# TACKLING COMMUNICATION BARRIERS AND INFORMATION GAPS IN WOMEN'S CONTRACEPTIVE CHOICES IN OYE LGA, EKITI STATE, NIGERIA

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## Abstract

The availability of correct information and communication is key to the reproductive health decisions of women, especially in rural areas, where the socio-cultural barriers are still strong. This study examined the barriers to communication and information gaps in the contraceptive decision-making of women in Oye LGA, Ekiti State, Nigeria. The objectives were to identify major sources of contraceptive information, determine the barriers women face in accessing such information, assess the impact of these barriers on informed decision-making, and suggest strategies to improve communication and uptake. A survey design was adopted, with structured questionnaires administered to women of reproductive age in Oye LGA. Data collected from a sample size of 310 respondents were analyzed using descriptive and inferential statistics, with hypotheses tested at the 0.05 significance level. Results showed that healthcare providers, community health workers, and family/peers were the most important sources of information, and mass media were less important. Nevertheless, cultural beliefs (x = 3.80) and stigma (x = 3.90) turned out to be the most severe communication barriers, compared with language or physical access limitations. The paper then concludes that the problem is not the lack of information in Oye LGA, but rather the socio-cultural restrictiveness which perverts its efficiency. It suggests a multi-pronged communication strategy that empowers health providers, deals with stigma, and incorporates family planning into community and school systems.

**Keywords:** Communication barriers, Information gaps, Women's contraceptive choices, Oye LGA, Breaking the silence

## Introduction

Access to and use of modern contraceptives is globally central to curbing maternal mortality, preventing unwanted pregnancies and promoting health outcomes of women. However, the sub-Saharan African region continues to have one of the lowest contraceptive prevalence rates despite an increase in awareness (Ochako, Izugbara, and Wekesa, 2021). In Nigeria, modern contraceptive prevalence (mCPR) is estimated at about 1217 in Nigeria, despite a relatively high level of knowledge about contraceptive methods among women of reproductive age (1549 years). Only a small part of women using contraceptives actually uses the methods (Adebowale and Palamuleni, 2021). Such discrepancy between awareness and practise supports the long-term impact of communication barriers and misinformation, religious limits, and spousal resistance (Anjorin and Adebowale, 2022; Chima, Okafor and Akinyemi, 2023).

Recent data in Nigeria show that 98.6 % of women know at least one modern birth control method, but only approximately 50.5 % of the population are using it (Owolabi, Adewole & Bello, 2020). The most common deterring factors are that one wants more children, is afraid of side effects, and the partner is not supportive. In addition, socio-demographic factors including educational level, marital status and religious affiliation play a key role in influencing contraceptive decisions (Owolabi et al., 2020). At the same time, the expansion of the digital technologies, especially mobile phones and social media, has created new

opportunities in terms of spreading the information on contraceptives. These platforms provide privacy and accessibility particularly to young women who act in a conservative environment. Still, there is an issue of the reliability of online news, and misinformation is one of the prominent concerns (Adebayo, Lawal and Adeyemi, 2024). In line with this, though traditional channels like health workers and radio broadcast still have their place, the interplay between modern and traditional information sources and the obstacles that persistently exist in this context should be subjected to intensive research.

Although the level of awareness of contraceptive methods by women in Nigeria and especially in Ekiti State has been on the increase, the level of its use is still sub-optimal. The obstacles women still have to face include religious and cultural resistance, spouse rejection, misunderstandings about side effects, and negative health provider attitudes (Chima et al., 2023; Adebowale and Palamuleni, 2021). Despite the abundance of information on contraception, the sources of information are widely different in terms of their credibility and accessibility. As an illustration, health workers can make the right information available but not always be approachable, and digital and peer sources can be more easily accessible but often spread misinformation (Adebayo et al., 2024). As a result, the issue is not just a lack of contraceptives uptake, but rather a combination of information sources and communicative barriers that jointly influence the decision of women to contraceptives in Ekiti State. In the absence of a subtle knowledge of these dynamics, reproductive health interventions will become useless, hence, denying many women the chance to make informed reproductive decisions.

**Objectives of the Study**
1. To identify the different sources of information regarding contraceptive methods available to women in Oye LGA, Ekiti State
2. To investigate the communication barriers women face when seeking information about contraception
3. To assess the impact of communication barriers on women's ability to make informed decisions about contraceptive methods.
4. To ascertain the strategies for improving communication and information sources towards improving reproductive health outcomes in Oye LGA.

**Research Hypothesis**
H$_o$1: Women in Oye LGA do not experience significant communication barriers when seeking contraceptive information.
H$_o$2: Communication barriers have no significant impact on women's ability to make informed decisions about contraceptive methods in Oye LGA, Ekiti State.
H$_o$3: Improved communication and information dissemination strategies do not significantly influence contraceptive uptake or reproductive health outcomes among women in Oye LGA.

**Literature/Theoretical Review**
Contraceptive use is an intentional behaviour to prevent pregnancy, enhance reproductive health, and maternal and child wellbeing, gender equality, and economic development (WHO, 2023). Hormonal methods, intrauterine devices, barrier methods, permanent procedures, and emergency contraception are all types of modern contraceptives, and withdrawal, rhythm, and lactational amenorrhea are all types of traditional contraceptives (Bello, 2021; Okonkwo and Adeyemi, 2022). Although practised worldwide, the use of contraceptives in sub-Saharan Africa, including Nigeria, is low due to cultural practises, religious beliefs, misinformation and lack of access to health-care services (Adebayo, 2021; Olatunji, 2020). Education and economic independence have a great impact on the contraceptive decisions of women: those who are educated and financially independent tend to use modern methods. The choice of contraceptives is influenced by the media, peers and social networks as well, and gender inequalities and low male participation remain the barrier to adoption (UNFPA, 2022; WHO, 2023).

Availability of information that is sound is a pillar of good contraceptive decision-making. The most reliable source is healthcare providers who provide counselling on the features of methods, their effectiveness, and possible adverse effects, thus increasing the rates of utilisation (Okonkwo, 2022; Omotayo, 2020). The mass-media campaigns can be used to raise awareness among people and change attitudes, especially in city residents, but their effectiveness depends on cultural relevance, repetition, and message clarity (Ajibade, 2023; Abubakar & Yusuf, 2022). Contraceptive preference also depends on interpersonal communication in the family and peer network, and digital platforms provide easily accessible

information that can sometimes be misleading (Umar & Adeniyi, 2022; Ogunyemi, 2023). Misinformation, stigma, and disapproval of society, in particular, of unmarried women and adolescents reduce the tendency to use contraceptive services (Adebayo & Oladipo, 2022; Ojo, 2022).

The socio-cultural and religious determinants are still quite a challenge. According to empirical evidence, the inculcation of beliefs and doctrinal teachings tends to discourage the use of contraceptives; thus, numerous women tend to listen to the advice of relatives, religious leaders, and the elders of the community instead of listening to professional caregivers (Bello, 2023; Akinola & Adeyemi, 2019; Ogunleye & Salami, 2022). The wrong beliefs about negative outcomes, infertility, or ethical consequences also discourage acceptance, especially in rural communities like Oye Local Government Area (Ojo, 2022; Adeyemi, 2021). The access to accessible healthcare services, quality counselling, and culturally sensitive educational programmes play a central role in bridging the gap between knowledge and use since women in urban and higher-socioeconomic settings are more likely to embrace contraceptives than their rural counterparts (Akinyemi 2020; Adebowale 2021).

Several studies have already shown that the increase in contraceptive use requires multi-faceted interventions. In partnership with religious and traditional custodians; community mobilisation, culturally sensitive communication, and media campaigns coupled with professional counselling will help to break the misconceptions and make people make informed decisions (Eze, 2020; Bello, 2023; Akinola & Adeyemi, 2019).

It is necessary to integrate communication barriers, social stigma, and healthcare access gaps, especially among the adolescent demographic, unmarried women, and rural communities. It is repeatedly demonstrated in the literature that the use of contraceptives depends on the interplay of personal knowledge, existing socio-cultural conventions, health-care facilities and communications strategies, which explains the importance of context-specific and customised interventions in the environment like Oye LGA, Ekiti State.

**Theoretical Review**

This study is guided by the Health Belief Model. The model was propounded in the 1950s by social psychologists in the United States Public Health Service, like Godfrey M. Hochbaum, Irwin M. Rosenstock and others, as a means of explaining why individuals did not engage in preventive health programmes like tuberculosis screening (Hochbaum, 1958; Rosenstock, 1974). According to the model, the probability that an individual will engage in a protective health behaviour is determined by cognitive appraisals of a health threat and the benefits versus costs of action. Constructs of the health belief model are perceived susceptibility (belief of personal risk), perceived severity (belief of seriousness of the condition), perceived benefits (belief that a recommended action will reduce threat), perceived barriers (perceived costs or obstacles to action), cues to action (triggers that prompt behaviour), and subsequent additions like self-efficacy (confidence in ability to act) (Rosenstock, 1974; StatPearls, 2024). The model is therefore simply a decision-making model: when perceived threat (susceptibility x severity) and perceived benefits are greater than perceived barriers, and when there are enough cues and self-efficacy, behaviour change is more likely (Jones, 2014; StatPearls, 2024). The model is relevant to this study since it guides focus to the role of perception of vulnerability to pregnancy, the severity they attach to unintended pregnancy (or its effects), their beliefs about the advantages of different contraceptive methods, and the perceived barriers (cost, side-effects, partner opposition, cultural stigma, misinformation) in combination with the perception of vulnerability to pregnancy determine contraceptive uptake. Also, its focus on action cues is directly overlaid on the information sources: trusted health workers, community influencers, mass media, or interpersonal networks may be used as cues that trigger contraceptive decision-making, whereas poor or conflicting communication may be used as a barrier that reduces perceived benefits or increases perceived costs (Jones, 2014; StatPearls, 2024).

**Materials and Method**

The study adopted a survey research design using structured questionnaire as the instrument. The population comprising of women between the ages of 15 and above in Oye LGA, is 120,000 according to the Ekiti State Ministry of Health and Human Services (2024). Meanwhile, the sample size calculated using Krejcie and Morgan (1970) formula is 310.

A multistage sampling procedure was employed. In the first instance, Oye-Ekiti LGA was purposively selected as the area of study because of its proximity to the researchers and also, because the subject of study has not been well researched in the location. In determining the number of communities to

be selected, simple random sampling was used to give every participant a fair chance of being selected. The researchers adopted the lottery method, whereby each community was given a number and then numbers were individually written on slips of paper. The slips were placed and mixed thoroughly in a bowl. Then, the researchers asked some persons that were present as at the time of the lottery, five (5) persons to be specific were asked to pick one slip each out of the various slips in the bowl which they did. This technique was used by the researcher to select five (5) communities on which the questionnaires were administered. From the process, Araromi, Idofin, Egbe, Oye-Egbo and Irona communities emerged.

Questionnaires were administered proportionately across these communities. Emerging from the process, questionnaires were administered in the following proportions: Egbe=98, Araromi=79, Idofin=51 Irona=43, and Oye-Egbo=39. Consequently, within each community, convenience sampling was used to reach eligible respondents who satisfied the inclusion criteria such as those who were females; residents of the community; within reproductive age from 15 and above; and willing to participate.

The instrument validity was determined through an expert review panel and a pilot test carried out on 27 women in Ifaki, Ido Osi Ekiti LGA. Some changes were made based on the pilot results to enhance clarity and reliability of the content. The data were analyzed using descriptive statistics and the hypotheses were tested relying on inferential analysis from chi-square tests.

**Presentation of Results**
A total of 310 semi-structured questionnaire was distributed to the target respondents out of which only 300 were fully completed and returned valid. This represents 97 percent rate which is significant enough to proceed with the study.

**Data Presentation/ Analysis**
**Table 1: Demographic Characteristics of the Respondents**

| Variables | Category | Frequency (n=300) | Percentage |
|---|---|---|---|
| Age | 15 – 24 years | 13 | 4.30 |
| | 25 – 34 years | 94 | 31.3 |
| | 35 – 44 years | 130 | 43.3 |
| | 45 – 49 years | 51 | 17.0 |
| | 50 years and above. | 12 | 4.00 |
| | | 17 | 6.00 |
| Marital status | Single | 224 | 75.0 |
| | Married | 46 | 15.0 |
| | Divorced | 13 | 4.30 |
| | Widowed | | |
| | | | 1.00 |
| Level of education | No formal education | 3 | 4.00 |
| | Primary school | 13 | 32.0 |
| | Secondary school | 96 | 58.0 |
| | Tertiary | 173 | 5.00 |
| | Postgraduate | 15 | |
| | | | 8.00 |
| Occupation | Unemployed | 24 | 36.0 |
| | Self-employed | 109 | 33.0 |
| | Public sector employee | 98 | 18.0 |
| | Private sector employee | 54 | 5.00 |
| | Student | 15 | |
| Monthly income range | Below ₦10,000 | - | |
| | ₦10,000 - ₦30,000 | 41 | 13.0 |
| | ₦30,000 - ₦50,000 | 56 | 19.0 |
| | ₦50,000 - ₦100,000 | 102 | 34.0 |
| | Above ₦100,000 | 101 | 37.0 |

The demographic profile of the respondents (n=300) shows that the majority (43%) were aged 35–44 years, followed by 31% aged 25–34 years, while only 4% were below 24 or above 50 years. Most respondents were married (75%), with 15% divorced, 6% single, and 4% widowed. In terms of education, 58% had tertiary education, 32% secondary, 5% postgraduate, and only 5% had primary or no formal education. Occupationally, 36% were self-employed, 33% worked in the public sector, 18% in the private sector, 8% were unemployed, and 5% students. Regarding income, 37% earned above ₦100,000 monthly, 34% between ₦50,000–₦100,000, 19% between ₦30,000–₦50,000, and 13% between ₦10,000–₦30,000.

**Table 2: Sources of information available to women in Oye LGA, Ekiti State, regarding contraceptive methods**

| S/N | Questionnaire Items | SA | A | N | SD | D | X | SD | Remark |
|---|---|---|---|---|---|---|---|---|---|
| 1. | I receive information about contraceptive methods from healthcare providers (doctors, nurses, etc.). | 170 (57%) | 75 (25%) | 31 (12%) | 6 (2%) | 18 (6%) | 3.80 | .11 | Accepted |
| 2. | I get information about contraception through media channels (radio, TV, social media). | 119 (40%) | 115 (38%) | 29 (10%) | 13 (4%) | 24 (8%) | 3.00 | .20 | Accepted |
| 3. | My family and friends provide me with information on contraceptive methods. | 50 (18%) | 88 (29%) | 78 (26%) | 46 (15%) | 38 (13%) | 3.90 | .30 | Accepted |
| 4. | I rely on printed materials (brochures, pamphlets, magazines) for contraceptive information. | 85 (28%) | 54 (18%) | 69 (23%) | 39 (13%) | 39 (18%) | 3.70 | .44 | Accepted |
| 5. | Community health workers are a reliable source of information on contraceptives. | 146 (49%) | 101 (34%) | 42 (14%) | 5 (1%) | 6 (2%) | 3.70 | .90 | Accepted |
| | Overall cluster average | | | | | | 3.62 | .39 | Accepted |

*Keys: **X** = Mean of responses, SD = Standard Deviation, A = Agree, N= Neutral SA = Strongly Agree*

Table 2 shows that women in Oye LGA access contraceptive information from multiple sources. Healthcare providers ranked highest ($\overline{x}$ = 3.80), followed closely by family and friends ($\overline{x}$ = 3.90) and community health workers ($\overline{x}$ = 3.70). Media channels ($\overline{x}$ = 3.00) and printed materials ($\overline{x}$ = 3.70) were also identified as relevant sources. The overall mean score of 3.62 (SD = .39) indicates that respondents generally agreed that diverse sources of information on contraceptive methods are available to women in the area.

**Table 3: Communication barriers women in Oye LGA face when seeking information about contraception**

| S/N | Questionnaire Items | SA | A | N | SD | D | X | Remark |
|---|---|---|---|---|---|---|---|---|
| 1. | Language differences make it difficult for me to understand information about contraceptive methods. | 35 (12%) | 58 (19%) | 74 (25%) | 93 (31%) | 40 (13%) | 3.20 | Rejected |
| 2. | Cultural beliefs and traditions | 150 | 96 | 22 | 14 | 18 | 3.80 | Accepted |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | discourage open discussions about contraception in my community. | (50%) | (32%) | (7%) | (5%) | (6%) | | |
| 3. | I find it difficult to access healthcare providers for information on contraceptives. | 19 (6%) | 66 (22%) | 83 (28%) | 67 (23%) | 65 (21%) | 3.30 | Rejected |
| 4. | Limited access to contraceptive information due to distance from health centers is a challenge for me. | 56 (19%) | 53 (18%) | 108 (36%) | 47 (16%) | 36 (12%) | 3.80 | Rejected |
| 5. | Social stigma surrounding contraception makes it hard for me to seek information. | 51 (17%) | 80 (27%) | 56 (19%) | 66 (22%) | 47 (16%) | 3.90 | Accepted |
| | Overall cluster average | | | | | | 3.60 | Accepted |

*Key: $\overline{X}$ = Mean of responses, SD = Standard Deviation, A = Agree, N= Neutral SA = Strongly Agree*

**Decision rule**: Accept the statement if the mean is 3.0 or more otherwise reject the statements.
Table 3 shows that cultural beliefs ($\overline{x}$ = 3.80) and social stigma ($\overline{x}$ = 3.90) are major barriers women face when seeking contraceptive information in Oye LGA. Language differences ($\overline{x}$ = 3.20), difficulty accessing healthcare providers ($\overline{x}$ = 3.30), and distance from health centers ($\overline{x}$ = 3.80) were not considered strong barriers by most respondents. Overall, the cluster mean of 3.60 (SD = .22) indicates that women generally acknowledged the presence of communication barriers, with cultural and social factors being the most significant.

**Table 4: If communication barriers impact on women's ability to make informed decisions about contraceptive methods**

| S/N | Questionnaire Items | SA | A | N | SD | D | X | Remark |
|---|---|---|---|---|---|---|---|---|
| 1. | The communication barriers I face prevent me from making informed decisions about contraception. | 61 (20%) | 161 (54%) | 28 (9%) | 24 (8%) | 26 (%) | 3.30 | Accepted |
| 2. | Due to communication barriers, I feel uncertain about the different contraceptive options available. | 118 (39%) | 100 (33%) | 32 (11%) | 24 (8%) | 26 (9%) | 3.10 | Accepted |
| 3. | The lack of clear information hinders my ability to choose the most suitable contraceptive method for me. | 95 (32%) | 107 (36%) | 36 (12%) | 35 (11%) | 27 (9%) | 3.30 | Accepted |
| 4. | I often make contraceptive choices based on limited or unclear information due to communication challenges. | 105 (35%) | 134 (45%) | 20 (6%) | 20 (6%) | 21 (9%) | 3.10 | Accepted |
| 5. | The communication barriers I face contribute to my hesitation in using contraception. | 159 (53%) | 69 (23%) | 15 (5%) | 30 (10%) | 27 (9%) | 3.99 | Accepted |
| | **Overall cluster average** | | | | | | **3.33** | **Accepted** |

*Key: $\overline{X}$ = Mean of responses, SD = Standard Deviation, A = Agree, N= Neutral SA = Strongly Agree*

Table 4 indicate the communication barriers significantly affect women's ability to make informed contraceptive decisions. Respondents agreed that barriers prevent informed choices ($\overline{x}$ = 3.30), create uncertainty about available options ($\overline{x}$ = 3.10), and hinder selection of suitable methods ($\overline{x}$ = 3.30). Many also admitted making choices based on unclear information ($\overline{x}$ = 3.10). Importantly, a majority strongly agreed that these barriers contribute to hesitation in using contraception ($\overline{x}$ = 3.99). The overall cluster mean of 3.33 (SD = .14) confirms that communication barriers negatively impact informed decision-making.

**Table 5: Strategies for improving communication and information sources towards improving reproductive health outcomes in Oye LGA.**

| S/N | Questionnaire Items | SA | A | N | SD | D | X | SD | Remark |
|---|---|---|---|---|---|---|---|---|---|
| **1.** | Local health workers should be trained to effectively communicate family planning information to women in my community. | 168 (56%) | 124 (41%) | 6 (2%) | 2 (1%) | - | 3.5 | .60 | Accepted |
| **2.** | There should be more media campaigns to raise awareness about contraception and its benefits. | 176 (59%) | 110 (36%) | 6 (2%) | 6 (2%) | 2 (1%) | 3.5 | .70 | Accepted |
| **3.** | Community health outreach programs should focus more on providing information about contraceptive options. | 187 (62%) | 108 (36%) | 5 (2%) | - | - | 3.3 | .52 | Accepted |
| **4.** | It would be helpful to integrate family planning education into school curricula to reach younger women. | 124 (41%) | 129 (43%) | 23 (8%) | 5 (2%) | 19 (6%) | 3.88 | .05 | Accepted |
| **5.** | Improved access to healthcare facilities and services would make it easier for me to get reliable information on contraception. | 159 (53%) | 137 (45%) | 4 (1.3%) | - | - | 3.5 | .52 | Accepted |
| | Overall cluster average | | | | | | 3.54 | .50 | Accepted |

*Key: $\overline{X}$ = Mean of responses, SD = Standard Deviation, A = Agree, N= Neutral SA = Strongly Agree*

Table 5 indicate that respondents strongly supported several strategies to improve contraceptive communication and uptake in Oye LGA. Key strategies identified include training local health workers ($\overline{x}$ = 3.50), increasing media campaigns ($\overline{x}$ = 3.50), expanding community health outreach ($\overline{x}$ = 3.30), integrating family planning into school curricula ($\overline{x}$ = 3.88), and improving access to healthcare facilities ($\overline{x}$ = 3.50). The overall mean of 3.54 (SD = .50) indicates broad agreement that these measures would enhance communication, information sources, and reproductive health outcomes in the community.

**Statement/Test of Hypothesis**
**H$_1$:** Women in Oye LGA do not experience significant communication barriers when seeking contraceptive information.

**Table 6: Women in Oye LGA and communication barriers when seeking contraceptive information.**

| Table item | 1 | 2 | 3 | 4 | 5 | Fo | Fe | Fo - Fe | $\frac{(Fo - Fe)^2}{Fe}$ |
|---|---|---|---|---|---|---|---|---|---|
| Strongly agreed | 170 | 119 | 50 | 85 | 146 | 570 | 160 | 410 | 1050.63 |
| Agreed | 75 | 115 | 88 | 54 | 101 | 433 | 160 | 273 | 465.81 |
| Undecided | 31 | 29 | 78 | 69 | 42 | 249 | 160 | 89 | 49.51 |
| Disagreed | 6 | 13 | 46 | 39 | 5 | 109 | 160 | -51 | 16.26 |
| Strongly disagreed | 18 | 24 | 38 | 39 | 6 | 125 | 160 | 92 | 7.66 |
| Total | 300 | 300 | 300 | 286 | 300 | 1486 | | 813 | 1589.87 |

*$X^2$ calculated value = 1589.87, alpha. = 0.05, df= 4, $x^2$ table value = 124.5*

**Decision rule:**

When $X^2$-calculated is greater than the $X^2$-tabulated, that is, $X^2$-cal> $X^2$-tab. Hence, we reject the null hypothesis ($H_0$)

Table 4.2.1 shows that the table's value (124.5) is less than the calculated value (1589.87). Therefore, the $H_0$ (null) that state that "women in Oye LGA do not experience significant communication barriers when seeking contraceptive information" is rejected, while the alternate hypothesis which state that "women in Oye LGA experienced significant communication barriers when seeking contraceptive information" is accepted.

**Hypothesis two**

**$H_2$:** Communication barriers have no significant impact on women's ability to make informed decisions about contraceptive methods in Oye LGA, Ekiti State.

**Table 7: Communication barriers have significant impact on women's ability to make informed decisions about contraceptive methods in Oye LGA, Ekiti State.**

| Table item | 1 | 2 | 3 | 4 | 5 | Fo | Fe | Fo - Fe | $\frac{(Fo - Fe)^2}{Fe}$ |
|---|---|---|---|---|---|---|---|---|---|
| Strongly agreed | 35 | 150 | 19 | 56 | 51 | 311 | 151 | 160 | 169.54 |
| Agreed | 58 | 96 | 66 | 53 | 80 | 353 | 151 | 202 | 270.23 |
| Undecided | 74 | 22 | 83 | 108 | 56 | 343 | 151 | 192 | 244.13 |
| Disagreed | 93 | 14 | 67 | 47 | 66 | 287 | 151 | 136 | 122.49 |
| Strongly disagreed | 40 | 18 | 65 | 36 | 47 | 206 | 151 | 55 | 20.033 |
| Total | 300 | 300 | 300 | 300 | 300 | 1500 | | 745 | 826.42 |

*$X^2$ calculated value = 3655.1, alpha. = 0.05, df= 4, $x^2$ table value = 118.4*

**Decision rule:**

When $X^2$-calculated is greater than the $X^2$-tabulated, that is, $X^2$-cal> $X^2$-tab. Hence, we reject the null hypothesis ($H_0$)

Table 7 shows that the table's value (118.4) is less than the calculated value (826.42). Therefore, the $H_0$ (null) that state that "communication barriers have no significant impact on women's ability to make informed decisions about contraceptive methods in Oye LGA, Ekiti State" is rejected, while the alternate hypothesis which state that "communication barriers have significant impact on women's ability to make informed decisions about contraceptive methods in Oye LGA, Ekiti State." is accepted.

**Hypothesis three**

H3: Improved communication and information dissemination strategies do not significantly influence contraceptive uptake or reproductive health outcomes among women in Oye LGA.

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**Table 8: Improved communication and information dissemination strategies do not significantly influence contraceptive uptake or reproductive health outcomes among women in Oye LGA**

| Table item | 1 | 2 | 3 | 4 | 5 | Fo | Fe | Fo - Fe | $\frac{(Fo - Fe)^2}{Fe}$ |
|---|---|---|---|---|---|---|---|---|---|
| Strongly agreed | 168 | 176 | 187 | 124 | 159 | 814 | 140 | 674 | 3244.83 |
| Agreed | 124 | 110 | 108 | 129 | 137 | 608 | 140 | 468 | 1564.46 |
| Undecided | 6 | 6 | 5 | 23 | 4 | 44 | 140 | -96 | -65.83 |
| Disagreed | 2 | 6 | 0 | 5 | 0 | 13 | 140 | -127 | 115.21 |
| Strongly disagreed | 0 | 2 | 0 | 19 | 0 | 21 | 140 | -119 | 101.15 |
| Total | 300 | 300 | 300 | 300 | 300 | 1500 | | 800 | 4959.82 |

*$X^2$ calculated value = 4959.82, alpha. = 0.05, df= 4, $x^2$ table value = 120.5*

**Decision rule:**

When $X^2$-calculated is greater than the $X^2$-tabulated, that is, $X^2$-cal> $X^2$-tab. Hence, we reject the null hypothesis ($H_0$)

Table 8 shows that the table's value (120.5) is less than the calculated value (4959.82). Therefore, the $H_0$ (null) that state that "improved communication and information dissemination strategies do not significantly influence contraceptive uptake or reproductive health outcomes among women in Oye LGA." is rejected, while the alternate hypothesis which state that "improved communication and information dissemination strategies have significantly influence contraceptive uptake or reproductive health outcomes among women in Oye LGA" is accepted.

**Discussion of Findings**

This paper investigated communication barriers and information gaps in women's contraceptive choices in Oye LGA, Ekiti State, Nigeria. Objective one sought to identify the different sources of information available to women in Oye LGA, Ekiti State. Results reveal that women in Oye LGA obtain information on contraceptives through various sources with the most important sources being healthcare providers (x = 3.80), family and friends (x = 3.90), and community health workers (x = 3.70). The media (x = 3.00) and printed materials (x = 3.70) are also relevant, but not significant. This trend supports the claim of Okonkwo (2022) and Omotayo (2020) that professional medical staff is the most credible source of information since they provide systematic counselling on contraception use, its side effects, and long-term effects. Health workers are also more relevant in rural areas like Oye where doctors or specialists are less available. But the moderately high impact of family and peers suggests that interpersonal communication continues to play a role in reproductive decision-making. This is equally in line with Umar and Adeniyi (2022) and Ogunyemi (2023), who emphasised that women usually rely on the opinions and testimonies of trusted social networks before embracing health innovations. Experiential information of peers and relatives is competing with biomedical information in most Nigerian communities, particularly rural ones, and in some cases, this results in the strengthening of myths or fears regarding contraception. Weaker impact by mass media is opposite to Ajibade (2023) and Abubakar and Yusuf (2022), who highlighted the strength of media campaigns in reproductive behaviour formation. This could be explained by the socio-cultural situation of Oye LGA, where the penetration of radio and television may be lower than interpersonal communication, or the content of the media sources may not be culturally relevant to appeal to local listeners and viewers. Urban-rural differences, as Akinyemi (2020) suggested, affect the reaction of women to health campaigns, with rural residents depending more on community-based communications than on mass-mediated ones. In this way, the research points to different information sources, despite the credibility being socially constructed like the health workers and peers perceived as credible, while mass media messages constructed as remote or abstract.

The second objective examined the communication obstacles that women experience in their search of information about contraception. Rejection of Hypothesis One (H01) confirms that women within Oye LGA do experience high communication barriers in accessing contraceptive information. Cultural beliefs

(x = 3.80) and social stigma (x = 3.90) were found as the most significant barriers, and language (x = 3.20) and access to providers (x = 3.30) were not critical. This is consistent with Bello (2023) and Ojo (2022), who pointed out that conventional norms and stigma are still at the core of the barriers to contraceptive uptake in Nigeria. Most respondents admitted that family planning still remains a taboo topic, especially when talking about contraception with unmarried women or those who are perceived to be too young to talk about family planning. This is in line with what Adeyemi (2021) notes as cultural scripts frequently aligning contraceptive use with promiscuity and thus scaring women off when seeking information openly. Surprisingly, language turned out to be not a significant barrier, unlike in more linguistically diverse settings (e.g., northern Nigeria, see Adebayo, 2021). This can be attributed to the relative linguistic homogeneity in Ekiti State where Yoruba is popular and well-known. In the same vein, physical access to providers was not as important, perhaps because of the community health workers who act as go-betweens. That stigma and cultural beliefs prevail suggests that barriers are not merely infrastructural, but also symbolic-based on the meanings that communities place on reproductive behaviour. This is in line with Akinola and Adeyemi (2019), who suggested that women do not use the services fully even when they are available due to social disapproval and myths (including fear of infertility). So, the identified barriers are mostly cultural-psychological, but not linguistic-structural, which means that culturally sensitive interventions, focusing on perceptions and social norms, have to be provided.

In addition, the study examined how these communication barriers affected the capacity of women to make informed choices regarding contraceptive methods. The rejection of Hypothesis Two (H02) established that communication barriers play a significant role in the capacity of women to make informed decisions when it comes to contraceptives. Respondents said that barriers cause uncertainty (x = 3.10), make it difficult to understand the methods available (x = 3.30), and in some cases result in contraceptive decisions made based on incomplete or misleading information (x = 3.10). The percentage of those who said that these barriers are a contributive factor to reluctance to adopt contraception is also high (x = 3.99). This observation supports WHO (2023) and Adebayo & Oladipo (2022), who emphasised that misinformation, stigma, and ineffective counselling negatively affect the capacity of women to select the right approaches. What it means is that not all contraceptive decision-making in Oye is rational and well-informed, but is mediated by partial knowledge and the fear of communal disapproval. The result also confirms Ogunleye and Salami (2022), who hypothesised that fear of being labelled as promiscuous will deter women to seek the services of health workers. Consequently, most women are left to use second hand and usually inaccurate information provided by their peers or their family members. This has resulted in a paradox, in which sources of information exist, yet communication barriers water down their usefulness. The result is consistent with the Health Belief Model suggesting that health-related behaviours are not only related to perceived benefits, but also perceived barriers. Here, although the women may be able to recognise the advantages of contraception, the stigma and cultural disapproval makes them less likely to make informed choices.

The final objective was to ascertain the strategies for improving communication and information sources towards improving reproductive health outcomes in Oye LGA. Rejection of Hypothesis Three (H03) emphasises how better communication and information dissemination plans have a significant impact on contraceptive uptake. The most supported strategies were training health workers (x = 3.50), community health outreach (x = 3.30), media campaigns (x = 3.50), incorporating family planning in school curricula (x = 3.88) and enhancing access to healthcare (x = 3.50). These results are consistent with Eze (2020) and Bello (2023) who emphasised the need of multi-pronged interventions. Special attention was paid to training local health workers, and this corresponds to the request of Okonkwo (2022) to provide culturally sensitive counselling. The argument in favour of school-based education echoes the argument by UNFPA (2022) that having access to reproductive health knowledge early in life enables young women to dispel myths. The fact that media campaigns are being recognised as a required strategy although they play a minimal role at present indicates that the problem is not the medium but the message. Media can work when the campaigns are culturally tailored, regular, and communal as Ajibade (2023) argued. The focus of the respondents on community outreach indicates that interventions are needed that extend beyond individual counselling to collective sensitization, where stigma is addressed in the community, as opposed to addressing it in women only.

**Conclusion**
This study examined sources of information and communication obstacles to contraceptive use among women in the Oye Local Government Area in Ekiti State. The results indicate that women turn to healthcare

providers, family, friends, and community health workers to obtain contraceptive information more than the mass media. Nevertheless, the usefulness of these sources of information is constrained by cultural beliefs and stigma, which turned out to be the most prominent barriers to communication. These obstacles make it difficult to make informed choices and, in many cases, women will be left with half-baked or misguided information. Nevertheless, these challenges notwithstanding, the respondents were very much in support of training healthcare workers, community sensitization, media campaigns, and school-based education as a way of enhancing communication and uptake. The paper concludes that contraceptive decision-making in Oye is not influenced by lack of information as much as it is influenced by cultural and social connotations of contraception.

## Recommendations
i.  Government should enhance the functions of health providers and community health workers by engaging in constant training and capacity building. This will keep the information they give correct, culturally sensitive and sensitive to the concerns of women.
ii. Culturally sensitive communication campaigns aimed at targeting stigma and myths about contraceptives in particular need to be designed and implemented. Influencers in the community, religious leaders, and women should be actively involved in changing negative cultural scripts and minimizing the social stigma around the use of contraceptives.
iii. Organized counselling and education programmes should be set up in primary healthcare centres by the various stakeholders so that women can be helped to make well-informed decisions. These programmes must also incorporate the element of confidential consultations, myth-busting sessions, and peer-support groups where women can openly address contraceptive issues without feeling judged.
iv. A multi-pronged strategy that integrates community outreach, media campaigns and school-based reproductive health education is required. In particular, family planning issues must be included in the secondary school curricula, and media campaigns must be adjusted locally to Yoruba language and cultural settings.

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