

An Assessment of the Socio-Economic and Cultural Determinants of Family Planning Utilization in Sokoto State, North Western Nigeria

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Abstract

Family planning is a critical component of reproductive health and population management. However, its utilization remains low in many rural and predominantly Islamic societies due to socioeconomic and cultural constraints. This study assesses the influence of socioeconomic and cultural determinants on the use of family planning services in Sokoto State, Nigeria. The study employs both quantitative and qualitative research methods, including structured questionnaires, focus group discussions (FGDs), and in-depth interviews (IDIs) with 500 female respondents and key informants. The findings reveal that education, income level, occupation, and marital status significantly influence the awareness and utilization of family planning services. While 70% of respondents had heard about family planning, only 20.2% were currently using any method. Cultural and religious beliefs emerged as major barriers, with many respondents associating family planning with religious disapproval and the preference for large families. The study concludes that addressing cultural resistance, male involvement, and healthcare accessibility is crucial for improving family planning uptake in Sokoto State. It recommends targeted awareness campaigns, subsidized family planning services, and enhanced community outreach programs to promote informed reproductive health choices. These findings provide valuable insights for policymakers and stakeholders seeking to improve family planning services in northern Nigeria.

Keywords: Assessment, Socio-Economic, Cultural Determinants, Family Planning, Utilization, Sokoto State, North West.

Introduction

Family planning plays a crucial role in improving maternal and child health, reducing unintended pregnancies, and enhancing socioeconomic development. However, in many parts of Nigeria, particularly in Sokoto State, the uptake of family planning services remains significantly low due to a combination of socioeconomic and cultural factors. The state, located in Northwestern Nigeria, has one of the highest fertility rates in the country and faces challenges such as limited access to contraceptives, high poverty levels, and deeply entrenched cultural and religious beliefs that influence reproductive health decisions (Okonofua and Durajaye, 2020). Despite national and international efforts to promote family planning, the utilization of modern contraceptive methods remains low in Sokoto

State. The 2018 Nigeria Demographic and Health Survey (NDHS) reported that the contraceptive prevalence rate in the state is one of the lowest in the country. Socioeconomic disparities, low literacy levels, misconceptions about family planning, and societal norms that emphasize high fertility contribute to this trend. Additionally, religious beliefs play a major role in shaping attitudes toward family planning, with many viewing contraceptive use as incompatible with traditional values.

While existing studies have explored family planning utilization at the national level, there is limited research focusing on the specific socioeconomic and cultural determinants affecting uptake in Sokoto State. Understanding these determinants is essential for designing effective interventions that align with local realities and improve access to family planning services. This study aims to fill this gap by examining how factors such as education, income level, marital status, and cultural beliefs influence the use of contraceptives among women in Sokoto State. Despite the proven benefits of family planning in reducing maternal mortality, improving child survival rates, and fostering economic growth, its adoption remains low in Sokoto State. The combination of socioeconomic constraints and cultural resistance creates a significant barrier to the utilization of modern contraceptives (Adamu and Salihu, 2020). Many women lack the necessary education and financial resources to access family planning services, while others face opposition from family members or community leaders. Religious and traditional beliefs further reinforce resistance, limiting the acceptability of contraceptive methods (Adebayo, 2020). Additionally, misinformation and fear of side effects discourage many women from seeking family planning services. Some believe that contraceptive use leads to infertility, while others fear societal stigma. These factors contribute to the high fertility rates in Sokoto State, putting immense pressure on families and increasing maternal health risks (Odetola, 2019). Despite the availability of family planning services in health facilities, uptake remains low, raising critical questions like: What are the key socioeconomic barriers preventing women from using family planning services? How do cultural and religious beliefs shape attitudes toward contraceptive use in Sokoto State? What role does education play in influencing family planning decisions? To what extent do income levels and employment status affect access to family planning?

Addressing these questions is crucial for developing policies and interventions that are both culturally sensitive and socially inclusive. Without targeted solutions, family planning programs will continue to face resistance, limiting their impact on reproductive health and overall development in Sokoto State. This study will provide evidence-based insights that can inform health policymakers, reproductive health practitioners, and advocacy groups in designing strategies to increase family planning uptake while respecting the cultural and religious values of the people in Sokoto State.

Literature Review

Family planning refers to the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births through the use of

contraceptive methods (Cleland et al., 2006). It plays a significant role in improving maternal and child health, reducing unintended pregnancies, and contributing to overall economic and social development (Sedgh, Ashford, & Hussain, 2016). The utilization of family planning services is influenced by multiple factors, including socioeconomic status, cultural and religious beliefs, education, income levels, and access to health services (Babalola & John, 2012). In regions such as Sokoto State, where traditional and religious norms heavily influence reproductive behavior, understanding these determinants is critical for improving contraceptive uptake. A cross-sectional study conducted in Karnataka, India, examined the knowledge and practice of family planning among Muslim women. The study revealed that while a significant proportion of Muslim women were well-informed about modern contraceptive methods, their actual usage remained relatively low. Factors such as age and faith in family planning were significantly associated with its practice. Notably, women aged 31–40 were less likely to practice family planning compared to those aged 21–30. Additionally, individuals expressing faith in family planning were more likely to engage in its practice, highlighting the influence of personal beliefs on contraceptive behaviors. Education is a key determinant of contraceptive use. Studies have shown that higher levels of formal education are positively associated with increased family planning awareness and utilization (Akinyemi, Adedini, & Hounton, 2015). Educated women are more likely to understand the benefits of contraception, have better access to health information, and make informed reproductive health decisions. In Northern Nigeria, where literacy levels among women are generally low, lack of knowledge and misconceptions about family planning methods contribute to resistance (National Population Commission & ICF International, 2019). Women with little or no formal education often rely on traditional beliefs, which may discourage contraceptive use. Economic factors also play a crucial role in determining access to family planning services. Research suggests that women from low-income households are less likely to use contraceptives due to financial constraints and the cost of obtaining modern contraceptive methods (Okech, Wawire, & Mburu, 2011). In Sokoto State, where a large proportion of the population is engaged in subsistence farming and informal employment, the affordability of family planning services remains a challenge. Additionally, economic dependency on male partners often limits women's autonomy in making reproductive health decisions (Bankole, Sedgh, & Okonofua, 2020). In patriarchal settings, men often control financial resources, making it difficult for women to access contraceptives without their husband's approval. Employment status influences family planning choices. Studies indicate that women engaged in formal employment are more likely to use modern contraceptive methods than those who are unemployed or engaged in informal work (Onwujekwe, Hanson, & Uzochukwu, 2012). Women who work outside the home are often exposed to more health information and are more likely to prioritize birth control for economic and career-related reasons. Religious teachings play a significant role in shaping attitudes toward family planning in predominantly Islamic societies like Sokoto State. Some Islamic scholars advocate for natural methods of birth control, while others perceive modern

contraceptives as being contrary to religious doctrines (Feyisetan & Bankole, 2002). Misinterpretations of religious texts sometimes lead to perceptions that family planning is forbidden, discouraging its uptake. However, studies have shown that family planning is not inherently against Islamic teachings, as Islam emphasizes maternal health and child well-being (Ballard Brief, 2023). The challenge remains in bridging the gap between religious interpretations and reproductive health advocacy. Cultural norms that promote high fertility rates and large family sizes discourage family planning in Sokoto State. Research focusing on Muslim men's perceptions in Kenya uncovered that attitudes toward family planning varied significantly between regions with differing poverty levels. The study emphasized the importance of involving men in family planning programs, as their perceptions and attitudes can significantly influence contraceptive use within families. In many communities, having many children is considered a sign of wealth and social status, particularly in rural areas where children contribute to agricultural labor (Clements & Madise, 2004). Additionally, male dominance in reproductive decision-making limits women's autonomy in contraceptive use. Many women must seek their husband's or family's approval before accessing family planning services, and in some cases, men oppose contraception due to fears of infidelity or loss of masculinity (Ajayi & Adeniyi, 2019). Research shows that knowledge of family planning methods does not always translate into use (NURHI, 2017). While some women may have heard about contraceptives, misinformation and myths often deter them from using them. Common misconceptions include fears that contraception causes infertility, cancer, or birth defects (BMJ Open, 2020). Additionally, poor dissemination of information contributes to low uptake. Many women in Sokoto State receive family planning information from informal sources such as family members and friends, which may reinforce myths rather than provide accurate guidance (Sedgh, Ashford, & Hussain, 2016). The physical availability of family planning services is another critical factor. In many rural areas of Sokoto State, health facilities offering contraceptive services are limited, and stock-outs of contraceptive supplies are common (National Population Commission & ICF, 2019). Poor road networks, long distances to health centers, and lack of trained providers further restrict access. Community-based distribution and mobile clinics have been suggested as solutions to bridge the gap between rural women and family planning services (Tandfonline, 2023). However, without addressing socioeconomic and cultural barriers, service availability alone may not lead to increased utilization. A qualitative study exploring socio-cultural factors influencing family planning among Muslim communities in Kenya identified several barriers to contraceptive use. These included misconceptions about family planning methods, cultural norms favoring large families, and limited access to accurate information. The study suggested that community-based interventions, including engaging local leaders and healthcare providers, are crucial in addressing these challenges. Understanding the perspectives of Muslim religious leaders is vital for the successful implementation of family planning programs. A study in rural Tanzania highlighted that while some religious leaders supported family planning, others had reservations based on religious teachings. The

research recommended developing educational strategies that align with religious values to foster acceptance and support from these leaders, thereby enhancing community uptake of family planning services. Designing effective family planning programs in Muslim communities requires a nuanced understanding of cultural and religious contexts. Research from Nepal emphasized the need for policy-related considerations that address access and utilization challenges specific to Muslim populations. The study advocated for evidence-based approaches that incorporate community engagement and culturally sensitive communication strategies to improve reproductive health outcomes.

Methodology

The methodology is designed to achieve the study's objectives by systematically assessing the influence of socioeconomic and cultural factors on family planning utilization in Sokoto State, Nigeria. This study employs a cross-sectional survey research design, which is appropriate for examining population characteristics at a specific point in time. This design allows for the collection of quantitative and qualitative data on the socioeconomic, cultural, and demographic factors influencing family planning utilization. A mixed-methods approach was used: Quantitative methods involve structured questionnaires administered to women of reproductive age (15–49 years). Qualitative methods include focus group discussions (FGDs) and in-depth interviews (IDIs) with key stakeholders, such as religious leaders, healthcare providers, and community elders. Primary data was collected from Structured questionnaires administered to respondents. FGDs with women of reproductive age and community members. IDIs with religious leaders, healthcare providers, and policymakers. Secondary data sources include Reports from the Nigeria Demographic and Health Survey (NDHS, 2018). Publications from the National Population Commission (NPC). Studies from peer-reviewed journals and government reports on family planning. The sampling frame includes women of reproductive age (15–49 years) residing in Sokoto State. The study focuses on both urban and rural communities to ensure a comprehensive understanding of the disparities in family planning use. The sample size was determined using Cochran's formula for population-based surveys:

$$n = \frac{Z^2 P(1-P)}{d^2}$$

Where: n = sample size, z = standard normal deviate (1.96 at 95% confidence level)

p = estimated prevalence of contraceptive use (assumed 10% from NDHS 2018)

d = margin of error (5%)

Using this formula, the estimated sample size is 384 women, rounded to 500 respondents to account for non-responses and ensure robust statistical power. A multi-stage sampling technique was employed. First stage was the selection of three Local Government Areas (LGAs) one urban and two rural. Second stage is the selection of four wards per LGA using simple random sampling. Third stage is the selection of households using systematic sampling. Final stage is the selection of one eligible respondent per household using simple random sampling. For qualitative data, purposive sampling was used to select 10 healthcare providers, 10 religious leaders, and 10 community

elders for IDIs, and four FGDs (each with 8 participants). A structured questionnaire was developed to collect quantitative data on Demographic and socioeconomic characteristics (age, education, income, occupation, marital status). Awareness and knowledge of family planning. Cultural and religious influences on contraceptive use. Access to family planning services. FGDs were conducted with women of reproductive age to explore perceptions, attitudes, and community beliefs regarding family planning. IDIs were conducted with healthcare providers (to understand service delivery challenges). Religious leaders (to assess faith-based perspectives on contraception). Community elders (to explore traditional beliefs on family planning). Quantitative data from questionnaires were analyzed using SPSS (Statistical Package for the Social Sciences). Descriptive statistics were applied to analyze and summarize the data. Qualitative data from FGDs and IDIs were analyzed using thematic analysis, which involved Transcription of recorded discussions, Coding key themes related to cultural beliefs, barriers, and facilitators of family planning. Triangulation with quantitative findings to enhance validity. The qualitative data obtained from Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) were analyzed using thematic analysis to identify patterns, key themes, and narratives related to family planning service utilization in Sokoto State. The following steps were followed in the analysis:

Transcription and Translation. Audio recordings from FGDs and IDIs were transcribed verbatim in the local language (Hausa) and then translated into English for analysis. To ensure accuracy, the transcripts were reviewed and compared with the original recordings by multiple research team members.

Familiarization with the Data. Researchers read through the transcripts multiple times to gain an in-depth understanding of the content. Notes and initial impressions were documented to guide the coding process.

Coding and Categorization. Open coding was conducted, where key phrases and statements related to family planning knowledge, accessibility, cultural beliefs, and decision-making were identified. Codes were grouped into categories based on similarities and relationships.

Theme Development. Broader themes were generated by grouping related codes and categories. The themes reflected key patterns in respondents' perspectives, barriers, and facilitators of family planning use.

Interpretation and Validation. The identified themes were interpreted in relation to the study objectives and existing literature. To ensure credibility, member checking was conducted, where some participants reviewed the findings for accuracy. Triangulation was applied by comparing qualitative insights with quantitative findings to enhance the robustness of conclusions.

Justification for the Selection of LGAs and Wards

The selection of Local Government Areas (LGAs) and wards was based on purposive and stratified sampling techniques to ensure a representative study covering diverse socio-

cultural, economic, and geographic characteristics of Sokoto State. The justification includes:

1. Urban-Rural Representation: LGAs were selected to represent both urban and rural populations, recognizing that access to and perceptions of family planning services may vary significantly between urban centers and rural communities.
2. Socio-Cultural and Religious Diversity: Given the predominance of Islamic practices in Sokoto State, selected LGAs included those with strong religious and cultural influences on reproductive health decisions.
3. Health Infrastructure Distribution: LGAs with varying levels of healthcare service provision were selected to examine how facility availability impacts family planning utilization.

Ethical Considerations

The study adhered to ethical research standards to ensure the safety, confidentiality, and rights of all participants. The ethical procedures followed included: Ethical approval was obtained from the Sokoto State Health Research Ethics Committee before data collection commenced. The study protocol, including survey instruments, informed consent forms, and interview guides, was reviewed to ensure compliance with ethical research principles. Participants were provided with detailed information about the study's purpose, objectives, procedures, and potential benefits or risks. Consent was obtained in both written and verbal formats (depending on literacy levels). Participants were informed that their participation was voluntary, and they could withdraw at any time without any consequences. No participant was coerced or pressured into responding. Given the sensitivity of family planning discussions, trained facilitators used culturally appropriate language and were mindful of participants' comfort levels. Emotional support was provided through referrals to health professionals in cases where participants had concerns about contraceptive use.

Results Presentation, Analysis, and Discussion

The results indicate that individuals in Sokoto State face considerable socioeconomic barriers to accessing and using family planning services. The high unemployment rate and low levels of education, especially among women, can limit access to healthcare and information. As Ogunjuyigbe and Orji (2018) noted, lower educational levels are often associated with lower knowledge of family planning methods and a decreased likelihood of using them. The occupation data shows a heavy reliance on informal sectors, with many respondents engaged in trading and unemployment, indicating economic instability. As a result, the affordability of family planning services may be a significant barrier. Access to services may also be restricted for those with low income or irregular work, as highlighted by Ugwu et al. (2020). Cultural and religious factors are likely to play a significant role in family planning decisions in Sokoto State. Although the data did not directly capture religious beliefs, Sokoto State is predominantly Muslim, and Islamic teachings can influence

the acceptance of certain family planning methods. In some cases, there may be resistance to methods that are perceived as interfering with natural fertility processes (Ntoimo et al., 2017). Future research could explore the role of religion and cultural beliefs in shaping attitudes toward family planning.

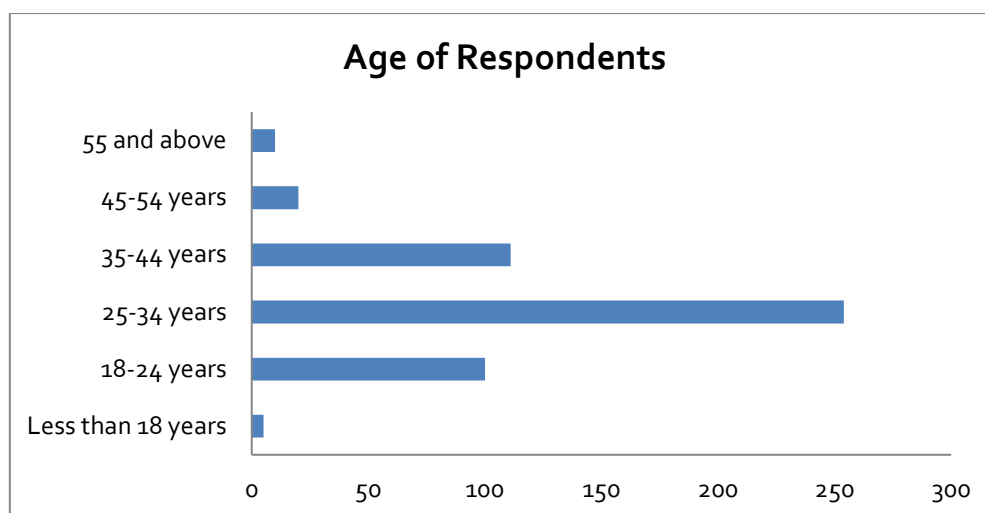


Figure 1 Age of respondents

Source: Field work, 2025

The majority of respondents fall within the 25-34 age group, making up about 50.8% of the total sample. This suggests that family planning services are likely to be of greatest concern for individuals in their reproductive years. The relatively small percentage of respondents in the younger (<18 years) and older (>55 years) age groups indicates that family planning may be less relevant to these age categories, either due to legal, social, or physiological reasons. A study by Oguntunde and Alabi (2018) emphasized that age plays a critical role in the adoption and use of family planning methods, with younger individuals often facing barriers such as lack of information or cultural opposition. Age is a significant factor in family planning decisions. The study indicates that younger women, particularly those in their early reproductive years (18-34 years), form the majority of respondents. This aligns with previous studies showing that younger women are more likely to seek contraceptive information but may face barriers such as spousal disapproval and cultural norms (Sedgh & Hussain, 2014). Older women (35 and above) tend to rely more on traditional methods or avoid contraceptives due to perceived reduced fertility (Cleland et al., 2012). These findings highlight the need for age-specific reproductive health interventions.

Table 4.2 Gender of Respondents

Gender	Frequency	Percentage
Male	00	00
Female	500	100
Total	500	100

Source: Field work, 2025

The sample consists solely of female respondents. This reflects the focus on women in family planning studies, as they are the primary users of family planning methods. It is consistent with the idea that women make most of the decisions related to fertility control (Ugwu et al., 2020). The absence of male respondents may limit the study's ability to capture male perspectives on family planning, as men's attitudes and involvement in family planning play a significant role in decision-making (Ntoimo et al., 2017). The study exclusively surveyed female respondents, reflecting the fact that women bear the primary responsibility for family planning decisions in many societies, including northern Nigeria. However, male involvement remains crucial, as studies have shown that husbands often have the final say on contraceptive use (Ezeh, Bongaarts, & Mberu, 2012). The absence of male respondents reinforces the challenge of gendered decision-making in reproductive health. Interventions must incorporate male-focused educational programs to enhance acceptance and joint decision-making in contraceptive use.

Male involvement in family planning is crucial, especially in patriarchal societies where men are primary decision-makers regarding family size and reproductive health. Studies have shown that spousal communication about family planning is often limited, leading to low male participation in contraceptive practices. Factors influencing male involvement include educational attainment, employment status, and exposure to family planning information. Men with higher education levels and those employed are more likely to participate in family planning services. However, traditional norms and misconceptions about contraceptive methods can hinder male engagement. Interventions that have successfully increased male involvement often involve direct engagement through community-based programs, counseling sessions, and mass media campaigns that address specific concerns and promote the benefits of family planning for family well-being. Encouraging open communication between partners and involving men in educational sessions can lead to more supportive attitudes toward contraceptive use.

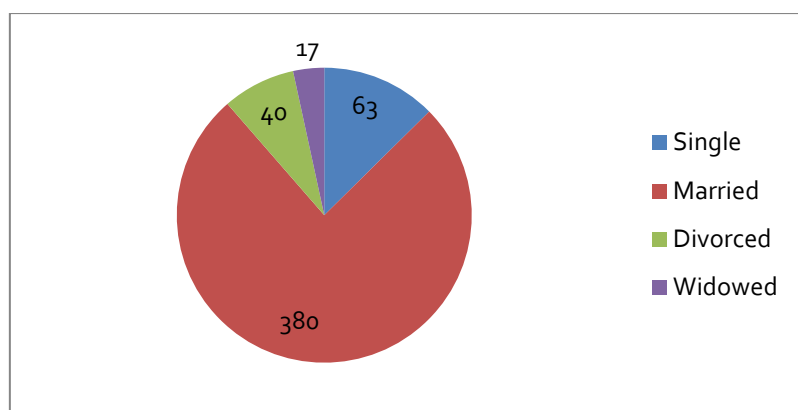


Figure 2: Marital status of Respondents

Source: Field work, 2025

A significant proportion of the respondents (76%) are married, which is typical in studies on family planning, as married couples are often more likely to use family planning methods due to childbearing concerns. The relatively low percentages of divorced (8%) and widowed (3.4%) individuals suggest that family planning practices may be more relevant to individuals in stable, marital relationships, where the discussion around family size and birth control is more pronounced (Ali et al., 2019). The single individuals (12.6%) represent a small portion, which is important to note as family planning services might be perceived differently for single versus married individuals, with married individuals likely having more children and thus more immediate concerns about family planning. Findings indicate that the majority of respondents are married, consistent with studies showing that married women have higher contraceptive needs due to active childbearing (National Population Commission & ICF, 2019). However, single and divorced women face additional challenges due to stigma and limited access to contraceptive services, as societal norms often discourage unmarried women from seeking family planning (Sedgh et al., 2016). Widowed and divorced women may have different contraceptive needs, particularly in cases where remarriage is common.

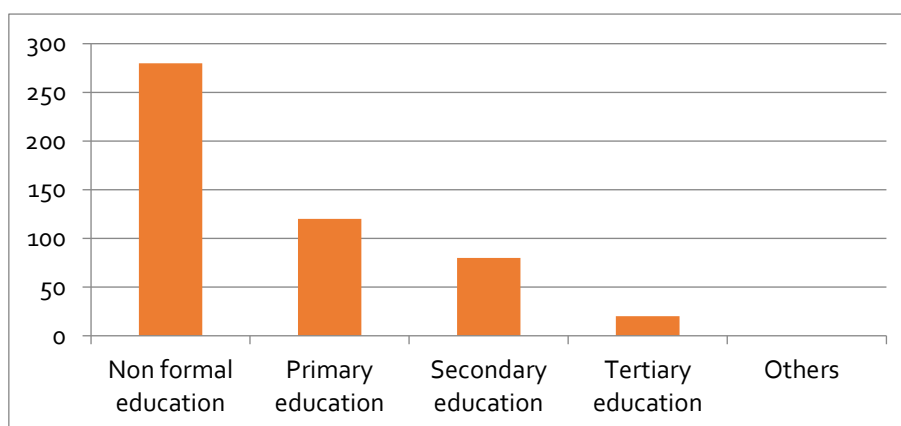


Figure 3: Educational Level of respondents

Source: Field work, 2025

A substantial proportion of respondents (56%) have no formal education, which may hinder access to information about family planning methods and services. Education is known to be a significant determinant in family planning utilization, with higher levels of education often correlating with greater knowledge and adoption of family planning methods (Ogunjuyigbe & Orji, 2018). The findings indicate that efforts to promote family planning in Sokoto State must target education, especially among individuals with no formal education, as they may be less likely to seek out or understand family planning options. Education significantly influences family planning awareness and utilization. The study finds that most respondents lack formal education or have only primary-level education. Previous research has established that higher educational attainment is strongly correlated with increased contraceptive use and reduced fertility rates (Bongaarts, 2015). Women with formal education tend to have greater autonomy, better health literacy, and access to modern contraceptives. This underscores the need for educational interventions to improve reproductive health knowledge among less-educated women.

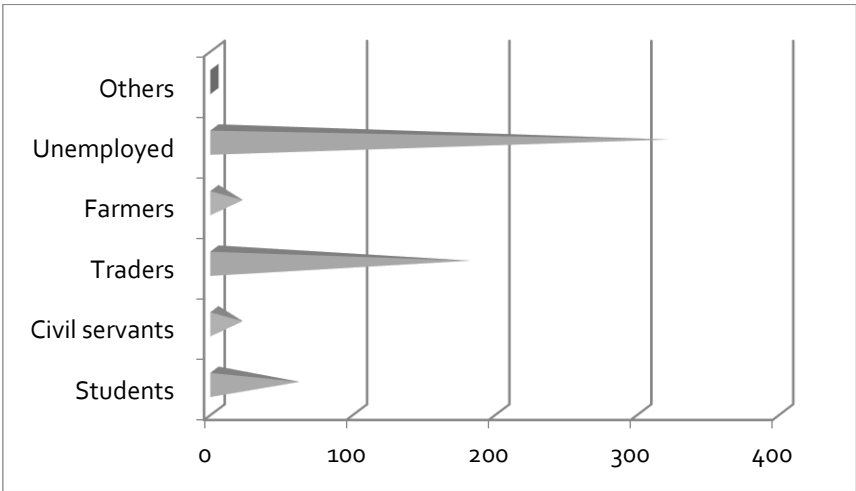


Table 4.5 Occupation of Respondents
Source: Field work, 2025

A significant proportion of respondents (64%) are unemployed, which may be a contributing factor to limited access to family planning services, as employment status is often associated with financial stability and health service access. The high number of traders (36%) suggests that many individuals in the study area rely on informal occupations, which might not offer the same access to health services or family planning information as formal employment. The relatively small proportion of civil servants and farmers indicates that the family planning services may need to address the specific needs of those in informal sectors (Adamu et al., 2020). The findings show that a large proportion of respondents are unemployed or engaged in informal economic activities, such as trading and farming. Studies suggest that employment and financial independence increase contraceptive use, as women with stable incomes can afford healthcare services (Adebowale, Palamuleni, & Odimegwu, 2019). Unemployed women, particularly those financially dependent on

spouses, may face barriers due to economic constraints and male-controlled decision-making. Expanding economic opportunities for women can therefore indirectly enhance contraceptive uptake.

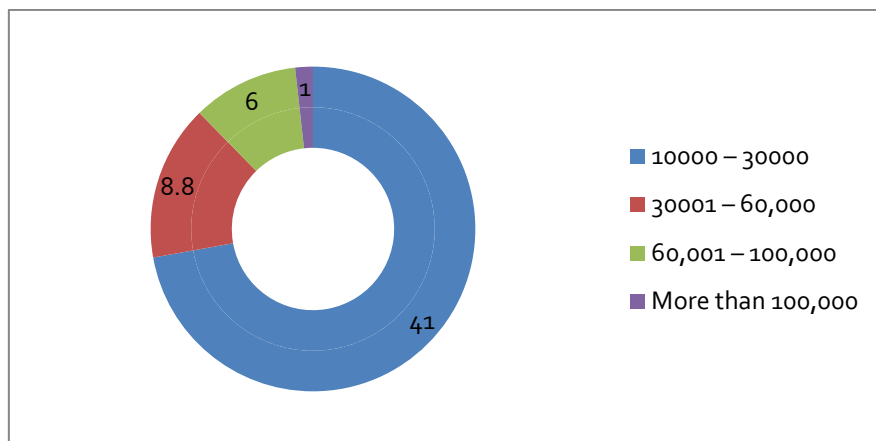


Figure 4: Income Level of Respondents

Source: Field work, 2025

The majority of respondents (43.2%) earn less than ₦10,000 per month, and another 41.0% fall within the ₦10,000 - ₦30,000 range. This indicates that a significant portion of the population belongs to the low-income group, which could limit their access to healthcare services, including family planning. A small proportion (1.0%) of respondents earn above ₦100,000 per month, suggesting that high-income earners are a minority in the study area. The presence of a few higher-income respondents slightly alters the previous analysis, as it suggests that while extreme poverty is widespread, a small elite group may have better access to healthcare, including family planning services. Since nearly 84.2% of respondents earn ₦30,000 or less per month, affordability remains a significant barrier. Lower-income individuals may prioritize basic needs over healthcare, limiting their ability to access family planning services. Higher-income earners may have access to private healthcare services, where family planning options are more readily available and better supported. Disparities in Awareness and Utilization. Studies (e.g., Ogunjuyigbe & Orji, 2018) indicate that higher-income earners are more likely to access and utilize family planning services, while lower-income groups face financial constraints that discourage use. Previous studies in northern Nigeria (Ali et al., 2019) have shown that household income strongly correlates with family planning uptake. Women from higher-income households tend to use modern contraceptives more frequently, whereas low-income women rely more on traditional or no methods at all. This suggests that financial empowerment programs, subsidies, and free access to contraceptive services could help bridge the gap in family planning utilization across income groups. Income level remains a crucial determinant of family planning access and utilization. With the majority of respondents in the low-income bracket, financial constraints may hinder contraceptive use,

emphasizing the need for government intervention, subsidized services, and increased awareness programs to promote family planning in Sokoto State.

The study's findings align with existing literature on family planning in predominantly Muslim communities, particularly in Northern Nigeria. The low contraceptive prevalence rate observed in this study is consistent with previous research indicating that Muslim women in Nigeria have a significantly lower contraceptive use (5.6%) compared to their Christian counterparts. This disparity is often attributed to cultural and religious beliefs that influence perceptions of family planning. Additionally, misconceptions about modern contraceptive methods persist, with some community members viewing them as a Western imposition aimed at limiting Muslim population growth. Such beliefs contribute to resistance against adopting family planning practices. The involvement of religious leaders has been identified as a critical factor in shaping community attitudes toward family planning. Engaging these leaders in promoting the benefits of birth spacing has led to increased acceptance and utilization of modern contraceptive methods in similar settings. This underscores the importance of culturally sensitive interventions that collaborate with influential community figures.

Conclusion

This study has examined the influence of socioeconomic and cultural determinants on the utilization of family planning services in Sokoto State, Nigeria. The findings reveal that while awareness of family planning exists, actual usage remains low due to a combination of economic constraints, cultural beliefs, religious perceptions, and limited access to healthcare services. Socioeconomic factors such as education, income level, and occupation significantly impact family planning adoption, with women who have higher education and financial stability being more likely to use contraceptives. However, deeply rooted cultural norms and religious interpretations continue to shape reproductive health decisions, leading to resistance against modern contraceptive methods. The study highlights the critical role of male involvement in family planning decisions, as many women require their husband's consent before using contraceptives. To improve family planning uptake in Sokoto State, it is essential to address misinformation, engage religious and community leaders, and design culturally sensitive interventions that align with local beliefs while promoting reproductive health. Strengthening healthcare facilities, expanding outreach programs, and ensuring contraceptive affordability will also enhance accessibility. Moreover, integrating men into family planning education programs can foster shared decision-making and reduce resistance.

Recommendations

Based on the findings of this study, the following recommendations are proposed to enhance the accessibility and utilization of family planning services in Sokoto State, Nigeria:

1. Strengthen family planning awareness and education by conducting community-based sensitization programs to address misconceptions and myths surrounding family planning. This could be done through integration of family planning education into school curricula and adult literacy programs to increase awareness among different age groups. In addition to that, use mass media, social media, and community dialogues to promote accurate information on contraceptive methods and their benefits.
2. Increase male involvement in family planning, this could be done as to organize targeted awareness campaigns for men to encourage their support for family planning. Engage religious and traditional leaders to advocate for male participation in reproductive health decisions. Promote couple-based counseling sessions in healthcare facilities to foster joint decision-making on contraceptive use.
3. Improve accessibility and affordability of family planning services by expanding family planning service delivery points, especially in rural areas, through mobile clinics and outreach programs. Provision of subsidized or free contraceptives for low-income women to remove financial barriers. Training of more healthcare providers to offer high-quality family planning services and counseling.
4. Address cultural and religious concerns by working with Islamic scholars and religious leaders to develop culturally acceptable family planning messages. Encourage faith-based organizations to support reproductive health initiatives that align with religious teachings. Organize community forums and discussions to bridge the gap between modern contraceptive methods and cultural values.

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