



KNOWLEDGE OF CONTRACEPTIVES AMONG MARRIED WOMEN IN AMASSOMA, BAYELSA STATE, NIGERIA

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ABSTRACT

Background: Knowledge of contraceptives is a fundamental precursor to their adoption and correct use, yet awareness does not always translate into accurate understanding of what contraceptives are or which methods exist. This study assessed the level and depth of knowledge of contraceptives among married women in Amassoma, a riverine community in Bayelsa State, Nigeria. **Methods:** A descriptive cross-sectional design was used. In 2024, a structured, interviewer-administered questionnaire was completed by 400 married women in Amassoma, Bayelsa State, yielding a 100% response rate. Data were analyzed using IBM SPSS Statistics version 25.0, and results are presented as frequencies and percentages, illustrated with pie and bar charts. **Results:** Respondents' mean age was 31.0 (± 7.8) years, and most had secondary (40.3%) or tertiary (38.5%) education. Most respondents (82.8%) reported knowing what contraceptives are, correctly defining them as methods used to prevent pregnancy. However, only 18.0% could name multiple contraceptive types (pills, condoms, implants and injections together), while implants were the single most recognized method (27.3%); 17.3% could not name any method. Sixty percent recognized a benefit of contraceptive use, while 44.5% held at least one myth or misconception about contraceptives. **Conclusion:** General awareness of contraceptives in this community is high, but detailed, method-specific knowledge is narrower and misconceptions remain common. Targeted health education emphasizing the range of available methods and dispelling common myths is recommended.

KEYWORDS: *contraceptives; knowledge; awareness; married women; Amassoma; Bayelsa State; Nigeria.*

1. INTRODUCTION

Contraception remains one of the most cost-effective public health interventions for reducing unintended pregnancies, unsafe abortion and maternal mortality, yet its uptake across Nigeria remains among the lowest globally, with a modern contraceptive prevalence rate of only 12% to 20% among currently married women.^[1,2] A precondition for contraceptive use is knowledge: a woman cannot adopt a method she does not know exists, and a woman who holds inaccurate beliefs about a method is unlikely to trust or sustain its use.^[3] National surveys consistently report a paradox in Nigeria whereby awareness of contraception is comparatively high while actual practice lags far behind, a discrepancy that a recent South-South Nigeria analysis attributed to the country

having achieved widespread contraceptive awareness without a corresponding shift into routine contraceptive practice.^[3]

Evidence from the South-South geopolitical zone, where Bayelsa State is located, mirrors this national pattern: a large majority of childbearing women report having heard of at least one contraceptive method, yet actual use remains low, and knowledge itself is not uniform, varying by the specific method and by the depth of understanding of how the method works.^[3] Community-level studies within Bayelsa State have similarly found that while general awareness of family planning is often high, detailed and accurate knowledge of specific methods, their mechanisms and correct use is considerably more limited

and is shaped by education, religion and access to reliable sources of information.^[4,5] Consistent with this, a community-based survey comparing urban and rural women in Bayelsa State found persistently high unmet need for family planning despite general awareness of contraception, particularly among rural women.^[11] A study conducted among adolescents in Amassoma itself found generally high knowledge of emergency contraception, underscoring that this community has meaningful exposure to reproductive health information, but also that knowledge quality can vary depending on the population and contraceptive method examined.^[5]

Persistent myths and misconceptions, such as beliefs that contraceptives cause infertility, illness or promiscuity, have also been repeatedly documented across Nigeria and sub-Saharan Africa as a barrier that operates independently of basic awareness.^[6,7] Understanding not merely whether married women in a given community have heard of contraceptives, but what they believe contraceptives are, which specific methods they can name, and what misconceptions they hold, is therefore essential for designing effective family planning education programmes. Despite Amassoma's significance as host community to the Niger Delta University and a site of prior reproductive health research, there is limited published data specifically describing contraceptive knowledge among its married women, a population whose fertility decisions carry the greatest direct bearing on maternal and child health outcomes. This study therefore assessed the level and content of contraceptive knowledge among married women in Amassoma, Bayelsa State, Nigeria.

1.1 Novelty of the Study

Most existing Bayelsa-based studies measure contraceptive knowledge as a single binary item, whether a woman has "heard of" contraceptives, which conceals how awareness actually breaks down in practice. To our knowledge, this is the first study conducted in a Niger Delta riverine host-community to formally decompose contraceptive knowledge into its constituent layers within a single sample: general awareness, correct definitional understanding, method-specific recall, perceived benefit, and prevailing misconceptions, and to present this layered decomposition visually through pie and bar charts rather than as an undifferentiated awareness figure. By quantifying precisely where the awareness-to-knowledge gap emerges, largest at the level of method-specific recall rather than general awareness, this study offers a more actionable, diagnostic evidence base than prior single-item awareness surveys for designing targeted health education in Amassoma and comparable Niger Delta communities.

2. METHODS

2.1 Study Design and Setting

This was a descriptive cross-sectional study conducted in 2024 among married women in Amassoma, a riverine community in Southern Ijaw Local Government Area of

Bayelsa State, in the core Niger Delta region of Nigeria, and host community to the Niger Delta University.

2.2 Sample Size Determination

The minimum sample size was determined using the Cochran (1977) formula for estimating a single population proportion: $n = Z^2pq/d^2$, where $Z = 1.96$ (the standard normal deviate at a 95% confidence level), p = the anticipated prevalence of contraceptive use, $q = 1 - p$, and $d = 0.05$ (a 5% margin of error). In the absence of a prevalence estimate specific to Amassoma, the modern contraceptive prevalence of 36.8% previously reported among women in the Bayelsa Central Senatorial Zone^[4] was adopted as the most geographically proximate and contextually comparable prior estimate. This yielded a minimum computed sample size of 357 women ($n = 1.96^2 \times 0.368 \times 0.632 \div 0.05^2 = 357.4$), which was inflated by 10% to allow for anticipated non-response and incomplete questionnaires ($357 \times 1.10 \approx 393$) and rounded up to a final target of 400 married women. This target was fully achieved: all 400 women approached completed the questionnaire, giving a response rate of 100%.

2.3 Sampling Technique and Eligibility

A multi-stage sampling technique was used to select respondents. Amassoma was first stratified into its constituent quarters (wards); within each quarter, households were then selected by systematic random sampling, using a sampling interval derived from the total number of households in the quarter relative to the proportion of the overall sample allocated to it. In households with more than one eligible married woman, a single respondent was selected by simple random sampling (balloting). Eligible participants were married women aged 15–49 years who had been resident in Amassoma for at least six months at the time of the survey and who provided informed consent; women who were not currently married, not usually resident in the community, or unable to provide informed consent were excluded. This sample size and sampling procedure is reported consistently across the three companion manuscripts arising from this dataset (knowledge; utilization and correlates of use; and facilitators and barriers) to ensure methodological coherence across the series.

2.4 Data Collection Instrument

Data were collected using a structured questionnaire administered by trained interviewers. The instrument captured respondents' socio-demographic characteristics and their knowledge of contraceptives, including whether they had heard of contraceptives, their understanding of what contraceptives are, and the specific methods they could identify.

2.5 Data Analysis

Data were entered and analysed using IBM SPSS Statistics version 25.0. Descriptive statistics (frequencies and percentages) were used to summarise socio-demographic

characteristics and knowledge variables; key distributions are additionally presented as pie charts (for two-category variables) and bar charts (for multi-category variables) to aid interpretation.

2.6 Ethical Considerations

Participation was voluntary, and informed consent was obtained from each respondent prior to data collection. Confidentiality of responses was assured throughout the study.

3. RESULTS

3.1 Socio-Demographic Characteristics

Table 1 shows the socio-demographic characteristics of the 400 respondents. The mean age of respondents was 31.0 (± 7.8) years, with the largest proportion (33.0%) aged 31-36 years. Most respondents had attained secondary (40.3%) or tertiary (38.5%) education, were predominantly Christian (99.0%), and were mostly engaged in personal business (58.0%). Nearly a third (32.5%) had no living children at the time of the study.

Table 1: Socio-Demographic Characteristics of Respondents (N = 400)

Variable	Frequency	Percent (%)
Age (years) 19–24	125	31.3
25–30	57	14.2
31–36	132	33.0
37–42	47	11.8
43 and above	39	9.8
Education: No education	15	3.8
Primary	16	4.0
Secondary	161	40.3
Tertiary	154	38.5
Postgraduate	54	13.5
Religion: Christianity	396	99.0
Islam	1	0.3
Traditional	3	0.8
Occupation: Fishing	12	3.0
Farming	40	10.0
Personal business	232	58.0
Civil servant	20	5.0
Student	89	22.3
Housewife	7	1.8
Parity: None	130	32.5
1–2	97	24.3
3–4	70	17.5
5–6	82	20.5
7–8	21	5.3

Data presented as number (%). Mean age ($\pm$ SD) = 31.0 $\pm$ 7.8 years.

3.2 Knowledge of Contraceptives

Figure 1 shows that the majority of respondents (82.8%) reported knowing about contraceptives, while 17.3% did not. Among those who understood the concept, the correct definition of contraceptives as "things or techniques employed to prevent pregnancy" was the most frequently selected response (82.8%), while smaller proportions incorrectly described contraceptives as things used to avoid sex (10.3%) or to stop menstruation (7.0%).

Knowledge of Contraceptives (N = 400)

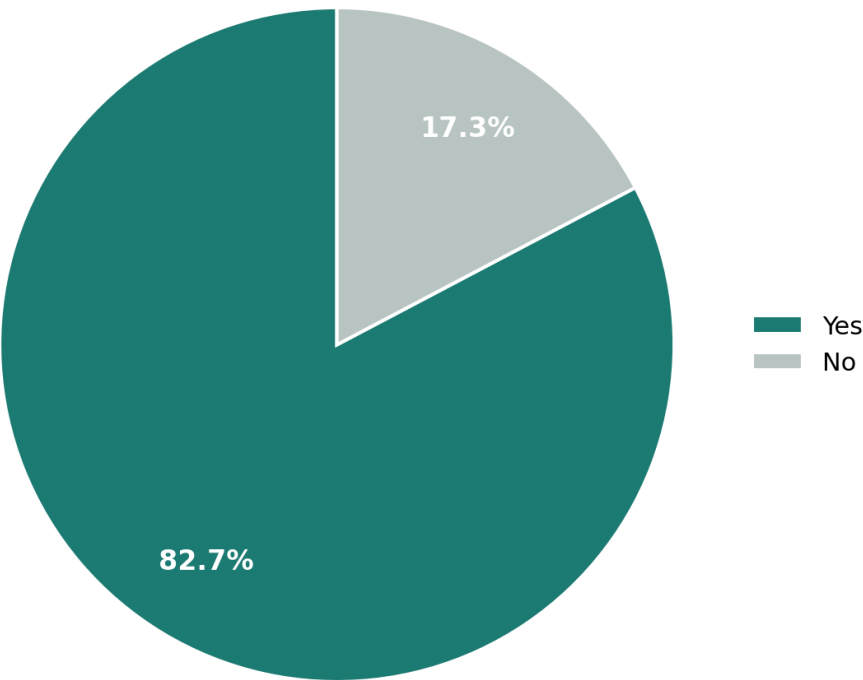


Figure 1: Knowledge of Contraceptives among Respondents (N = 400)

Regarding specific method knowledge, Figure 2 shows that implants were the single most recognised contraceptive type (27.3%), followed by respondents who could name a combination of pills, condoms, implants and injections together (18.0%). Individually, condoms (12.3%), injections (9.3%) and pills (7.5%) were less frequently

named, and awareness of the withdrawal (2.5%) and calendar (0.5%) methods was minimal. Notably, 17.3% of respondents could not name any contraceptive method at all, matching the proportion who reported not knowing about contraceptives generally.

Specific Contraceptive Methods Named by Respondents (N = 400)

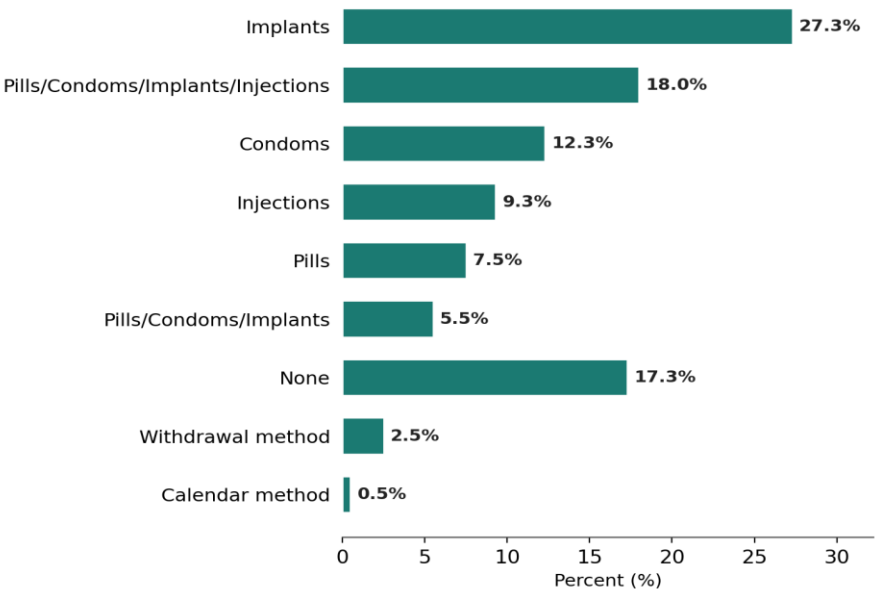


Figure 2: Specific Contraceptive Methods Named by Respondents (N = 400)

Sixty percent of respondents recognised at least one benefit of contraceptive use, while 40.0% did not (Figure 3). Despite generally high awareness, 44.5% of

respondents held at least one myth or misconception about contraceptives, compared with 55.5% who reported none (Figure 4).

Awareness of a Benefit of Contraceptive Use (N = 400)

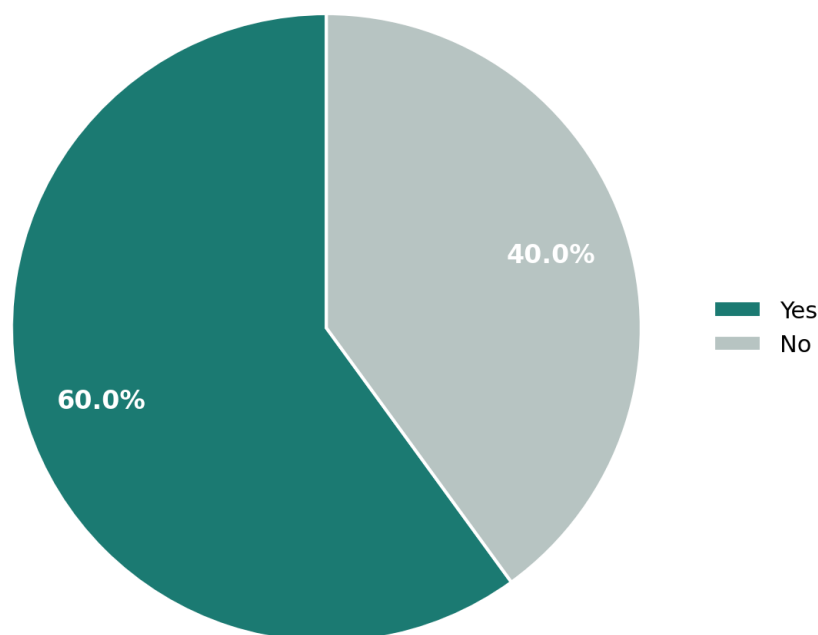


Figure 3: Awareness of a Benefit of Contraceptive Use (N = 400).

Holds a Myth/Misconception about Contraceptives (N = 400)

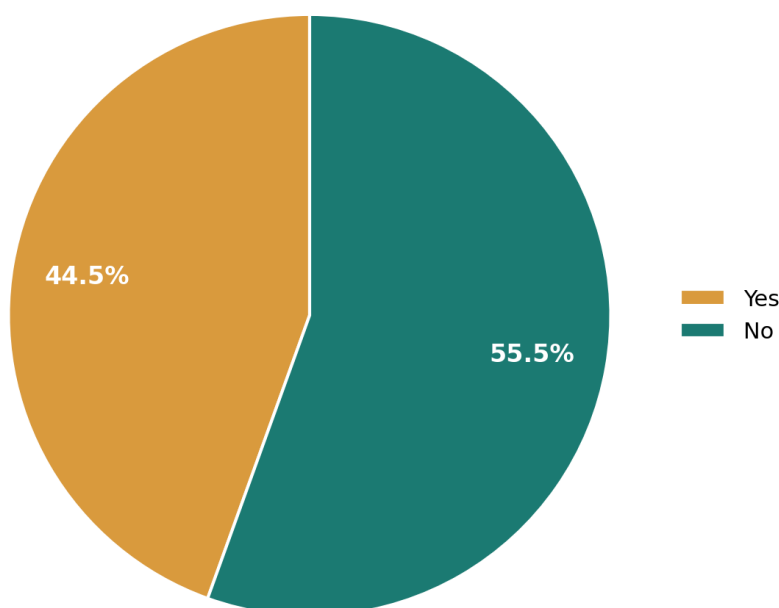


Figure 4: Holds a Myth/Misconception about Contraceptives (N = 400).

4. DISCUSSION

This study found that a large majority of married women in Amassoma (82.8%) had heard of and could correctly

define contraceptives, a level of awareness broadly consistent with national and sub-national data indicating high general awareness of family planning across Nigeria

and sub-Saharan Africa.^[3,8] This finding also aligns with an earlier community study among adolescents in the same Amassoma community, which similarly documented substantial awareness of contraceptive methods, suggesting sustained exposure to reproductive health information in this locality, likely linked in part to the presence of the Niger Delta University and associated health outreach.^[5]

However, a closer look at method-specific knowledge reveals a narrower picture than the headline awareness figure suggests. Only 18.0% of respondents could identify a broad combination of methods, while implants alone accounted for the single highest method-specific recognition (27.3%), and 17.3% could not name any method. This gap between general awareness and detailed method knowledge mirrors findings from a South-South Nigeria analysis of the 2018 Nigeria Demographic and Health Survey, which similarly reported that although the large majority of women knew of at least one contraceptive method, this awareness did not equate to comprehensive or accurate method-specific knowledge, and did not reliably translate into use.^[3] A recent nationwide analysis of contraceptive intention similarly found that knowledge, while necessary, was only one of several sociodemographic and attitudinal factors shaping women's actual reproductive decisions, reinforcing that awareness campaigns alone are unlikely to be sufficient.^[10] Similar findings have been reported among women in the Bayelsa Central Senatorial Zone, where education and exposure to reliable information sources were identified as key determinants of the depth of contraceptive knowledge.^[4]

The finding that 44.5% of respondents held at least one myth or misconception about contraceptives is consistent with a substantial body of evidence from Nigeria and other sub-Saharan African settings documenting persistent beliefs that contraceptives cause infertility, illness, weight gain or promiscuity.^[6,7] Such misconceptions, as demonstrated in qualitative work from Kaduna State, can undermine confidence in contraceptive methods even where basic awareness is high, and often circulate through informal social networks rather than health facilities.^[6] The comparatively high educational attainment of this sample (79% with secondary education or higher) may explain the relatively favourable overall knowledge profile observed, since higher education has consistently been associated with better contraceptive knowledge in similar Nigerian populations.^[4] This is further supported by a recent comparative study of Kano and Bayelsa States, which found that contraceptive knowledge levels were statistically similar across the two states despite their very different socio-cultural and religious contexts, suggesting that the gap between knowledge and practice observed nationally is not simply an awareness problem but reflects deeper, context-specific barriers to translating knowledge into confident, accurate understanding and use.^[9]

These findings suggest that health education interventions in this community should move beyond simply raising awareness that contraceptives exist, toward building specific, method-level literacy, particularly around underused methods such as pills, injections and calendar-based methods, while directly and repeatedly addressing common myths, especially fears around infertility and side effects, which appear to persist even in a well-educated population.

4.1 Limitations

This study has two notable limitations. First, knowledge was assessed using single-response, forced-choice items on definitions and method names, which may understate partial or fragmented understanding and cannot capture the depth or accuracy of what respondents believe about how each method works. Second, the sample was drawn from a single riverine community with a specific socio-demographic profile (notably, near-universal secondary-or-higher education), so findings may not generalize to other communities in Bayelsa State or the wider Niger Delta with different educational and cultural contexts.

5. CONCLUSION AND RECOMMENDATIONS

General awareness of contraceptives among married women in Amassoma is high, but detailed knowledge of the range of available methods is narrower, and misconceptions remain common in over four in ten respondents. Community-based health education, delivered through trusted local channels and reinforced by health workers, is recommended to broaden method-specific knowledge and directly counter prevailing myths, with a particular focus on women with lower educational attainment who may have less exposure to accurate information.

6. CONTRIBUTIONS TO KNOWLEDGE

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

- It provides the first documented, method-level breakdown of contraceptive knowledge specifically among married women in Amassoma, moving beyond the single "have you heard of contraceptives" item used in most prior Bayelsa-based surveys and the adolescent-focused knowledge data previously available for this community.
- It empirically quantifies the size of the awareness-to-knowledge gap in this population: 82.8% general awareness narrows to 18.0% multi-method recall and 27.3% single-method (implant) recall, with 17.3% able to name no method at all, showing precisely where health education efforts are most needed.
- It documents that myths and misconceptions remain common (44.5%) even in a comparatively highly educated riverine population (79% with secondary education or higher), challenging the assumption that educational attainment alone is sufficient to dispel misinformation about contraceptives.

- It demonstrates and models a layered, visually-driven analytic approach (pie charts for binary awareness/attitude items and bar charts for multi-category method recall) that other community-level contraceptive knowledge surveys in the Niger Delta can adopt to make similar awareness-knowledge gaps visible.
- It establishes a locally anchored sample-size methodology (Cochran's formula applied to the most geographically proximate prior prevalence estimate) that can be reused as a template for future community-based reproductive health surveys in Bayelsa State.
- It generates baseline, community-specific knowledge indicators for Amassoma against which the effectiveness of future family planning education interventions in this and comparable Niger Delta host communities can be evaluated.

Conflict of Interest

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

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