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Barriers to Contraceptive Use in Primary Healthcare: Implications for Hormonal Regulation and Reproductive Health Outcomes

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ABSTRACT

Background: Many people, especially women in low- and middle-income countries, still have major hurdles preventing contraceptive use despite international initiatives to improve access to contemporary contraceptives. Because of multifactorial hurdles, primary healthcare (PHC) sites—which are the frontline for reproductive health services—remain underused. The goal of this systematic analysis was to find and combine the obstacles impeding contraceptive use in primary healthcare (PHC) systems throughout different areas and communities. **Methodology:** Between January 2000 and April 2025, papers were found via systematic searches across the CINAHL, Scopus, Web of Science, and PubMed databases. If studies investigating obstacles to contraceptive use in PHC contexts among those of reproductive age were included. Both qualitative and quantitative methodologies were taken into account. Personal, social, and health system-level obstacles were found by extracting and thematically evaluating data. The Joanna Briggs Institute and Newcastle-Ottawa Scale instruments were employed to evaluate methodological quality. **Results:** Nineteen studies, including a range of people aged 14-55 years from Africa, the Middle East, and North America, were incorporated. Thematic analysis revealed important personal-level impediments like widespread myths and beliefs, the terror of side effects, lack of information, and negative attitudes toward birth control. Stigma, partner and family disapproval, gender expectations, and religious opposition all comprise obstacles within society. Health system-related issues included facility physical inaccessibility, lack of privacy, provider prejudice, and bad communication. These connected elements greatly hampered reproductive decision-making autonomy and contraceptive use. **Conclusion:** In PHC situations, complex interactions of personal beliefs, cultural norms, and institutional health care restrictions restrain contraceptive usage. To increase access to and acceptance of contraception, interventions have to take a multi-level approach addressing misinformation, actively involve communities, educate providers, and modify PHC distribution system. To get over constant obstacles, policies should give first priority to youth-friendly, inclusive, and culturally sensitive approaches.

Keywords: Contraceptive utilization barriers, Primary healthcare services, Reproductive health decision-making, Sociocultural influences on contraception, Health system constraints

INTRODUCTION

One of the pillars of reproductive health and a basic human right acknowledged by the World Health Organization (WHO) (Gaffield & Kiarie, 2021), access to good contraception is Use of contraception is strongly related to decreases in unintended pregnancies, maternal morbidity and death, and advances in family wellbeing and gender equality (Asrat et al., 2024; Askew et al., 2023). Although these well-known advantages exist, the global need for contraception is still great, especially in low- and middle-income countries (LMICs) where approximately 257 million women want to avoid pregnancy not using a modern contraceptive method as of 2023 (Gelaw et al., 2023; Belay et al., 2024; Coulson et al., 2023). Although primary healthcare (PHC) systems are absolutely essential for providing contraceptive services, utilization rates remain low in many situations because of a complex interaction of obstacles at the personal, interpersonal, institutional, and systematic levels (Chutke et al., 2022; Suchman et al., 2023).

Growing evidence indicates that often anchored in cultural, informational, and provider-related issues, these obstacles go beyond simply logistical or economic ones (Gele et al., 2020). Studies have found that misunderstandings about side effects, lack of awareness, cultural or religious objection, and stigma greatly restrict contraceptive usage (Shumet et al., 2024; Namasivayam et al., 2022; Mbachu et al., 2021). On the supply side, inadequate healthcare provider training, contraceptive supply stock-outs, constrained method combination, and tight rules might further hamper service delivery via PHC outlets (Muhoza et al., 2020). Furthermore restrict women's autonomy in making reproductive decisions since they impact gender dynamics, power inequalities in relationships, and insufficient male involvement often (De Haas et al., 2025).

Hence, this systematic review seeks to find, classify, and carefully assess the current research on obstacles to contraceptive use in primary care environments across various demographics and geographical areas. This analysis aims to guide the creation of more just, accessible, and sensitive family planning services by emphasizing shared themes and context-specific obstacles.

METHODOLOGY

This systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations. To find publications released between January 2000 and April 2025, a thorough literature search was conducted across several electronic databases: PubMed, Scopus, Web of Science, and CINAHL. Medical Subject Headings (MeSH) and free-text terms pertinent to "contraceptive use," "barriers," and "primary healthcare. " were combined in the search strategy. The search was tightened using Boolean operators like AND, OR, and NOT, and filters were set to include only peer-reviewed papers released in English.

Eligibility requirements were established a priori on the basis of the PICO (Population, Interest, Context) framework. Studies were included if they concentrated on women of reproductive age (usually 15–49 years), examined obstacles to contraceptive use, and were set within the framework of primary healthcare systems. Cross-sectional studies, cohort studies, case-control studies, and qualitative interviews or focus groups among others both qualitative and quantitative research methodologies were examined. Studies done in secondary or tertiary healthcare facilities, or those concentrating only on clinical effectiveness or pharmacological characteristics of birth control, were rejected. Also removed from the ultimate synthesis were systematic reviews, comments, opinion pieces, and conference abstracts.

Reference management software received imports of all retrieved citations; duplicates were eliminated. For relevance, two reviewers independently checked titles and abstracts. Then, to ascertain final inclusion, entire text papers of possibly eligible studies were carefully examined. Through conversation and agreement, or by asking a third reviewer when needed, any differences among reviewers were fixed.

A standard form gathering study characteristics (e.g., author, year, country, design), population information, sort of contraceptive evaluated, and stated hurdles to use was used to extract data. Thematic categories of barriers included individual, socio-cultural, provider-related, and systemic variables. Appropriate tools based on study design—the Joanna Briggs Institute (JBI) checklist for qualitative and cross-sectional investigations, and the Newcastle-Ottawa Scale (NOS) for cohort and case-control research—were used to evaluate the methodological quality of the included publications. Two reviewers

independently conducted quality evaluations; studies were considered in the interpretation of results and were not excluded just on quality scores.

Because of variance in study designs, populations, and results, the results of the included studies were compiled narratively. An inductive content analysis technique helped to find developing themes so enabling a thorough grasp of the multifactorial obstacles affecting contraceptive use in primary care facilities.

RESULTS

The final review included 19 studies (Figure 1, (Abdel-Salam et al., 2020; Miskeen et al., 2025; Atlam et al., 2022; Taheri et al., 2019; Hassan & Shabaan, 2024; Ashoor et al., 2023; Rokicki, 2018; Hall et al., 2018; Burke et al., 2017; Otoide et al., 2001; Flaherty et al., 2005; Ochako et al., 2015; Hall et al., 2016; Capurchande et al., 2016; Tabane & Peu, 2015; Castle, 2003; Hokororo et al., 2014; Hall et al., 2015; Wolgemuth et al., 2019)) conducted across a range of countries, predominantly in the Middle East (Abdel-Salam et al., 2020; Miskeen et al., 2025; Atlam et al., 2022; Taheri et al., 2019; Hassan & Shabaan, 2024; Ashoor et al., 2023) and sub-Saharan Africa (Rokicki, 2018; Hall et al., 2018; Burke et al., 2017; Otoide et al., 2001; Flaherty et al., 2005; Ochako et al., 2015; Hall et al., 2016; Capurchande et al., 2016; Tabane & Peu, 2015; Castle, 2003; Hokororo et al., 2014; Hall et al., 2015), with one study from the United States (Wolgemuth et al., 2019). With a few studies aimed expressly at teenagers and young adults aged 15-24, most of the research concentrated on reproductive-age women between 15 and 49 years. While some qualitative research used focus group talks or semi-structured interviews to get more in-depth social and cultural aspects affecting contraceptive usage, most studies depended on self-administered questionnaires or structured interview forms. Reflecting both qualitative and quantitative methodological orientations with total sample size of 4264 women, sample sizes varied greatly—from little qualitative cohorts of under 50 members to major surveys spanning over 1,000 people. Most of the research covered a wide range of contraceptive options, including injectables, intrauterine devices, and condoms, even if a few concentrated on particular techniques like contraceptive pills or contemporary contraceptives (Table 1).

Table 1. General characteristics of studies included in the final review.

Author(s)	Year	Country	Contraceptives of focus	Age groups	Data collection methods	Sample size
Abdel-Salem [15]	2020	Saudi Arabia	All	18-49	A structured interview questionnaire	369
Miskeen E et al. [16]	2025	Saudi Arabia	All	18-55	A structured online questionnaire	1489
Rokicki&Merten [17]	2018	Ghana	Contraceptive pills	18–24	A structured interview questionnaire	32
Hall et al. [18]	2018	Ghana	All	15–24	A structured interview questionnaire	63
Burke et al. [19]	2017	Senegal	All	18–24 (with disabilities)	A structured interview questionnaire	144
Borg H et al [20]	2022	Egypt	All	18-50	Self-administered questionnaire	430
Otoide et al. [21]	2001	Nigeria	All	15–24	Focus Group Discussion	149
Taheri et al. [22]	2019	UAE	All	15-54	A structured questionnaire	384
Flaherty et al. [23]	2005	Uganda	All	14–20	Focus Group Discussion	29
Ochako et al. [24]	2015	Kenya	Modern Contraceptives	15–24	A structured interview questionnaire	34
Hall et al. [25]	2016	Ghana	All	15–24	A structured interview questionnaire	63
Capurchande et al. [26]	2016	Mozambique	All	15–24	Focus Group Discussion	42
Tabane&Peu [27]	2015	South Africa	All	15–19	A structured interview questionnaire	15
Hassan J et al [28]	2024	Iraq	All	18-44	Questionnaire and interview method	200
~~Castle [29]~~	~~2003~~	~~Mali~~	All	15–24	A structured interview questionnaire	84
Hokororo et al. [30]	2015	Tanzania	All	15–20	Focus Group Discussion	49
Hall et al. [31]	2015	Ghana	All	15–24	A structured interview questionnaire	67
Wolgemuth T et al.	2020	USA	All	18-44	Semistructured	189

[32]					telephone interviews	
Ashoor R et al. [33]	2023	Saudi Arabia	All	19-49	Self-administered questionnaire	432

A complex and interdependent array of personal, social, and health system-based hurdles to contraceptive use in primary care settings was revealed upon study of the reported barriers. Among the most often mentioned were personal-level roadblocks. Among younger women or those without children, especially, there was a prevailing theme of myths and misunderstandings, including convictions that using contraceptives encourages promiscuity, lowers sexual pleasure, or causes long-term infertility (Abdel-Salam et al., 2020; Miskeen et al., 2025; Rokicki, 2018; Otoide et al., 2001; Flaherty et al., 2005; Ochako et al., 2015; Capurchande et al., 2016; Hassan & Shabaan, 2024; Castle, 2003; Wolgemuth et al., 2019). These misperceptions were worsened by a general distrust in contraceptive effectiveness and worries about known side effects—from menstrual abnormalities and weight gain to psychological anguish and hypertension—often reported by participants across many areas (Abdel-Salam et al., 2020; Miskeen et al., 2025; Atlam et al., 2022; Taheri et al., 2019; Otoide et al., 2001; Ochako et al., 2015; Capurchande et al., 2016; Tabane & Peu, 2015; Ashoor et al., 2023). Furthermore, inadequate access to trustworthy and nonjudgmental sources of information as well as limited understanding of the mechanism and correct usage of birth control fostered unfavorable attitudes and decreased motivation for use, particularly among unmarried women and teenagers (Rokicki, 2018; Otoide et al., 2001; Atlam et al., 2022; Taheri et al., 2019; Flaherty et al., 2005; Capurchande et al., 2016; Tabane & Peu, 2015; Hokororo et al., 2014; Wolgemuth et al., 2019). Additionally, financial obstacles surfaced as affordability problems restricted access to both contraceptive products and associated services in low-resource environments (Miskeen et al., 2025; Rokicki, 2018; Otoide et al., 2001; Atlam et al., 2022; Hassan & Shabaan, 2024).

Many kinds of stigma and disapproval greatly affected birth control choices at the social level. Particularly in more conservative or patriarchal environments, women who used contraception frequently faced divorce fears, accusations of promiscuity or witchcraft, or general community-based stigma (Abdel-Salam et al., 2020; Hall et al., 2018; Atlam et al., 2022; Hall et al., 2016; Capurchande et al., 2016; Castle, 2003; Hokororo et al., 2014; Hall et al., 2015). Furthermore, aggravating the situation were societal expectations that gave male dominance and fertility top priority in reproductive decision-making. Many respondents expressed disapproval of contraceptive use by partners, family members, or religious authorities, which reflects widespread gendered and cultural resistance to family planning (Miskeen et al., 2025; Hall et al., 2018; Otoide et al., 2001; Taheri et al., 2019; Capurchande et al., 2016; Tabane & Peu, 2015; Hassan & Shabaan, 2024; Ashoor et al., 2023). In some research, contraception was seen only as a woman's duty; open talks about sexual health or family planning were thought to be socially unsuitable (Rokicki, 2018; Otoide et al., 2001; Capurchande et al., 2016; Hassan & Shabaan, 2024).

Often cited as well were obstacles based on health systems, both structural and interpersonal. Particularly for unmarried or teenage women, a large proportion of respondents cited the absence of privacy and confidentiality at healthcare institutions as a barrier to seeking contraceptive services (Abdel-Salam et al., 2020; Otoide et al., 2001; Flaherty et al., 2005; Hassan & Shabaan, 2024; Hokororo et al., 2014; Wolgemuth et al., 2019). Also rather common were bad interactions with medical providers, including acts of disrespect, refusal of services, or discriminating treatment (Hall et al., 2018; Flaherty et al., 2005; Hassan & Shabaan, 2024; Hokororo et al., 2014; Wolgemuth et al., 2019). Women were sometimes denied contraception outright or were not given enough counseling as a result of prejudices among healthcare providers (Abdel-Salam et al., 2020; Tabane & Peu, 2015; Hassan & Shabaan, 2024; Wolgemuth et al., 2019). Long waiting times, bad communication especially the use of overly technical language, and power imbalances between suppliers and young consumers further limited access (Otoide et al., 2001; Capurchande et al., 2016; Hassan & Shabaan, 2024; Wolgemuth et al., 2019). In a few situations, especially among persons with impairments, physical barriers such inaccessible infrastructure or a need for support to obtain services were reported (Burke et al., 2017; Atlam et al., 2022; Hassan & Shabaan, 2024) (Table 2).

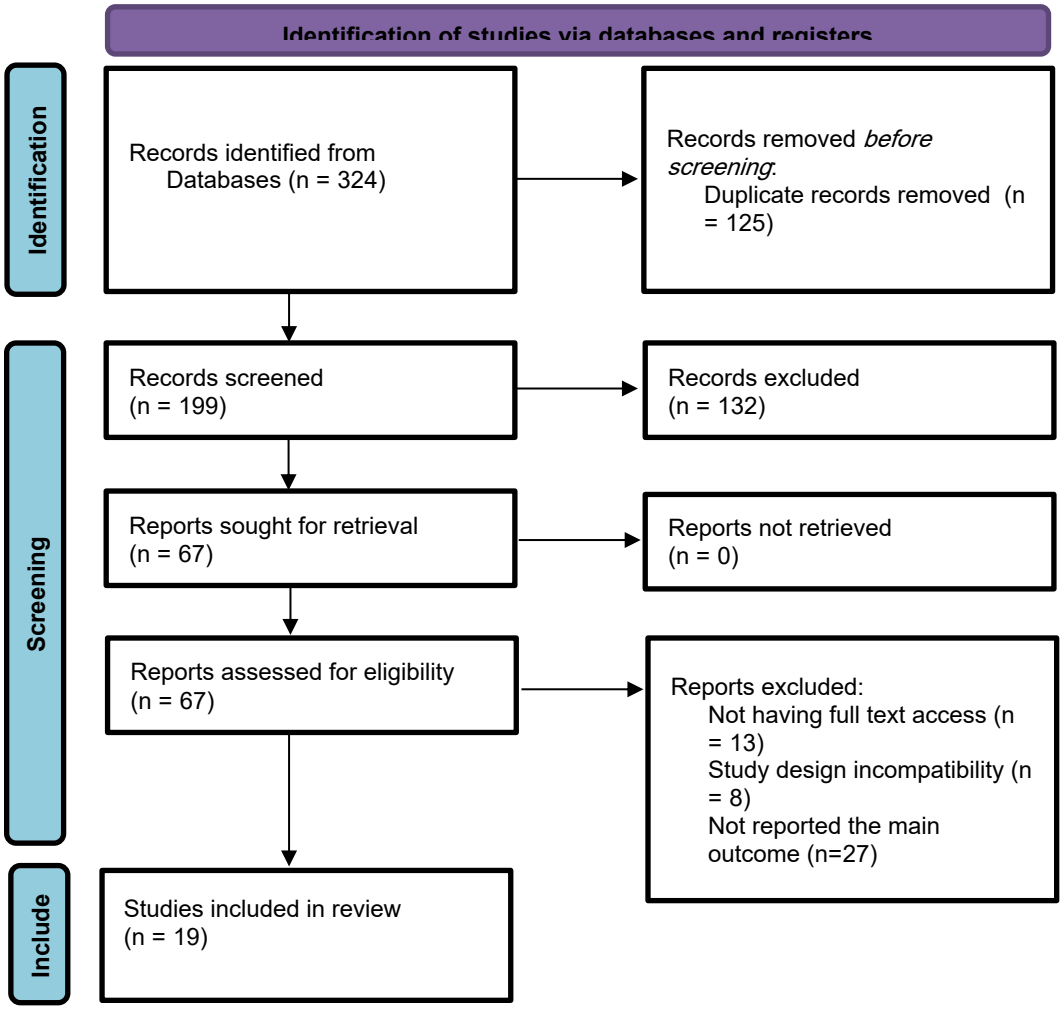

Figure 1: PRISMA flow for including studies

Table 2. Barriers to contraceptive use among different populations

Main theme	Sub-theme	Codes	Studies
Personal	Myths and misconceptions	Contraceptive use encourages promiscuity and straying (cheating)	(Burke et al., 2017; Ochako et al., 2015; Rokicki & Merten, 2018)
		Thinking that using contraceptive methods is bad behavior.	(Abdel-Salam et al., 2020)
		Lack of trust in contraceptives	(Hassan & Shabaan, 2024; Rokicki & Merten, 2018)
		Contraceptive should be used by older women	(Hassan & Shabaan, 2024)
		Contraceptive use reduces sexual pleasure	(Capurchande et al., 2016; Ochako et al., 2015; Rokicki & Merten, 2018)
		There is a risk of future infertility with contraceptive use	(Abdel-Salam et al., 2020; Castle, 2003; Flaherty et al., 2005; Miskeen et al., 2025; Ochako et al., 2015; Otoide et al., 2001; Wolgemuth et al., 2019)
		Perceived ineffectiveness of contraceptives in preventing conception	(Capurchande et al., 2016; Hokororo et al., 2014; Miskeen et al., 2025; Otoide et al., 2001; Taheri et al., 2019; Wolgemuth et al., 2019)
	Known side effects of	Psychological side	(Ashoor et al., 2023; Miskeen et al., 2025;

	contraceptives	effects	Taheri et al., 2019)
		Weight gain, headache, bleeding, high blood pressure, and disruption of the menstrual cycle	(Abdel-Salam et al., 2020; Ashoor et al., 2023; Atlam et al., 2022; Capurchande et al., 2016; Hassan & Shabaan, 2024; Miskeen et al., 2025; Ochako et al., 2015; Otoide et al., 2001; Rokicki & Merten, 2018; Tabane & Peu, 2015; Taheri et al., 2019)
	Negative attitude towards contraceptive use	Lack of personal motivation and willingness to utilise contraception	(Abdel-Salam et al., 2020; Tabane & Peu, 2015)
		Contraceptive use (mainly condom) is boring, stressful, too much of a responsibility, and clinical	(Capurchande et al., 2016; Tabane & Peu, 2015)
	Lack/Inadequate knowledge	Poor knowledge on the mechanism of action of contraceptives and on how to utilise them	(Abdel-Salam et al., 2020; Atlam et al., 2022; Capurchande et al., 2016; Flaherty et al., 2005; Hokororo et al., 2014; Otoide et al., 2001; Rokicki & Merten, 2018; Tabane & Peu, 2015; Wolgemuth et al., 2019)
		Lack of reliable, trusted and non-judgemental sources of information on contraceptives	(Burke et al., 2017; Flaherty et al., 2005; Rokicki & Merten, 2018)
	Financial challenges	Unaffordability of contraceptives and contraceptive services	(Atlam et al., 2022; Burke et al., 2017; Hassan & Shabaan, 2024; Miskeen et al., 2025; Rokicki & Merten, 2018)
Societal based	Social consequences of contraceptive use	Divorce	(Castle, 2003)
		Accusations of witchcraft	(Castle, 2003)
		Stigma	(Abdel-Salam et al., 2020; Capurchande et al., 2016; Hall et al., 2015; Hall et al., 2016; Hokororo et al., 2014; Atlam et al., 2022)
		The tag of being promiscuous	(Hall et al., 2018)
	Social norms	Disproval of contraceptive use by partener, family and the larger society	(Atlam et al., 2022; Burke et al., 2017; Hall et al., 2018; Hassan & Shabaan, 2024; Miskeen et al., 2025; Tabane & Peu, 2015; Taheri et al., 2019)
		The desire to having children	(Abdel-Salam et al., 2020; Ashoor et al., 2023; Hassan & Shabaan, 2024; Taheri et al., 2019)
		Contraception being considered an issue only for females	(Capurchande et al., 2016)
		Societal prohibition of discussions on issues concerning contraception	(Burke et al., 2017; Capurchande et al., 2016; Hassan & Shabaan, 2024; Rokicki & Merten, 2018)
		Disproval of contraceptive use by friends and colleagues	(Tabane & Peu, 2015)
		Religious prohibitions	(Atlam et al., 2022; Burke et al., 2017; Taheri et al., 2019)
Health systems-based	Lack of privacy and confidentiality at health facilities		(Abdel-Salam et al., 2020; Burke et al., 2017; Flaherty et al., 2005; Hassan & Shabaan, 2024; Hokororo et al., 2014; Wolgemuth et al., 2019)
	Negative attitude of health professionals	Being treated disrespectfully	(Flaherty et al., 2005)
		Being entirely refused contraceptive services	(Flaherty et al., 2005; Hassan & Shabaan, 2024; Hokororo et al., 2014; Wolgemuth et al., 2019)
		Being denied teaching	(Abdel-Salam et al., 2020; Hassan &

		about contraceptives	Shabaan, 2024; Tabane & Peu, 2015; Wolgemuth et al., 2019)
		Discrimination	(Burke et al., 2017; Hall et al., 2018)
	Long waiting time		(Hassan & Shabaan, 2024; Hokororo et al., 2014)
	Poor communication between health professionals and young people	Overly technical language used at health facilities	(Burke et al., 2017; Capurchande et al., 2016; Hassan & Shabaan, 2024)
		Power asymmetry in communication between health professionals and young people	(Abdel-Salam et al., 2020; Capurchande et al., 2016; Wolgemuth et al., 2019)
	Physical inaccessibility of health facilities	Staircases are unfriendly having to be accompanied by someone to facilitate access	(Atlam et al., 2022; Burke et al., 2017; Hassan & Shabaan, 2024)

DISCUSSION

The results of this study emphasize the multifactorial character of obstacles to birth control use in primary healthcare environments, therefore confirming that personal and structural influences are both very important in restricting access and consumption. Across the included studies, individual-level impediments, including myths, misunderstandings, and worries about contraception techniques, were quite visible. This supports prior studies that have revealed that misconceptions such as the belief that contraceptives cause infertility, encourage promiscuity, or negatively impact sexual satisfaction still serve as a major barrier, especially among teenagers and unmarried women in conservative societies (Sedgh & Hussain, 2014; Blackstone et al., 2017; Bain et al., 2021). Anecdotal stories inside communities and a lack of available, medically accurate information from reliable sources help to exacerbate these worries (Williamson et al., 2009).

A recurring theme was a lack of understanding of contraceptive techniques and modes of action, echoing results from a meta-analysis that found poor health literacy causes delayed or inconsistent contraceptive use (Gelaw et al., 2023). Moreover, in environments where talking about reproductive health is traditionally prohibited, misunderstandings are frequently magnified in the absence of complete sex education (Tohit Mohd & Haque, 2024; Egbende et al., 2024). Hall et al. (2015) found likewise that young people in Ghana lacked dependable means for information, which resulted in reluctance to seek services and dependency on peers or online sources, therefore helping to spread rather than debunk myths (Hall et al., 2015).

Particularly in low-income groups, financial obstacles, including contraceptive unaffordability and associated treatments, were also recorded. The Guttmacher Institute (2022) claims that although technically accessible, contemporary contraceptives are frequently beyond reach for many women in low-resource environments owing to out-of-pocket charges, especially when services are not entirely incorporated into public health systems or are inconsistently distributed (Guttmacher Institute, 2022). Moreover, hidden costs, including lost wages from lengthy waiting times and transportation, can further inhibit access (Newton-Levinson et al., 2024).

The impact of social conventions, stigma, and gender dynamics remains a significant impediment to contraception use at the societal level. In both Middle Eastern and African contexts, patriarchal beliefs limiting women's autonomy in reproductive choice have been well documented (Capurchande et al., 2017; Shattuck et al., 2011).

Particularly influential in determining women's contraceptive choices were partner resistance, family condemnation, and religious limitations. Women frequently told needing permission from male partners or facing threats of divorce or social ostracism when starting contraception; these results are consistent with earlier studies highlighting the need for male-inclusive family planning interventions (Wambete et al., 2024; Kabagenyi et al., 2014).

Equally important were barriers connected with the health system, which also point to major flaws in primary care delivery. Lack of privacy, provider bias, and unfavorable attitudes among healthcare personnel were frequently cited in the evaluated studies. Schwandt et al. (2017) reported similar findings, noting that young and unmarried women were dissuaded from asking for contraceptives by judgmental attitudes and moralizing behavior from providers (Schwandt et al., 2017). Furthermore, users—especially those with less education or new to contraceptive services—can be alienated by bad communication marked by dismissive interactions and overly technical language (Wood & Jewkes, 2006). Discriminatory actions and confidentiality breaches further erode confidence in healthcare systems, therefore lowering the possibility of repeat appointments or word-of-mouth referrals.

Though less often noted, the physical inaccessibility of buildings adds extra difficulty for some groups, including those with disabilities. Emphasizing that structural obstacles like badly planned clinic facilities and lack of trained personnel present disproportionate difficulties for disabled women seeking reproductive care, Burke et al. (2017) highlighted this worry (Burke et al., 2017).

CONCLUSION

Finally, this study highlights the complex and closely linked obstacles to contraceptive usage in primary healthcare environments, encompassing individual misconceptions, societal stigma, gendered conventions, and institutional health service deficiencies. These barriers not only impair access but also undercut knowledgeable decision-making and reproductive freedom. Dealing with them calls for context-specific, multi-level treatments combining appropriate health education, culturally sensitive community involvement, enhanced provider training, and better service delivery infrastructure. Achieving universal reproductive health targets and lowering the unmet need for family planning depend on improving the acceptability, access, and quality of contraceptive services in primary care.

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