Iwaya (Boadu, 2022). The consequences of this low uptake include high rates of unintended pregnancies, unsafe abortions, maternal mortality, and pressure on already strained healthcare and economic systems (Johnson, 2017).

Women of reproductive age, defined as those between 15 and 49 years, hold significant influence over population dynamics through their fertility patterns (Ajala, 2020). Unfortunately, this demographic is also disproportionately affected by sexual violence, unintended pregnancies, and unsafe abortion practices, partly due to the low use of contraceptives (Alo et al., 2020). Although contraceptive use among married women is alarmingly low (12%), usage is higher among sexually active unmarried women (37%), of whom 28% use modern methods (Alo et al., 2020). The implications of poor contraceptive coverage are stark. In Nigeria, 17% of pregnancies are unwanted, and 51% of these end in induced abortion, highlighting the critical need for family planning services (Simegn, 2020). Contraceptive use plays a vital role in reducing maternal mortality, preventing unsafe abortions, and curbing unsustainable population growth. The long-term benefits of increased contraceptive use extend beyond individual health to improved child well-being, enhanced women's educational attainment, greater economic productivity, and stronger national development (Singh et al., 2021).

Dowerah et al. (2020) reported that 55.1% of women in urban Mysuru were using contraceptives, with tubectomy as the most commonly used method, followed by male condoms. The study found an unmet need for contraception at 18.16%, with 8.06% for spacing and 10.6% for limiting. Similarly, Sinha et al. (2023) found that 50.47% of women in an urban setting in Rajasthan were not using any contraceptive method. Male condoms were the most widely used (36.26%), and the primary reason for non-use was husbands' disapproval (31.28%). Socio-economic status was not significantly associated with contraceptive use, though misconceptions and fear of side effects influenced non-use. Konate et al. (2021), studying women in Kita, Mali, found a relatively low contraceptive prevalence rate (19.6%). Contraceptive use was significantly associated with age, number of living

children, knowledge and attitude towards contraception, decision-making autonomy in the household, and education. Interestingly, marital status and access to family planning information did not significantly influence contraceptive use.

In Ghana, Abdulai et al. (2020) observed a contraceptive prevalence rate of 36.8%. Women with secondary education and those who shared decision-making on childbearing with their partners were more likely to use contraceptives. Conversely, unemployment, lack of spousal awareness, and cultural or religious opposition reduced contraceptive uptake. Sheng et al. (2024) assessed knowledge, attitudes, and practices (KAP) regarding contraceptives among women with unplanned pregnancies in Hubei, China. The study found low KAP scores, with higher knowledge associated with urban residence and higher education. Knowledge and attitude were significantly associated with improved contraceptive practices. Singh et al. (2024) reported that 68% of women in Saharanpur had moderate knowledge of contraception, with media and healthcare workers being key sources. A majority (77%) had a favourable attitude, and 2.6% did not use any contraception. Use of barrier methods (25.3%) and oral contraceptive pills (21.3%) was most common. Knowledge was associated with education, residence, family size, and age.

Sato et al. (2021) in Turkey found a 71.9% contraceptive prevalence among urban women, with withdrawal being the most common method. Accessibility significantly influenced method choice—distance to facilities with long-acting methods decreased their usage but increased short-acting methods like condoms. Paul et al. (2022) in Kenya highlighted disparities between modelled and self-reported travel times to family planning facilities. Women often bypassed the nearest facility in favour of those further away, suggesting that perceived service quality and availability shape contraceptive behaviours.

Despite the wealth of national data, there remains a notable gap in understanding the localised factors influencing contraceptive use in urban communities like Iwaya. This study seeks to address this gap by assessing the prevalence of contraceptive use, the influence of socio-demographic characteristics, knowledge levels, and accessibility of services in Iwaya. Identifying these determinants is essential for developing tailored interventions that promote contraceptive use, enhance reproductive health outcomes, and support the autonomy of women in Lagos State.

The main objective of this study is to assess the determinants of contraceptive use patterns among women aged 15–49 in Iwaya, Lagos State, Nigeria. Specifically, the study seeks to determine the prevalence of contraceptive use among women of reproductive age in the Iwaya community, identify the socio-demographic factors such as age, education, income, and marital status that are associated with contraceptive use among respondents, assess the level of knowledge about different contraceptive methods among the women in the study population, and evaluate the accessibility of contraceptive services by measuring the distance to the nearest health facility.

Methods

A quantitative descriptive cross-sectional survey design was adopted to provide a comprehensive understanding of contraceptive use patterns among women in Iwaya, Lagos State. This design enables data collection at a specific point in time, offering a snapshot of current contraceptive practices and associated factors. The study population comprises women of reproductive age (15–49 years) residing in Iwaya community, aligning with standard demographic health survey parameters to ensure focus on individuals most impacted by contraceptive decisions. Inclusion criteria required that participants be within the reproductive age range, reside in the community, and give informed consent. Women who

declined participation or were critically ill were excluded from the study. The sample size was determined using Taro Yamane's formula for a single population proportion, with a population size of 144 and a significance level of 0.05, yielding a calculated sample size of 106. To account for possible non-responses or attrition, an additional 10% (approximately 11 participants) was included, bringing the total sample size to 117. A structured sampling technique was used to recruit 117 women of reproductive age from Iwaya community in the Yaba Local Council Development Area of Lagos State, ensuring broad and representative data collection for the purpose of the study.

Data for this study was collected using a structured, interviewer-administered questionnaire designed to assess patterns of contraceptive use and the factors influencing contraceptive decisions among women in the Iwaya community. The instrument, developed in English and translated into Yoruba and Pidgin English for accurate comprehension, comprised four main sections. Section A focused on socio-demographic information, gathering data on age, education, marital status, occupation, and other relevant personal characteristics. Section B explored contraceptive use history, including age at first use, frequency, specific methods used in the past year, consistency, and future intentions. Section C assessed knowledge of various contraceptive methods through ten questions covering sources of information, identification of modern methods, effectiveness, emergency contraception, STI protection, and myths. Section D examined accessibility to contraceptive services through eleven questions addressing distance, transportation, cost, affordability, service adequacy, healthcare provider availability, stock-outs, convenience, and safety concerns.

To ensure content validity, the questionnaire was reviewed by a panel of experts comprising three reproductive health specialists, two public health researchers, and a community health worker familiar with Iwaya. Feedback led to rephrasing for clarity and inclusion of questions on traditional methods. Reliability was confirmed through a pilot test with 11 women from Iwaya not included in the main study. Data was analysed using SPSS version 25.0, employing descriptive statistics and Chi-square tests with a 95% confidence level. Ethical approval was obtained from appropriate institutional review boards, and ethical standards were upheld through informed consent, voluntary participation, confidentiality, secure data handling, and protection of vulnerable participants, ensuring research integrity and respect for participants' rights.

Results

Table 1: Socio-demographic Characteristics of Respondents

Variables	Frequency (n =117)	Percentage (%)
Age (in years) 31.1 ±4.31		
20-29	39	33.3
30-39	74	63.2
40-49	4	3.5
Gender	117	100
Female		
Religion	71	60.7
Christianity	41	35,0
Islam	5	4.3
Others		
Marital Status		
Single	15	12.8
Married	101	86.3

Widowed	1	0.9
Ethnicity		
Yoruba	63	53.8
Igbo	37	31.6
Hausa	14	12.0
Others	3	2.6
Educational Level		
SSCE	49	41.9
BSc/HND	57	48.7
MSc	3	2.6
OND	5	4.3
Postgraduate degree	3	2.6

As shown in Table 1 above the mean age of the respondents was 31.1 ±4.3years. Most (60.7%) of the respondents were christian and married (86.3%) . More than half (53.8%) of the respondents were Yoruba and Almost half (48.7%) had Bachelor/HND degree.

Table 2: Distribution of the Respondents Contraceptive Use

Variables	**Frequency (n =117; * n = 106)**	**Percentage (%)**
Have you ever use any contraceptive method?		
Yes	106	90.6
No	11	9.4
Are you currently using any method?		
Yes	99	84.6
No	18	15.4
*At what age did you first use any contraceptive method		
Below 20 years	14	13.2
20-24 years	57	53.8
25-29years	26	24.5
30 years and above	9	8.5
How frequemtly do you use contraceptive		
Always	69	59.0
Sometimes	24	20.5
Rarely	6	5.1
Never	18	15.4
**Which contraceptive methods have your used in the past 12 months		
Condoms	28	18.8
Oral contraceptive pills	21	14.1
Imjectables	8	5.4
Intrautrine devices	35	23.5
Implants	40	26.8
Emergency contraceptives	6	4.0
Traditional methods (withdrawal, calendar)	11	7.4
*How consistent is your contraceptive use		

Very consistent	63	59.4
Consistent	28	26.4
Inconsistent	12	11.4
Very inconsistent	3	2.8
*Would you consider using contraceptives in the further		
Yes	11	100

As shown in Table 2 above majority (90.6%) of the respondents reported to ever use contraception and 84.6% reported to current use of contraceptive methods. More than half (53.8%) of the respondents reported ever use of contraceptive between 20-24 years. Fifty-nine percent reported they always use contraceptive. Of those who reported ever use 26.8% reported the use of implants and 59.4% reported they use contraception very consistently. All (100) those who reported never use stated that they would use it sometimes in the future. Furthermore, the respondents prevalence of contraceptive use measured on a 8-point rating scale showed a mean score and standard deviation of 6.17 and 2.12. This translate to 77.1% prevalence. Most (80.3%) of the respondents use any form of contraception (See, table 3).

Table 3: Categorization of the Respondents Contraceptive Use

	Frequency(n)	Percentage (%)	Mean ±SD
Low (0-4)	23	19.7	6.17± 2.12
High (5-8)	94	80.3	

Table 4: Distribution of the Respondents Socio-demographic (Age, Education and Martial status) associated with Contraceptive Use

Socio-demographic Variables	Contraceptive use		X^2	P-value
	Low F(%)	HighF(%)		
Age (in years)			3.27	0.19
20-29	4(10.3)	35(89.7)		
30-39	18(24.3)	56(75.7)		
40-49	1(25.0)	3(75.0)		
Education level				
SSCE	7(14.3)	42(85.7)	7.27	0.12
BSc/ HND	12(21.1)	45(78.9)		
M.Sc	1(33.3)	2(66.7)		
OND	3(60.0)	2(40.0)		
Postgraduate	0(0.0)	3(100)		
Marital staus			2.23	0.37
Single	5(33.3)	10(66.7)		
Married	18(17,8)	83(82.2)		
Widowed	0(0,0)	1(100)		

As shown in Table 4 above, there is no significant association between the respondent age (X^2 = 3.27; p = 0.19) ; level of education (X^2 = 7.27; p = 0.12); marital status (X^2 = 2.23; p = 0.37) and contraceptive use.

The respondent level of knowledge was measured on a 18 point rating scale. It was divided into poor (0-6); fair (7-12) good (13-18). The respondents had a mean knowledge score of 12.67 and standard deviation of 2.02. Most (67.5%) of the respondents had good level of knowledge about contraceptives

Table 5: Categorization of the Respondents Level of Knowledge about Contraceptive

	Frequency(n=117)	Percentage (%)	Mean ±SD
Poor (0-6)	1	0.9	12.67± 2.02
Fair (7-12)	37	31.6	
Good (13-19)	79	67.5	

Table 6: Respodents Level of Knowledge about Contraceptive Methods

Variables	Frequency (n =117)	Percentage (%)
Have you received information about contraceptive methods from healthcare provider		
Yes	114	97.4
No	3	2.6
*Which of the following are modern contraceptive methods		
Condoms	98	23.1
Oral contraceptives pills	99	23.3
Withdrawal	10	2.4
Intrauterine device (IUDs)	105	24.8
Implants	106	25.0
Calendar method	6	1.4
Which contraceptive methods is the most effective I preventing pregnancy		
Condom	18	15.4
Oral contraceptive pills	6	5.1
Intrauterine devices (IUDs)	85	72.6
Withdrawal methods	1	0.9
I do not know	7	6.0
Can emergency contraceptive pill prevent pregnancy if take after unprotected		
Yes	99	84.6
No	6	5.1
I do not know	12	10.3
Which contraceptive method can protect against sexually transmitted infection		
Oral contraceptive pills	3	2.6
Condoms	106	90.6
Injectables contraceptives	3	2.6
I do not know	5	4.3
How long does a contraceptive implant typically last		
1 year	9	7.7
3-5 years	97	82.9
10 years	3	2.6

I do not know	8	6.8
Are there permanent methods of contraception		
Yes	104	88.9
No	7	6.0
I do not know	6	5.1
Which of the following is a permanent contraceptive method for women		
Tubal ligation	96	82.1
IUDS	11	9.4
Oral pills	10	8.5
I do not know		
*Where can you access accurate information about contraceptive methods		
Health care centers	115	66.9
Pharmacies	27	15.7
Media (TV, radio,internte)	15	8.7
Friends and family	13	7.6
Religious institutions	2	1.2
Do you believe myths about contraceptive affect women's decision to use them		
Yes	79	67.5
No	24	20.5
I do not know	14	12.0

As shown in Table 6 above Majority (97.4%) of the respondents had received information about contraceptive methods from healthcare provider. Less than half of the respondents stated the following as a modern contraceptive method condoms (23.1%); implants (25%); IUDs (24.8%) and oral contraceptive pills (23.3%). Most (72.6%) of the respondents listed intrauterine device as the most effective contraceptive methods and 84.6% of the respondents reported that emergency contraceptive could prevent pregnancy if use immediately after having unprotected sex. Majority (90.6%) of the respondents reported that the use of condom could help to protect against sexually transmitted infection. Most (82.9%) of the respondents reported that implants normally last between 3-5years.Majority (88.9%) of the respondents reported that there are permanent contraceptive method and tubal ligation is one of the permanent methods for women (82.1%). Most (66.9%) of the respondents listed the Healthcare center as the place to access accurate information about contraceptive methods. Sixty- eight percent of the respondents reported that the myth surrounding contraceptive affected women decision to to use.

Table 7: Respondents Accessibility of Contraceptive Services

Variables *** Multiple responses**	**Frequency (n =117)**	**Percentage (%)**
How far is the nearest health facility that provides contraceptive service from your home		
Less than 1 km	27	23.1
1-3 km	68	58.1
4-6km	15	12.8

More than 6 km	7	6.0
How do you usually get to the nearest health facility		
Walking	27	23.1
Bicycle/motocycle	13	11.1
Public transport	68	58.1
Private care	9	7.7
How much does it typically cost to access contraceptive service at the nearest health facility		
Free	19	16.2
Less than #500	35	29.9
#500-1000	35	29.9
More than #1,000	28	24.0
Are the contraceptive services affordable for you		
Yes	89	76.1
No	2	1.7
Sometimes	26	22.2
How long do you usually wait to be attended to when accessing contraceptive services		
Less than 30 minutes	32	27.4
30 minutes to 1Hour	56	47.9
1-2 hours	25	21.4
More than 2 hour	4	3.4
Do you feel the health facility is adequately equipped to provide contraceptive service		
Yes	100	85.5
No	7	6.0
Not Sure	10	8.5
Are there enough healthcare providers available to attend to client seeking contraceptive service		
Yes	95	81.2
No	7	6.0
Not sure	15	12.8
Have you experienced stock-outs of contraceptive at health facility		
Yes	42	35.9
No	75	64.1
Is health facility's operating time convenient for you to access contraceptive services		
Yes	82	70.1
No	6	5.1
Sometimes	29	24.8
Do you feel safe traveling to the facility for contraceptive service		
Yes	107	91.5
No	10	8.5
*What challenges do you face when trying to access contraceptive services		

Long distance to the facility	23	13.4
High cost of service	17	9.9
Long waiting times	33	19.2
Stock-out of contraceptive methods	25	14.5
Unfriendly healthcare providers	22	12.8
Limited operating hours	52	30.2

As shown in Table 7 above more than half (58.1%) of the respondent lived between 1-3km away from the the nearest health facility. Fifty-eight percent of the respondents used public transportation to the health facility. Above a quarter (29.9%) of the respondents reported that they spent more than 500-1000 naira on transportation. Most (76.1%) of the respondents reported that contraceptive service is affordable. Almost half (47.9%) of the respondents reported that they waited for between 30minutes to 1hour before they were being attended to. Majority (85.5%) of the respondents reported that the health facility is adequately equipped and there were enough healthcare provider to attend to those seeking contraceptive services (81.2%). Most (64.1%) of the respondents reported that they had never experienced stock-outs of contraceptive at the health facility. Majority (70.1%) of the respondents reported that the health facility operating time is convenient for them and that they feel safe to travel (91.5%). The respondents reported the following as the challenges they encountered while accessing contraceptive services; limited operating hours (30.2%); long waiting hours (19.2%); long distance to the health facility (13.4%) and unfriendly healthcare providers (12.8%).

Table 8: Relationship Between Respondents Knowledge and Contraceptive Use

	Contraceptive Use n= 117	
	R-value	P- value
Level of Knowledge	0.41	0.001

The Pearson correlation analysis showed a significant relationship between the respondents level of knowledge and contraceptive use (r = 0.41 ; *p* = 0.001).

Discussion

The findings of this study revealed a remarkably high prevalence of contraceptive use among women of reproductive age in the Iwaya community, with 90.6% reporting ever-use and 84.6% reporting current use—figures far surpassing the national average in Nigeria, which ranges between 12% and 17% according to Odusina et al. (2020). This aligns with the observations of Ajayi et al. (2022), who found similarly elevated contraceptive rates in urban southwestern Nigerian communities where community interventions are robust. Most respondents began using contraceptives between ages 20-24, mirroring trends reported by Adanikin et al. (2021) and indicating early adoption post-childbirth. Long-acting reversible contraceptives (LARCs), particularly implants and intrauterine devices, were the preferred methods, consistent with global shifts reported by Bietsch et al. (2022) and Darroch and Sully (2021), who noted growing LARC adoption due to their efficacy and convenience. These patterns also suggest successful outcomes of targeted urban health interventions, such as those highlighted by Tukur et al. (2022) and Ajaero et al. (2022), which improve access and consistency of use through community engagement and reliable supply chains.

Unexpectedly, socio-demographic factors such as age, education level, and marital status showed no significant association with contraceptive use in this study, deviating from findings by Asaolu et al. (2020), who reported a strong link between educational attainment and contraceptive use. The homogeneity of the sample—with most participants being married and educated—may have limited variability and obscured such associations. Additionally, the widespread use of contraceptives across all categories suggests a successful normalisation of contraceptive behaviours within the community, potentially driven by community-wide campaigns and accessible services that cut across social strata. This result highlights the importance of contextual factors and suggests that in environments with effective outreach and service provision, traditional socio-demographic predictors may become less influential.

Knowledge levels regarding contraceptive methods were notably high among participants, with 67.5% demonstrating good knowledge and 31.6% fair knowledge. These findings echo the results of Onwuzurike et al. (2020) and Asaolu et al. (2021), who both observed heightened awareness among urban women in Nigeria, driven by greater exposure to information and targeted health education. A significant association between knowledge and contraceptive use was established, consistent with findings from Adedini et al. (2021), who found that accurate knowledge significantly increased the likelihood of contraceptive uptake. Similarly, Akinola et al. (2020), in a regional review, emphasised knowledge as a critical determinant of continued contraceptive use. The implication is that educational interventions remain vital tools for improving uptake and sustained contraceptive behaviour, especially in densely populated urban settings where such efforts may yield amplified effects.

Accessibility of contraceptive services in Iwaya was generally favourable. Most respondents lived within 1-3 km of a health facility, aligning with WHO (2018) standards for accessible healthcare. However, 58.1% of participants relied on public transport, suggesting that while

geographic access is adequate, transportation could pose an occasional barrier. The affordability of services was encouraging, with 76.1% finding them reasonably priced and nearly half spending less than ₦500. This finding supports earlier conclusions by Adeyemi et al. (2020), Darroch et al. (2021), Gbenga-Epebinu and Ogunrinde (2020), and Gbenga-Epebinu et al (2020) who stressed cost as a potential hindrance to access. Facility-related factors such as equipment quality and provider availability were reported positively by most respondents, distinguishing Iwaya from similar urban areas where Munakampe et al. (2020) and Silumbwe et al. (2021) reported shortages and infrastructural inadequacies. Although moderate waiting times were recorded (30 minutes to 1 hour for 47.9% of respondents), nearly one-fifth still identified delays as a concern. Overall, the community appears to benefit from targeted healthcare investments that have improved service delivery and user satisfaction, contributing to the high rates of contraceptive use observed.

Conclusion

Based on the findings of the study, it can be concluded that the prevalence of contraceptive use among the respondents is high. The age of first contraceptive use was largely between 20–24 years, and consistent use was reported by a majority. Implants, IUDs, and condoms were the most commonly used methods in the past 12 months. The level of knowledge about contraceptives was generally good and healthcare providers served as the primary source of information for most respondents. While awareness of modern contraceptive methods such as implants, IUDs, and condoms was moderate, there were still notable misconceptions, as seen in the low correct identification of modern methods and the impact of myths on decision-making. Accessibility to contraceptive services appeared favourable, as most respondents lived within 3 km of a facility, primarily used affordable public transportation, and perceived the services as affordable and adequately equipped. No statistically significant associations were found between contraceptive use and socio-demographic factors such as age, education, or marital status. Overall, the study suggests that while contraceptive use and knowledge are relatively high, efforts are still needed to improve method-specific awareness, combat prevalent myths, and ensure consistent supply and accessibility of contraceptives at health facilities.

Recommendations

1. Health education programmes should focus on increasing awareness of various contraceptive methods, especially among individuals with lower knowledge levels, to enhance informed decision-making.
2. Efforts should be made to improve the affordability and accessibility of contraceptive services, particularly by addressing transportation costs and stock-outs of contraceptives.
3. Healthcare providers should be trained to offer more supportive and friendly services to reduce barriers such as unfriendly attitudes and long waiting times.
4. Policies should be developed to extend the operating hours of health facilities to accommodate individuals with varying schedules, ensuring better access to contraceptive services.

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