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BARRIERS TO FAMILY PLANNING UTILIZATION AMONG MARRIED COUPLES IN KEFFI LOCAL GOVERNMENT AREA, NASARAWA STATE, NIGERIA

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ABSTRACT :

This study investigated the barriers to family planning utilization among married couples in Keffi Local Government Area, Nasarawa State, Nigeria. The study examined the influence of cultural beliefs, religious beliefs, and socioeconomic status. The study anchored in the Health Belief Model, the study adopted a survey research design. A structured questionnaire was administered to 388 married respondents selected through multistage sampling, while Key Informant Interviews were conducted with healthcare providers, religious leaders, traditional leaders, and community stakeholders. Quantitative data were analysed using descriptive statistics, while qualitative data were analysed thematically. Findings revealed that preference for large families (25.3%) was the most influential cultural barrier, religious views concerning artificial contraception (26.0%) was the most influential religious barrier, and household income (23.5%) was the most influential socioeconomic barrier to family planning utilization. Qualitative accounts corroborated these findings, showing that extended family pressure, religious interpretations of contraception, and financial constraints jointly shape couples' reproductive decisions. The study concludes that family planning utilization in Keffi is not simply a function of awareness or service availability but is deeply embedded in the social, religious, and economic realities couples navigate daily. It recommends community-based education involving religious and traditional leaders, improved affordability and accessibility of family planning services, and couple-focused counselling to address the interconnected barriers identified.

Keywords*:* Family Planning, Contraceptive Utilization, Cultural Beliefs, Religious Beliefs, Socioeconomic Status

Introduction

Family planning is widely recognized as one of the most effective public health interventions for improving maternal and child health, reducing unintended pregnancies, promoting healthy birth spacing, and improving the quality of life of families. It enables couples to determine the number, timing and spacing of their children, voluntary use of safe and effective methods of contraception. According to the World Health Organization (2023), access to family planning is critical in reducing maternal and infant mortality, avoiding high-risk pregnancies and improving reproductive health. Similarly, the United Nations Population Fund (UNFPA, 2022) stated that family planning is a critical approach to promote gender equality, women's empowerment, and sustainable socioeconomic development.

Despite the availability of family planning, its uptake remains relatively low in many developing countries, especially in sub-Saharan Africa. Notwithstanding the years of increased knowledge of modern contraceptive methods, many couples do not use the services because of a number of barriers beside knowledge alone. Cleland et al (2018) highlighted the intricate relationship between cultural norms, religious beliefs, economic conditions, educational achievement and access to quality healthcare services that influence the use of family planning.

Nigeria continues to have one of the highest fertility rates in Africa and modern contraceptive use prevalence remains below the level needed to meet national reproductive health targets. The National Population Commission (NPC) and ICF (2019) noted that while more than 90 percent of married women are aware of contraceptive methods, the utilization of modern contraceptives is substantially lower. This gap indicates that other factors beyond awareness continue to hinder the adoption of family planning methods. However, Akinyemi et al. (2022) observed that misconceptions, fear of side effects, poor spousal communication, limited male involvement and inadequate access to reproductive health services still discourage many Nigerian couples from using family planning. *Ezeanolue et al. (2015)* argue that deeply rooted cultural values often discourage contraceptive use, particularly where childbearing is considered a demonstration of marital success and social status.

Accordingly, *Adedini et al. (2018)* found that cultural norms promoting high fertility continue to reduce the acceptance and utilization of modern contraceptive methods among married couples in Nigeria. Similarly, *Eke et al. (2021)* reported that misconceptions arising from religious interpretations contribute to low family planning utilization among married couples in several Nigerian communities. Bongaarts (2020) indicates that education results in better reproductive decision-making thru greater awareness, increased autonomy of women, and positive attitudes toward contraception. Similarly, Olugbenga-Bello et al. (2019) found that higher levels of education and better socioeconomic status are significant factors that increase the likelihood of

family planning use among Nigerian couples. Keffi Local Government Area of Nasarawa State is culturally diverse with different religious leanings and socioeconomic status which may influence reproductive health behaviors. It is against this background that this study seeks to examine the multidimensional barriers to family planning utilization among married couples in Keffi Local Government Area, Nasarawa State, Nigeria.

Objectives of the Study

The main objective of the study is to examine Barriers to Family Planning Utilization among Married Couples in Keffi Local Government Area, Nasarawa State, Nigeria. The specific objectives are to:

I. Examine the influence of cultural beliefs on family planning utilization among married couples in Keffi Local Government Area, Nasarawa State, Nigeria.

II. Assess the influence of religious beliefs on family planning utilization among married couples in Keffi Local Government Area, Nasarawa State, Nigeria.

III. Determine the influence of socioeconomic status on family planning utilization among married couples in Keffi Local Government Area, Nasarawa State, Nigeria.

Literature review

Conceptual Clarification

Family Planning Utilization

Family planning utilization denotes the degree to which individuals and couples engage with, adopt, and consistently utilize contraceptive methods and reproductive health services to attain their preferred family size and birth intervals. Family planning, which encompasses the use of contraception to avert unintended pregnancies, realize a desired family size, and maintain appropriate spacing between births (Ngole & Joho, 2025). This perspective frames utilization not merely as a fixed demographic measure but as a dynamic behavioral process influenced by personal choices, relationship dynamics, and the overarching health system in which reproductive choices are made.

Utilization is increasingly understood as a woman's capacity to autonomously select a family planning method through a well-informed process, devoid of undue influence from a partner or other significant individuals. This autonomy is regarded as a measurable factor in utilization rather than a secondary aspect (Anbesu, Aychiluhm, & Alemayehu, 2022). This perspective is supported by research indicating that the power to make decisions regarding family planning is significantly correlated with actual utilization outcomes, particularly among specific groups such as HIV-positive women accessing public health services, where restricted decision-making authority was associated with reduced utilization (Dejene, Girma, Adugna, et al., 2022). Furthermore, multilevel analyses of demographic and health survey data throughout sub-Saharan Africa have demonstrated that a married woman's decision-making authority consistently predicts whether family planning is utilized, regardless of the availability of methods (Demissie, Akalu, Gelagay, et al., 2022).

The utilization of family planning is also understood through the dimensions of service-level and health systems. Research on family planning service delivery highlights that utilization is influenced by the quality, accessibility, and integration of services within primary health care systems. Poor service readiness and inadequate integration with related maternal and reproductive health platforms hinder uptake, even when there is existing demand (Abay, Hagos, Dellie, Yazachew, Teshale, & Debie, 2022). Additionally, client satisfaction with family planning services has been recognized as a crucial factor that promotes ongoing utilization. Factors such as the quality of counseling, provider demeanor, waiting times, and privacy during service delivery have been shown to significantly affect whether clients continue to use their selected method (Ferede, Tassew, & Zeleke, 2025).

Multidimensional Barriers

Barriers to the utilization of family planning are increasingly viewed not as a singular challenge but as a complex interplay of constraints that operate simultaneously across various levels of an individual's life and environment. Recent academic discourse posits that access to contraception should be analyzed through a multi-level, multi-dimensional lens, as individual behavior is concurrently influenced by factors at the individual, interpersonal, community, health-system, and policy levels. Interventions that focus solely on one level often fail to address the underlying structure of barriers (Steiner et al., 2025). This shift in perspective encourages the field to move away from defining "access" or "unmet need" as a singular measurable gap, instead promoting the understanding of utilization as the result of overlapping, mutually reinforcing constraints that must be tackled collectively. In the individual level, recent research has identified several barriers, including fear of side effects, limited knowledge of available methods, negative perceptions of contraception, and a low perceived need for such services Habte, Dessu, Bogale, & Lemma, 2022). Concerns regarding side effects were a primary reason women either discontinued or avoided modern family planning methods, even when these methods were physically accessible. This finding suggests that psychological and experiential factors can take precedence over structural availability (Chrumpf et al., 2020). Furthermore, evidence indicates that psychosocial aspects of access such as perceived stigma, self-efficacy in negotiating contraceptive use, and internalized beliefs about contraception are significant predictors of both contraceptive use and future intentions to use, regardless of geographic or financial access (Zan & Rossier, 2024). At the community level, obstacles consist of dominant social norms, religious convictions, misinformation, and stigma that exist independently of an individual's personal beliefs. A qualitative study conducted in Kabwe District, Zambia, identified myths, rumors, and negative traditional or religious beliefs as significant barriers to contraceptive uptake at the community level, which operate alongside and often reinforce the challenges women face at health facilities (Silumbwe et al., 2018).

Empirical review

Ngole and Joho (2025) examined the use of modern family planning in Tanzania's Iringa Region and discovered that low utilization stemmed from a combination of individual-level knowledge deficiencies, interpersonal-level disapproval from husbands, community-level myths, and limitations within the health system. No single factor could adequately account for the lack of use on its own. This collection of findings reinforces the idea that barriers to

family planning are fundamentally multidimensional; addressing any one barrier in isolation is improbable to yield significant increases in utilization unless concurrent barriers at other levels are also tackled.

Sampson et al. (2023) conducted a study focusing on family planning access for internally displaced women in Abuja, Nigeria. They discovered that the low utilization of family planning services was influenced by a complex interplay of barriers rather than a single factor. These barriers included interpersonal-level issues such as the absence of spousal consent, individual-level concerns regarding potential adverse side effects, community-level misconceptions about contraception, sociocultural beliefs, and structural limitations like insufficient funds. Importantly, the implementation of a mobile-technology intervention that addressed these barriers simultaneously resulted in an increase in contraceptive prevalence within the camp, rising from 18.1% to 26.2%. Additionally, there was a significant decrease in the number of women citing lack of spousal consent as a reason for not using contraception. This finding indicates that improvements in utilization were only realized when interventions targeted multiple levels of the barrier framework at once, rather than focusing solely on the availability of services.

Jisso et al. (2023) conducted a qualitative case study across four regions of Ethiopia, categorizing barriers to the utilization of family planning services into four interconnected domains: individual barriers, which include fear of side effects and limited decision-making autonomy; community-related barriers, which encompass misconceptions and restrictive socio-cultural or religious norms; health-system barriers, characterized by inadequate provider skills and service interruptions; and broader contextual barriers, such as challenging topography, conflict, and disruptions caused by the COVID-19 pandemic. The authors pointed out that much of the previous research in Ethiopia has predominantly concentrated on individual and community-level barriers, thereby neglecting the cumulative impact of health-system and contextual constraints that coexist with them. Their findings support the broader conclusion that barriers to family planning are interrelated across different levels, indicating that policy interventions that focus solely on one domain for example, community awareness initiatives without parallel health-system enhancements are unlikely to lead to sustainable increases in service utilization.

Health Belief Model (HBM)

The Health Belief Model (HBM) stands as one of the earliest and most extensively utilized psychological frameworks for elucidating the reasons behind individuals' acceptance or rejection of health-related behaviors. This model emerged in the 1950s, developed by social psychologists within the United States Public Health Service, notably Irwin M. Rosenstock, Godfrey M. Hochbaum, and Stephen Kegels. It was created in response to the observed reluctance of many individuals to engage in preventive health programs, despite the availability of such services. The initial formulation of the HBM was significantly shaped by Hochbaum's research in 1958, which investigated individuals' willingness to partake in tuberculosis screening initiatives. Hochbaum discovered that the decision to participate was not solely determined by the service's availability but was also heavily influenced by individuals' perceptions of their susceptibility to disease and the perceived benefits of taking preventive measures. Expanding upon these insights, Rosenstock formally articulated the model in 1966, establishing it as a framework for comprehending individual choices related to preventive health behaviors.

The primary premise of the Health Belief Model posits that individuals' health-related behaviors are shaped by their perceptions of health threats and their evaluations of the advantages and obstacles linked to preventive measures. In essence, people do not automatically engage in health behaviors solely based on medical advice. Their choices are swayed by their comprehension of the health issue, their beliefs regarding the potential benefits of taking action, and their concerns about possible losses or challenges that may arise from such actions.

Perceived Susceptibility

Perceived susceptibility refers to an individual's belief about the likelihood of experiencing a particular health problem. The stronger an individual's perception of vulnerability, the greater the likelihood that the person will consider taking preventive action. In the context of family planning, perceived susceptibility can relate to a couple's understanding of the possibility and consequences of unintended pregnancy, closely spaced births, or pregnancy-related health complications. For example, a couple that recognizes the possibility that frequent pregnancies may negatively affect maternal health may perceive a stronger need for family planning. Conversely, if couples do not perceive closely spaced pregnancies or unintended pregnancies as significant threats, they may see little reason to use contraceptive methods. Cultural and religious beliefs may also influence perceived susceptibility by shaping how individuals understand pregnancy and fertility.

Perceived Severity

Perceived severity refers to an individual's belief about the seriousness of a health problem and its possible consequences. Individuals are more likely to take preventive measures when they believe that the consequences of a health problem are serious. Applied to the present study, couples may differ in the extent to which they perceive the consequences of unintended pregnancy, closely spaced births, or uncontrolled fertility as serious. A couple that considers repeated pregnancies financially, socially, or medically burdensome may be more inclined to utilize family planning. However, where large families are highly valued culturally, the perceived social benefits of having many children may reduce the perceived seriousness of the disadvantages associated with frequent childbearing.

Perceived Benefits

Perceived benefits refer to an individual's belief that adopting a particular health behaviour will reduce a perceived threat or produce desirable outcomes. In family planning, perceived benefits may include the ability to space births, protect maternal health, improve child welfare, manage household resources, and determine the desired family size. Where couples strongly recognize these benefits, they may be more willing to use family planning methods. However, awareness of benefits does not automatically lead to utilization. The perceived benefits must be sufficiently strong to outweigh the perceived barriers. This explains why some couples may acknowledge that family planning is beneficial while still choosing not to use contraceptive methods.

Perceived Barriers

Perceived barriers constitute one of the most important constructs of the HBM for the present study. They refer to the individual's perception of the difficulties, costs, risks, or disadvantages associated with adopting a recommended health behaviour. In relation to family planning, perceived barriers may include cultural disapproval, religious objections, fear of contraceptive side effects, lack of knowledge, financial difficulties, poor access to health facilities, distance to healthcare centres, lack of privacy, and negative attitudes from health workers, and opposition from spouses or family members.

For this study, the Health Belief Model is applied to provide a theory that would define the use of family planning as a behavior whose adoption is impacted by the perception of benefits and barriers by couples in relation to their social and socioeconomic environment. Cultural beliefs, religious

beliefs, and socioeconomic status emerge as some of the contextual variables which are likely to impact the perceptions of individuals in terms of their perceived benefits and barriers. In cases where the couples find themselves in situations where there are strong perceptions of benefits while at the same time the perceptions of barriers are low, utilization of family planning services should be high. On the other hand, in situations where the perceptions of barriers are strong due to cultural, religious, and socioeconomic factors, utilization of family planning services should be low.

Methodology

This study employed a survey research design combining quantitative and qualitative approaches to examine the multidimensional barriers to family planning utilization among married couples in Keffi Local Government Area, Nasarawa State, Nigeria. The design was considered appropriate because it enabled the study to obtain quantitative information on the patterns and factors influencing family planning utilization while also providing an opportunity to explore couples' experiences, perceptions, and beliefs concerning cultural, religious, and socioeconomic barriers to family planning. The study population comprised married men and women aged 18 years and above residing in Keffi Local Government Area. Keffi Local Government Area has an estimated population of 142,900 based on the projected population figures reported by the National Population Commission. The study focused on selected wards within the Local Government Area. The target population consisted of married couples who were of reproductive age and had lived in the study area for a reasonable period. In addition, key informants comprising healthcare providers involved in family planning services, religious leaders, traditional leaders, and relevant community representatives were included because of their knowledge and experience concerning reproductive health practices and family planning within the community. The sample size for the quantitative component of the study was determined using an appropriate sample size determination procedure for a finite population. A multistage sampling technique was employed to select respondents. In the first stage, the wards in Keffi Local Government Area were grouped into clusters. Selected wards were subsequently chosen through a simple random sampling procedure to provide geographical representation of the Local Government Area. In the second stage, eligible married couples were identified within the selected wards, while respondents were selected based on the predetermined sampling procedure. For the qualitative data, Key Informants (KII) were purposively selected based on their knowledge of family planning practices and the social conditions affecting contraceptive utilization. The key informants included healthcare workers, religious leaders, traditional leaders, and other relevant community stakeholders.

Data were collected using a structured questionnaire and Key Informant Interview (KII) guide. The questionnaire was administered to eligible married respondents using a combination of self-administered and researcher-assisted approaches. The questionnaire was structured into sections covering the respondents' socio-demographic characteristics, family planning utilization, cultural beliefs, religious beliefs, and socioeconomic factors influencing family planning utilization. The KII guide contained open-ended questions designed to obtain detailed information concerning community perceptions of contraception, cultural expectations, religious influences, economic difficulties, and other barriers affecting family planning utilization. The data collection process was supported by trained research assistants who were familiar with the study area and the administration of research instruments. For the quantitative data, the collected data were coded and analysed using descriptive statistical techniques. Frequencies and percentages were used to summarize the socio-demographic characteristics and major patterns of family planning utilization. The qualitative data obtained through the KII were transcribed, carefully reviewed, coded, and analysed thematically. Emerging themes were developed around cultural beliefs, religious beliefs, socioeconomic conditions, and family planning utilization. The qualitative findings were subsequently used to complement and explain the quantitative results.

Analysis/Result

Table 1: Socio-demographic Characteristics

Variables	Frequency (n)	Percentages (%)
Gender:		
Male	184	47.4
Female	204	52.6
Age:		
18–27 years	68	17.5
28–37 years	143	36.9
38–47 years	104	26.8
48–57 years	51	13.1
58 years and above	22	5.7
Educational Level:		
No formal education	39	10.1
Primary education	76	19.6
Secondary education	143	36.9
Tertiary education	130	33.5
Occupation:		
Farming	61	15.7
Trading/business	126	32.5
Civil/public service	109	28.1
Artisan	92	23.7
Household Income:		
₦40,000-49,000	48	12.4
₦50,000–₦99,999	128	33.0
₦100,000–₦149,999	103	26.5
₦150,000–₦199,999	66	17.0

₦200,000 and above	43	11.1
Duration of Married:		
Less than 5 years	71	18.3
5–9 years	112	28.9
10–14 years	94	24.2
15–19 years	61	15.7
20 years and above	50	12.9
Religion Status:		
Christianity	205	52.8
Islam	169	43.6
Traditional religion	14	3.6
Total	**388**	**100.0**

Source: Field Work, 2026

Table 1 show the socio-demographic features of the 388 participants of the research. The distribution indicates that 184 (47.4%) were males, while 204 (52.6%) were females, thus showing that there were more females among the respondents.

On the age of the respondents, the majority, 143 (36.9%), were aged 28-37 years. The second largest group of respondents were aged 38-47 years, 104 (26.8%). There were 68 (17.5%) aged 18-27 years, while 51 (13.1%) were aged 48-57 years. Those aged 58 years and above made the smallest proportion, 22 (5.7%).

On educational attainment, the highest proportion of respondents, 143 (36.9%), had secondary education, while 130 (33.5%) had tertiary education. There were 76 (19.6%) respondents who had primary education, while 39 (10.1%) did not have any formal education. Thus, the majority of the respondents had at least some kind of formal education.

As regards occupation, the highest proportion among the respondents, 126 (32.5%), was engaged in trading/business, while 109 (28.1%) were in civil/public service. There were 92 *(23.7%)***,** while farming constituted *61 (15.7%)*.

As seen from the distribution of the household income, a number of 128 respondents (33.0%) stated to have monthly incomes in the range of ₦50,000 to ₦99,999 which was the highest in the sample. The next higher household income group were the respondents with monthly income of ₦100,000-₦149,999, who counted 103 (26.5%). Households whose income ranged from ₦150,000-₦199,999 numbered 66 (17.0%), while 48 (12.4%) had monthly income of ₦40,000-₦49,000. The last category consisted of 43 respondents (11.1%) having monthly household income of ₦200,000 and above.

Considering the period of marriage, the respondents who had been married for 5-9 years constituted the largest number of people, totaling 112 (28.9%), followed by the respondents who have been married for 10-14 years, which counted 94 (24.2%). Respondents who had been married for less than five years numbered 71 (18.3%), while 61 (15.7%) respondents were married for 15-19 years. Finally, 50 (12.9%) respondents were married for 20 years and above.

Finally, Christianity emerged as the largest religion, comprising 205 individuals (52.8%), while Islam comprised 169 individuals (43.6%). The remaining 14 (3.6%) were affiliated with traditional religion. Thus, the demographic variables show that the study sample consisted of individuals from various age groups, educational backgrounds, occupation types, income categories, lengths of marriage, and religions. This makes an excellent point for examining the barriers to use of family planning services in Keffi LGA.

FAMILY PLANNING UTILIZATION

Table 2: Distribution of Respondent on Family Planning Method currently use

Methods	Frequency (n)	Percentages (%)
Male condom	96	24.7
Female condom	21	5.4
Oral contraceptive pills	67	17.3
Injectable contraceptives	81	20.9
Implant	54	13.9
Natural/traditional method	69	17.8
Total	**388**	**100.0**

Sources: Field Work, 2026

Table 2 results reveal that 96 participants (24.7%) indicated the use of male condoms, establishing it as the most frequently employed method among those surveyed. Following this, injectable contraceptives were reported by 81 participants (20.9%). Natural or traditional methods were utilized by 69 participants (17.8%), while 67 participants (17.3%) reported using oral contraceptive pills. The use of implants was noted by 54 participants (13.9%), and the female condom had the lowest usage, with only 21 participants (5.4%). This distribution implies that respondents utilized a range of family planning methods, although the extent of usage varied significantly among the different method.

CULTURAL BELIEFS AND FAMILY PLANNING

Table 3: Distribution of Respondents by the Cultural Belief They Consider Most Influential on Family Planning Use Among Married Couples in the Community

Cultural Belief	Frequency (n)	Percentages (%)
Preference for large families	98	25.3
Belief that many children increase family status	54	13.9
Expectation that marriage should produce many children	83	21.4
Belief that contraception interferes with natural childbearing	69	17.8
Pressure from extended family to have more children	58	14.9

Preference for having children of particular sex	26	6.7
Total	**388**	**100.0**

Sources: Field Work, 2026

Table 3 The results indicate that 98 respondents (25.3%) recognized a preference for large families as the most significant cultural belief. This was succeeded by the expectation that marriage should yield numerous children, as reported by 83 respondents (21.4%). Additionally, 69 respondents (17.8%) acknowledged the belief that contraception disrupts natural childbearing as a key cultural influence. Pressure from extended family to increase the number of children was noted by 58 respondents (14.9%), while 54 respondents (13.9%) viewed the belief that having many children enhances family status as influential. The preference for children of a specific sex received the fewest responses, with only 26 respondents (6.7%). These findings suggest that cultural expectations regarding family size and childbearing play a crucial role in couples' family planning decisions.

Health Worker Stated:

…….Some couples maintain the belief that a marriage is not truly fulfilled until they have several children. Despite being aware of family planning methods, the pressure from family can lead to hesitance in utilizing these options.
(KII, Health Worker, Keffi)

As stated by the Community Leader:

……The choice is not solely made by the husband and wife. At times, parents and relatives anticipate that the couple will keep having children, particularly when they perceive the family as still being small (KII,/Community Leader/, Keffi 2026).

A traditional leader observed:

……There are people who believe that the more children you have, the stronger your family becomes. Such people may not easily accept family planning because they see children as part of the strength and future of the family (KII/Traditional Leader/Keffi, 2026).

RELIGION BELIEFS AND FAMILY PLANNING

Table 4: Distribution of Respondents by the Religious Influence Considered to Have the Greatest Effect on Couples' Family Planning Decisions in the Community

Religion Belief	Frequency (n)	Percentages (%)
Religious teachings about childbearing	76	19.6
Religious views concerning artificial contraception	101	26.0
Advice from religious leaders	62	10.0
Belief that children are gifts from God	73	16.0
Religious preference for natural family planning methods	45	18.8
Fear of religious disapproval	31	11.6
Total	**388**	**100.0**

Sources: Field Work, 2026

Table 4 illustrates that the largest segment, comprising 101 respondents (26.0%), recognized religious perspectives on artificial contraception as the primary influence. This was succeeded by religious doctrines regarding childbearing, acknowledged by 76 respondents (19.6%). The notion that children are considered gifts from God was noted by 73 respondents (18.8%), whereas 62 respondents (16.0%) pointed to guidance from religious leaders as a significant factor. Additionally, 45 respondents (11.6%) indicated a religious preference for natural family planning methods, and 31 respondents (8.0%) expressed concerns about potential religious disapproval. These findings indicate that religious beliefs and interpretations related to contraception and childbearing may significantly influence family planning choices among married couples in the studied region.

A health worker elaborated:

……The influence of religion can significantly impact the choices made by certain couples, especially when they hold the view that the use of artificial contraceptives contradicts their religious beliefs. In these cases, even if the health worker outlines the advantages, the couple may still decline. (KII/Health Worker/Keffi, 2026).

Religion leader explained:

……There are individuals who firmly believe that children are a gift from God and that humans should not intervene in the process of childbirth. Due to this conviction, they may choose to entrust everything to God rather than intentionally prevent conception." (KII/Religious Leader/Keffi, 2026).

According to Community Leader:

…….People listen to their religious leaders. If a person is confused about family planning, they may first ask their religious leader. The advice they receive can influence whether they eventually go to the health facility or not *(KII/Community Leader/Keffi, 2026).*

SOCIOECONOMIC STATUS AND FAMILY PLANNING

Table 5: Distribution of Respondents by the Socioeconomic Factor Considered Most Influential on Household Utilization of Family Planning Services

Socioeconomic Factors	Frequency (n)	Percentages (%)
Household income	91	23.5
Educational level	63	16.2
Employment status	47	12.1
Cost of accessing family planning services	84	21.6
Distance to health facility	43	11.1
Availability of contraceptive methods	60	15.5
Total	**388**	**100.0**

Sources: Field Work, 2026

Table 5 indicates that 91 respondents (23.5%) identified household income as the most critical factor. This was closely succeeded by the cost of accessing family planning services, recognized by 84 respondents (21.6%). Educational level was cited by 63 respondents (16.2%), while 60 respondents (15.5%) noted the availability of contraceptive methods as influential. Employment status was reported by 47 respondents (12.1%), and the distance to the health facility received the lowest number of responses, with 43 respondents (11.1%). These findings suggest that household economic conditions, particularly income and the costs related to accessing family planning services, may represent significant socioeconomic barriers to the use of family planning among married couples in the Keffi Local Government Area.

Health Worker stated:

…….Some families recognize the significance of family planning; however, their financial circumstances often pose challenges. When individuals are unable to fulfill basic household requirements, the costs associated with transportation to health facilities or other service-related expenses can become problematic (KII/Health Worker/Keffi 2026).

A health worker also explained:

Even if the method itself is affordable, individuals may incur expenses for transportation and other costs before they can access the facility. For low-income households, these seemingly minor costs can present substantial obstacles (KII/Health Worker/Keffi, 2026)

Community leader explained:

……Education facilitates a better understanding of the various methods and their benefits. Individuals with limited education may rely more on information from others, which can sometimes be inaccurate (KII/Community Leader/Keffi 2026)

Discussion of Findings

Finding on the Cultural Beliefs and Family Planning Utilization revealed that the preference for larger families was the most significant cultural factor, accounting for 25.3%. This was followed by the belief that marriage should yield numerous children at 21.4%, the notion that contraception disrupts natural childbearing at 17.8%, and the influence of extended family pressure at 14.9%. Key informants noted that couples often experience pressure from relatives to expand their families, especially in contexts where larger families are associated with strength, status, or marital success. This finding is consistent with the work of Cleland et al. (2012) and Bongaarts (2015), who recognized social norms and fertility preferences as crucial factors influencing contraceptive behavior in high-fertility environments. Caldwell and Caldwell (1987) similarly posited that fertility behaviors in Africa are deeply rooted in kinship systems, where children hold social and economic importance that extends beyond the nuclear family, indicating that decisions regarding contraception frequently require negotiation with extended family members, rather than solely between partners.

Religious Beliefs and the Use of Family Planning: The most frequently mentioned religious influence on artificial contraception was religious views, cited by 26.0% of respondents. This was followed by religious teachings about childbearing at 19.6%, the belief that children are gifts from God at 18.8%, advice from religious leaders at 16.0%, a preference for natural methods at 11.6%, and fear of religious disapproval at 8.0%. Key informants reported that couples often view contraception through their faith and may avoid methods they perceive as conflicting with their religious beliefs, frequently seeking guidance from religious leaders before making decisions. This finding is consistent with the work of Bongaarts (2015) and Feyisetan and Bankole (2002), who emphasized that reproductive behavior in Nigeria is shaped by broader social institutions and values.

Finally, regarding Socioeconomic Status and Family Planning Utilization, household income emerged as the most commonly recognized socioeconomic factor at 23.5%. This was followed by the cost of accessing services at 21.6%, educational level at 16.2%, availability of contraceptive methods at 15.5%, employment status at 12.1%, and distance to health facilities at 11.1%. Key informants noted that households with low income often prioritize immediate necessities such as food, housing, and education over preventive reproductive healthcare. Additionally, indirect costs, such as transportation, can hinder utilization even when methods are available at low or no cost. This observation aligns with the findings of Ahmed et al. (2012) and Cleland et al. (2012), who associated contraceptive use and unmet needs with socioeconomic conditions and barriers to access. The significance of income indicates that mere knowledge is inadequate for utilization; practical financial constraints elevate perceived barriers within the Health Belief Model, even when the benefits are acknowledged. Education, as suggested by Bongaarts (2010), likely functions indirectly by enhancing knowledge and decision-making autonomy, while the availability of services illustrates how health system conditions interact with household situations.

Conclusion

This study concludes that family planning utilization among married couples in Keffi Local Government Area is shaped not by a single barrier but by the interaction of cultural, religious, and socioeconomic forces embedded in everyday marital and community life. Culturally, the enduring preference for large families, marital expectations around childbearing, and pressure from extended kin continue to discourage many couples from spacing or limiting births, underscoring that contraceptive choice is a social, not merely personal, decision. Religiously, beliefs about the acceptability of contraception and the guidance of religious leaders shape which methods couples consider legitimate — yet religion need not be an obstacle; when reproductive health messages are framed within culturally and religiously resonant language, religious institutions can become allies rather than barriers. Economically, income, cost of access, education, and service availability determine whether reproductive intentions translate into actual practice, meaning that awareness alone, without addressing affordability and access, yields limited impact among disadvantaged households. Viewed through the Health Belief Model, these findings converge on one insight: the gap between knowledge and practice in Keffi is a gap of perceived and real barriers, not of information. Couples may recognize the benefits of family planning yet still abstain because perceived social, religious, financial, or service-related costs outweigh those benefits.

Recommendations

- Strengthen community-based education and engagement with religious and traditional leaders to reduce cultural and religious misconceptions surrounding family planning.
- Improve affordability and accessibility of family planning services, particularly for low-income households, through subsidized costs and wider service coverage.
- Promote couple-focused counselling and dialogue to help spouses jointly navigate family, religious, and economic pressures in reproductive decision-making.

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