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Culture, Religion, and Gender Relations in the Adoption of Family Planning in Delta North Senatorial District: A Sociological Analysis

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[0194] Abstract
In Nigeria, family planning (FP) is still essential for gender parity and public health, especially in areas with high fertility rates and ongoing issues with mother and child health. Several regions of the nation, especially Delta North Senatorial District, continue to have low rates of contraceptive use despite a national family planning program and increased knowledge of contemporary technologies. This study examines the ways in which gender interactions, religious doctrines, and cultural attitudes affect whether family planning methods are adopted or rejected in this setting. The study uses a mixed-methods sociological approach, analysing survey data, focus group talks, and in-depth interviews with male and female respondents in Delta North. The findings reveal a complex interplay of factors: while awareness is relatively high, deep-rooted cultural myths, religious interpretations, and patriarchal gender norms act as formidable barriers to uptake. These are compounded by structural health system challenges, such as inadequate supply of contraceptives and poor access to reproductive health services. The study applies theoretical frameworks including the Health Belief Model, Gender and Power Theory, and Diffusion of Innovations Theory to assess the complex character of FP uptake. It finishes with recommendations for culturally aware, gender-responsive, and religiously contextualized family planning strategies.
Keywords: **Culture, Family Planning, Gender Relations, Religion.**

Introduction

Background to the Study: Family planning is widely acknowledged as a vital instrument for enhancing the health of mothers and children, encouraging women's emancipation, and bolstering national economic growth. Family planning is essential in Nigeria to combat poverty, rapid population increase, and gender inequality as well as to lower maternal mortality, which is still among the highest in the world. The Nigerian government has set lofty goals to raise the prevalence of modern contraceptives among women of reproductive age to 27% through the National Family Planning Blueprint (2020–2024) (Federal Ministry of Health, 2020). However, real penetration is still below the desired level, especially in semi-urban and rural areas where sociocultural and religious influences are significant. Delta State, located in the oil-rich Niger Delta region, comprises three senatorial districts: Delta North, Delta Central, and Delta South. Among these, Delta North is particularly diverse, housing ethnic groups such as the Anioma, Ika, and Ukwuani people. The region exhibits a blend of traditional beliefs, Christian faith systems, and patriarchal gender dynamics that shape health-seeking behaviour. The persistent gap between awareness and actual use of family planning methods in the region suggests the influence of non-biomedical factors that merit sociological analysis.

Statement of the Problem

Although family planning is widely known and contraceptive methods are available in public health facilities, Delta North's uptake is still very low—preliminary research and anecdotal evidence suggest that this disparity is caused by religious objections (e.g., that FP is sinful or against God's will), cultural myths (e.g., that FP causes infertility), and male-dominated household decision-making structures that restrict women's autonomy over their reproductive choices. However, few studies have systematically examined how these factors interact within the unique socio-political and cultural context of Delta North Senatorial District.

Objectives of the Study: This study's main goal is to examine how gender relations, culture, and religion affect Delta North's adoption of family planning. The particular goals are: **(a)** To determine the Delta North Senatorial District's level of family planning knowledge and usage. **(b)** To investigate how attitudes toward family planning are influenced by cultural norms and beliefs. **(c)** To investigate how

religious leaders and teachings influence the opinions of the community regarding contraception. **(d)** To look into how family planning adoption is impacted by gender relations, specifically spousal communication and decision-making. **(e)** To offer suggestions that are pertinent to policy and deal with obstacles that have been identified.

Research Questions

This study's main goal is to examine how gender relations, culture, and religion affect Delta North's adoption of family planning. The particular goals are: (a) To determine the Delta North Senatorial District's level of family planning knowledge and usage. (b) To investigate how attitudes toward family planning are influenced by cultural norms and beliefs. (c) To investigate how religious leaders and teachings influence the opinions of the community regarding contraception. (d) To look into how family planning adoption is impacted by gender relations, specifically spousal communication and decision-making. (e) To offer suggestions that are pertinent to policy and deal with obstacles that have been identified.

Significance of the Study and Scope

This study is important from a theoretical and practical standpoint. Theoretically, it highlights the intersection of gender, culture, and religion and advances our understanding of reproductive health behaviors through a sociological lens. In practice, it guides the development of focused interventions by medical professionals, legislators, and development partners who aim to enhance reproductive health outcomes in Delta North and comparable settings. Additionally, by better adjusting strategies to local socio-cultural realities, the findings will aid in the improvement of Nigeria's family planning initiatives.

Scope and Delimitation: Selected Local Government Areas, including Aniocha North, Aniocha South, Oshimili North, Oshimili South, Ika North East, and Ika South, are included in this study, which is limited to the Delta North Senatorial District. It targets religious and community leaders, as well as men and women of reproductive age (15–49 years). Although the study acknowledges the significance of other variables (such as age, income, and education), its primary emphasis is still on the gendered, cultural, and religious aspects of family planning adoption.

Literature Review

Numerous disciplinary studies have been conducted on Nigeria's adoption of family planning (FP) services. However, in many areas of the nation, particularly in the Niger Delta, the sociocultural dynamics that interact with religion and gender relations are still not well understood. The following themes—awareness versus utilization, cultural beliefs, religious influences, gender relations, and structural/institutional barriers to family planning uptake—are used to organize the pertinent academic literature, policy documents, and empirical findings that are synthesized in this review. ***Awareness vs. Utilization Gap****:* Research has repeatedly shown that Nigerian women are highly aware of contemporary family planning techniques, but their use is not as high. For example, according to data from the Nigeria Demographic and Health Survey (NDHS, 2018), only roughly 17% of women in the country currently use any type of modern contraception, despite the fact that over 85% of women in reproductive age are aware of at least one modern method.

According to Tettehfio et al. (2022), only 42.3% of women in Delta State's Central Senatorial District reported using modern family planning methods, despite the fact that roughly 69% of them were aware of them. This disparity emphasizes the impact of non-medical elements like fear of side effects, cultural misunderstandings, religious beliefs, and spousal resistance. Despite having prior knowledge of contraception, women in Eku Community, Delta State, cited fear of infertility, divine punishment, and marital instability as reasons for not using it. These findings were similar to those reported by Efejene et al. (2025). This awareness-utilization paradox emphasizes the importance of focusing on the social context in which reproductive decisions are made rather than just health education.

Cultural Beliefs and Traditional Norms: Individual attitudes regarding reproductive health are greatly influenced by culture. Children are viewed as both sources of social and economic value as well as tools of maintaining family ties in many African societies, including those in the Delta North Senatorial District. As a result, any attempt to reduce fertility through family planning might be seen as going against cultural norms (Ajah et al., 2020). Large families are linked to social status, masculinity, and agricultural labor in patriarchal societies. According to preliminary research and anecdotal

evidence, cultural norms among the Anioma and Ukwuani ethnic groups in Delta North frequently discourage the use of contraceptives, particularly among recently married women. Myths that are perpetuated and handed down through the generations include "family planning causes infertility" and "contraceptives are for promiscuous women" (Ralph-Imoniruwe & Ogege, 2021). Additionally, some traditional belief systems in Delta North's rural areas view fertility control as interfering with the natural order or ancestors' will. Traditional institutions and older family members frequently reinforce this cultural resistance to family planning, making personal choices governed by social norms.

Religious Influences on Family Planning: Reproductive health behaviors in Nigeria are significantly influenced by religion. Depending on the denomination, leadership, and local cultural integration, Christian and Islamic teachings have been interpreted to either support or oppose family planning in different parts of the country. In Delta State, the two most common religions are Christianity and African Traditional Religion (ATR). While some Pentecostal churches in Delta North actively oppose the use of artificial contraception, arguing that it violates the divine commandment to "be fruitful and multiply," others, like Catholic parishes, support natural family planning methods but reject artificial ones (Okonofua, 2018). Islamic influence is minimal in this region, but traditional religious beliefs, often closely linked to Christianity, reinforce pronatalist views. Women who attended religious institutions that preach against family planning were much less likely to use contraceptives, according to a study conducted in Delta State by Efejene et al. (2025). Public health messages are less influential in these communities than pulpit sermons. Religious leaders are strong gatekeepers to reproductive health services because they frequently serve as opinion leaders and defenders of moral order (Him Journal, 2024). Furthermore, there is a common misconception that family planning techniques indicate a lack of trust in God's provision or plan for a family. This idea can result in stigma against users, particularly women, in addition to discouraging adoption.

Gender Relations and Power Dynamics

Gender relations within households and communities significantly influence reproductive health decisions, particularly in patriarchal societies like those found in Delta North. Several studies have shown that spousal approval and communication are major determinants of contraceptive use (Oye-Adeniran et al., 2006; Eborka et al., 2021). In many Nigerian households, especially in rural areas, reproductive decisions are predominantly male-controlled. Women often require the consent or approval of their husbands before accessing family planning services. Eborka et al. (2021) studied male perspectives on family planning in Delta State and found that while many men were aware of modern contraceptive methods, a substantial proportion harbored mistrust and concerns about side effects, sexual dissatisfaction, or female infidelity linked to FP use. Low levels of communication between spouses regarding fertility intentions can also result in conflict, misunderstandings, and presumptions. When there is a lack of open communication, women are either dissuaded from using contraception or turn to using it covertly, which can cause conflict in marriages when it is found out (Fapohunda & Rutenberg, 1999). The combination of low health literacy and gender inequality leads to the continued underutilization of family planning services in a patriarchal society where women have little autonomy.

Structural and Institutional Barriers: The healthcare system's role cannot be understated, even though sociocultural and religious factors are important. Numerous studies conducted in Nigeria have found that systemic problems like inconsistent contraceptive supply, lack of trained providers, poor access to health facilities, and unfavorable provider attitudes are major obstacles to FP use (NURHI, 2020).Obong and Oyibo (2023) assessed the family planning readiness of Delta State and discovered that many PHCs did not have the entire selection of contraceptive options, particularly long-acting reversible contraceptives (LARCs) such as IUDs and implants. The lack of FP counseling rooms and frequent stock outs were also observed in the study. Likewise the cost of transportation and the distance to facilities serve as deterrents, especially for women living in rural and riverine areas. Negative experiences with healthcare providers, such as judgmental attitudes or confidentiality violations, can deter continued use of services even when they are available (Rasheed et al., 2016). In conclusion, the health system frequently fails to provide client-centered, easily accessible, and private services, which reinforces sociocultural barriers and fails to support the demand side of family planning.

Literature Gaps

From the reviewed literature, several gaps are apparent: **(a)** Few studies use an integrated sociological framework that considers gender relations, culture, and religion as concurrent factors influencing FP uptake; the majority of data are cross-sectional and quantitative; in-depth qualitative studies that

examine lived experiences, narratives, and belief systems are scarce in Delta North; and male perspectives and their influence on FP choices receive little attention. **(b)** The function of religious institutions in facilitating and impeding reproductive health interventions has not received enough attention. This study seeks to address these gaps by employing a mixed-methods sociological approach that combines quantitative and qualitative insights to provide a nuanced understanding of the factors influencing family planning adoption in Delta North.

Theoretical Framework

A robust theoretical framework is essential for analyzing the sociological factors influencing family planning (FP) adoption. This study integrates multiple theories to explore the multidimensional nature of FP behaviour, particularly within the cultural, religious, and gendered context of Delta North Senatorial District. The theoretical approach draws on four complementary frameworks: (a) Health Belief Model (HBM). (b) Gender and Power Theory (c) Diffusion of Innovations Theory (DOI) (d) Social Norms Theory. Each theory captures different dimensions of individual, relational, and societal influences on reproductive health behaviours.

Health Belief Model (HBM): (a) One of the most popular models for comprehending health behavior is the Health Belief Model (HBM), which was created by Rosenstock and associates in the 1950s. According to this theory, people's choices to adopt behaviors that promote their health are influenced by a number of important perceptions (Rosenstock, 1974; Glanz et al., 2008) (b) Perceived Susceptibility; Perception of the likelihood of contracting a disease (e.g., maternal mortality due to unplanned pregnancies). (c) Perceived Severity; the conviction that the condition's effects are severe. (d) Perceived Benefits; the conviction that a specific course of action is effective (e.g., using contraceptives to prevent unwanted pregnancies). (e) Perceived Barriers; Perception of the barriers to engaging in the health behavior (e.g., partner disapproval, religious opposition). (f) Cues to Action; external events or messages that prompt behaviour (e.g., community outreach, media campaigns). (g) Self-Efficacy; confidence in one's ability to perform the action (e.g., visiting a clinic to access FP services). In Delta North, many women and men are aware of family planning but do not perceive themselves as vulnerable to the negative consequences of unplanned pregnancies. Even when they do, their perceived barriers—such as fear of infertility, religious judgment, or male partner opposition—outweigh the perceived benefits. Cues to action, such as counseling from health workers or testimonies from other women, are often weak due to low facility access or absence of local champions. Thus, the HBM helps explain the individual-level cognitive barriers that limit FP adoption.

Gender and Power Theory: Gender and Power Theory (Connell, 1987) provides a structural lens for understanding how gender roles and hierarchies influence reproductive behaviour. The theory identifies three major structures of gendered power relations: **(a)** The Sexual Division of Labour; men are often breadwinners; women bear the reproductive burden. **(b)** The Sexual Division of Power; men typically have greater decision-making authority in households. **(c)** Cathexis (Emotional Attachments and Norms); cultural expectations about femininity, sexuality, and motherhood. In Delta North, male dominance in household decision-making often means that women cannot use family planning unless their husbands approve. This is reinforced by the cultural ideal of the submissive wife and the stigma associated with women who assert reproductive autonomy. Additionally, men may view family planning as a threat to their masculinity or a way for women to engage in promiscuity without consequences (Eborka et al., 2021). These power dynamics constrain women's ability to make choices about their bodies and reproduction. This theory is particularly useful in explaining why women with more education, employment, or social support may be more likely to use FP methods—they have slightly more negotiating power and autonomy within these structures.

Diffusion of Innovations Theory (DOI): Everett Rogers' (2003) Diffusion of Innovations Theory explains how new ideas, behaviours, or products are adopted and spread through a social system. Adoption depends on the innovation's; **(a)** Relative Advantage – is it better than current practice? **(b)** Compatibility – does it fit with existing cultural values and norms? **(c)** Complexity – is it easy to understand and use? **(d)** Trial ability – can it be experimented with before full adoption? **(e)** Observability – are the benefits visible to others? Modern family planning methods are often viewed as incompatible with cultural and religious norms in Delta North. For example, contraceptive use may be seen as anti-Christian or anti-traditional, especially among older women and men. Moreover, FP adoption may lack observability in a society where secrecy around sexual and reproductive matters is common. Women who use contraception may do so privately, and successful examples of FP benefits are not always visible or discussed publicly. The theory also highlights the importance of opinion

leaders; such as religious figures, community chiefs, and local influencers—in facilitating or obstructing the diffusion of FP norms. If these actors are against family planning, its uptake will remain limited, regardless of availability.

Social Norms Theory: Social Norms Theory posits that much of individual behaviour is shaped by perceptions of what is considered normal or acceptable in one's social group (Cialdini & Trost, 1998). These norms are of two types: **(a)** Descriptive Norms – beliefs about what others do. **(b)** Injunctive Norms – beliefs about what others think one ought to do. In many communities within Delta North, the norm is that women should bear many children, particularly sons, to secure their marriage and social standing. Early marriage and high fertility are celebrated, and women who delay or limit childbirth may face social exclusion or stigma. Even if a woman personally wants to use family planning, the perceived disapproval from her family, church, or community can discourage her. Similarly, if men believe other men in their community disapprove of FP, they are unlikely to support their partners in using it. Social norms also influence provider attitudes—health workers may inject their personal or religious beliefs into counseling sessions, which can result in moralizing or coercive behavior that deters clients. By applying Social Norms Theory, the study is able to explore the powerful influence of community expectations and collective behaviour patterns on individual FP decisions.

Integrated Analytical Framework

Each of the above theories addresses different levels of influence:

Theory	**Focus**	**Level**
Health Belief Model	Personal beliefs and perceptions	Individual
Gender and Power Theory	Household decision-making, autonomy	Interpersonal/Structural
Diffusion of Innovations	Spread of new ideas in social systems	Community/Societal
Social Norms Theory	Perceived expectations and peer influence	Community/Group

By integrating these theories, the study adopts a multilevel analytical lens, allowing for a nuanced understanding of the interplay between personal beliefs, interpersonal relationships, community dynamics, and institutional structures in shaping family planning behaviour. This integrated framework is essential for designing effective, context-sensitive interventions that address not only supply-side barriers (e.g., service availability) but also the more complex demand-side barriers (e.g., cultural expectations, religious teachings, power dynamics).

Data And Methodology

This section details the procedures and strategies employed in conducting the study on how culture, religion, and gender relations influence the adoption of family planning in Delta North Senatorial District. A mixed-methods approach was adopted, combining quantitative and qualitative data collection techniques to provide a comprehensive sociological analysis.

Study Area Description: Delta North Senatorial District is one of three senatorial districts in Delta State, Nigeria. It comprises nine Local Government Areas (LGAs): Aniocha North, Aniocha South, Ika North East, Ika South, Ndokwa East, Ndokwa West, Oshimili North, Oshimili South, and Ukwuani. The area is predominantly occupied by the Anioma people — a subgroup of the Igbo ethnic groupand is characterized by a mixture of urban and rural communities. The region is socio-culturally diverse, with Christianity being the dominant religion, alongside remnants of African Traditional Religion (ATR). Patriarchal norms are deeply entrenched, and fertility is culturally valued. Access to healthcare varies significantly between urban centers like Asaba and more rural areas like Ndokwa East.

Research Design: This study adopted a convergent parallel mixed-methods design (Creswell & Plano Clark, 2018), which allows for simultaneous collection of both quantitative and qualitative data. The rationale for this approach lies in its ability to provide both breadth (through surveys) and depth (through interviews and focus groups), offering a holistic understanding of the socio-cultural dynamics influencing family planning decisions.

Population of the Study: The study population comprised; **(a)** Men and women of reproductive age (15–49 years) **(b)** Religious leaders (Christian pastors, traditional priests) (c) Community leaders (chiefs, elders) (d) Healthcare providers (nurses, family planning officers).

Sample Size and Sampling Techniques

*Sample Size Determination (Quantitative)*A sample size of 400 respondents was determined using Cochran's formula for sample size estimation, adjusted for a population size below 10,000 in selected communities. This size was deemed sufficient to provide statistically significant results while being feasible in terms of logistics and resources. Sampling Procedure; A multistage sampling technique was used, (a)Stage 1: Selection of 6 LGAs from the 9 in Delta North using simple random sampling. (b) Stage 2: Two communities were selected from each LGA using purposive sampling to include both rural and semi-urban areas. (c) Stage 3: Households were selected through systematic random sampling.(d)Stage 4: One eligible respondent per household was selected using the Kish grid method. For qualitative data;6 Focus Group Discussions (FGDs) were held (3 male, 3 female groups) and 12 In-Depth Interviews (IDIs) were conducted with religious leaders, healthcare workers, and community leaders using purposive sampling based on influence and availability.

Data Collection Instruments

Quantitative Data Collection A structured questionnaire was administered face-to-face by trained field enumerators. The questionnaire included the following sections:(a) Demographic characteristics(b) Awareness and use of FP methods. (c) Cultural beliefs and myths about FP. (d) Religious views on FP. (e) Spousal communication and decision-making. (f) Access to services. The questionnaire was pretested in a similar community outside the sample area for clarity, reliability, and cultural sensitivity.

Qualitative Data Collection **(a)** FGDs: Conducted using a semi-structured guide that encouraged open discussion on sensitive topics such as fertility, contraception, and religion. **(b)** IDIs: Followed a flexible guide exploring personal experiences, institutional roles, and perceived community attitudes. All interviews and discussions were conducted in English or the local dialect (Igbo) where necessary, with audio recordings and field notes taken for transcription.

VARIABLES AND OPERATIONAL DEFINITIONS

Variable	Type	Operational Definition
Family Planning Adoption	Dependent	Current use of any modern contraceptive method
Cultural Beliefs	Independent	Traditional myths, fertility norms, and ethnic identity practices
Religious Beliefs	Independent	Teachings and attitudes from religious texts or leaders toward FP
Gender Power Dynamics	Independent	Spousal authority, communication patterns, decision-making power
Socio-demographics	Control	Age, sex, education, income, marital status

Validity and Reliability: **(a)** Quantitative: The questionnaire's content validity was ensured by expert review from public health and sociology scholars. Internal consistency was measured using Cronbach's alpha ($\alpha = 0.81$), indicating high reliability. **(b)** Qualitative: Credibility was ensured through member checking and triangulation across multiple data sources. Interview transcripts were independently coded by two researchers to ensure inter-coder reliability.

Ethical Considerations: **(a)** Ethical approval was obtained from the Delta State Ministry of Health Research Ethics Committee. **(b)** Informed consent (written or verbal) was obtained from all participants. **(c)** Participation was voluntary, with respondents free to withdraw at any time. **(d)** Privacy and confidentiality were maintained throughout the data collection and analysis processes.
(e) Identifiers were removed from transcripts, and audio files were securely stored.

Method of Data Analysis

Quantitative Data Analysis: Data from the questionnaires were entered into SPSS version 25. Descriptive statistics (frequencies, means, percentages) were computed to summarize key variables. Inferential statistics (Chi-square tests, logistic regression) were used to determine associations between FP adoption and independent variables such as cultural, religious, and gender-related factors.

Qualitative Data Analysis: Thematic content analysis was conducted using NVivo software. Transcripts were coded line-by-line, and recurring themes were grouped under predefined categories (e.g., "religious opposition," "male dominance," "myths about FP"). Emergent themes were also noted. Illustrative quotes were extracted to support findings.

Limitations of the Study **(a)** The study relied on self-reported data, which may be subject to social desirability bias, especially in discussing sensitive topics. **(b)** The qualitative data are not generalizable

but provide context-rich insights. **(c)** The time frame and available funding limited the scope to six LGAs, which may not capture all sub-regional variations.

Data Analysis and Discussion of Findings

This section presents a detailed analysis of the quantitative survey data alongside thematic insights from qualitative interviews and focus group discussions. The findings are discussed in relation to the key research questions on how culture, religion, and gender relations influence family planning adoption in Delta North Senatorial District.

Socio-Demographic Profile of Respondents: The study sample consisted of 400 respondents aged 15-49 years, with a mean age of 32.4 years. Females constituted 60% of the sample, males 40%. Approximately 55% were married, 30% single, and 15% divorced or widowed. About 48% had secondary education, while 20% had tertiary education, and 32% had primary or no formal education.

Awareness and Use of Family Planning Methods: **(a)** Awareness: 92% of respondents reported awareness of at least one modern FP method. The most recognized methods were male condoms (88%), pills (76%), injectables (65%), and implants (42%). **(b)** Use: However, only 37% reported current use of any modern contraceptive method. This gap between awareness and use aligns with previous findings (NDHS, 2018; Tettehfio et al., 2022) and indicates that knowledge alone does not guarantee uptake.

Cultural Beliefs and Family Planning

Approximately 58% of respondents agreed with statements such as "Having many children is important for family prestige" and "Using family planning can cause infertility." Qualitative data reinforced this, with many participants expressing those children are viewed as wealth and social security. "In our culture, a woman without many children is not respected. Family planning is seen as going against the natural way." — Female FGD participant, Oshimili South. This confirms that traditional cultural norms remain significant barriers to FP adoption.

Religious Influence on Family Planning: Among respondents, 67% reported that their religious leaders discourage the use of artificial contraceptives. Interviews with pastors revealed theological objections grounded in biblical injunctions to "be fruitful and multiply." "Our church teaches that family planning interferes with God's plan. Natural methods are acceptable, but pills and injections are forbidden." — Pastor, Aniocha South Statistical analysis showed that those reporting religious opposition were 2.3 times less likely to use FP ($p < 0.01$).

Gender Relations and Decision-Making: Only 28% of female respondents reported joint decision-making with their spouses on reproductive issues. A majority (56%) indicated that their husbands made the final decision on whether to use family planning. Male respondents expressed concerns about loss of control and mistrust, often linking FP use to infidelity. "If my wife uses contraception without telling me, I will lose respect for her. It may encourage other men to approach her." — Male FGD participant, Ndokwa East. This highlights how patriarchal power structures impede women's reproductive autonomy.

Healthcare Access and Provider Attitudes: Nearly 40% of respondents reported challenges in accessing FP services, citing distance to clinics, irregular supply of methods, and negative attitudes from healthcare workers. Qualitative data suggested that some providers personally disapprove of FP or provide inadequate counseling, particularly in rural areas.

Multivariate Analysis: Logistic regression showed that; (a) Positive attitudes toward FP (AOR = 3.5, 95% CI: 2.1–5.9) (b) Spousal communication (AOR = 2.7, 95% CI: 1.6–4.3). (c) Supportive religious views (AOR = 2.1, 95% CI: 1.2–3.7) were significantly associated with contraceptive use. Conversely, strong adherence to cultural pronatalist norms reduced likelihood of use (AOR = 0.4, 95% CI: 0.2–0.7).

Discussion

The findings support the integrated theoretical framework; (a) The Health Belief Model is reflected in the tension between perceived benefits and barriers, with fear of side effects and social disapproval lowering perceived benefits. (b) Gender and Power Theory explains the dominance of men in reproductive decisions, limiting women's agency. (c) The Diffusion of Innovations Theory is relevant to the role of community opinion leaders and religious institutions as gatekeepers to FP acceptance. (d) Social Norms Theory highlights the powerful influence of collective expectations on individual behaviour. These intersecting factors contribute to the persistent low uptake of family planning despite high awareness.

Conclusion and Recommendations

This study examined the complex interplay of culture, religion, and gender relations in influencing the adoption of family planning (FP) within Delta North Senatorial District. Despite widespread awareness of modern contraceptive methods, actual uptake remains relatively low, highlighting significant socio-cultural and structural barriers. The analysis demonstrated that deeply rooted cultural norms valorizing high fertility and large families strongly shape reproductive behaviours. Children are viewed not only as blessings but as vital sources of social status, economic security, and lineage continuity. Consequently, family planning is often perceived as contradictory to cultural identity and community expectations. Religious doctrines and leadership also play a critical role in shaping attitudes toward FP. Many religious leaders within Delta North actively discourage the use of artificial contraceptive methods, emphasizing procreation as a divine mandate. This religious opposition, combined with individual believers' internalization of these teachings, reduces the likelihood of contraceptive adoption. Moreover, entrenched gender inequalities profoundly affect reproductive decision-making. Patriarchal structures give men disproportionate control over family planning choices, while women frequently face stigma or punishment for attempting to assert reproductive autonomy. This dynamic is compounded by limited spousal communication on FP matters, further restricting women's capacity to negotiate contraceptive use. Healthcare access and quality, although important, are not the sole determinants of FP adoption in this context. Negative provider attitudes and inconsistent availability of contraceptives hinder service utilization, but sociocultural factors remain the primary obstacles. Overall, the study underscores the necessity of adopting a holistic approach to family planning interventions—one that goes beyond increasing knowledge or availability to actively engaging with cultural values, religious beliefs, and gender power relations. Efforts to promote FP must involve community and religious leaders as allies, encourage spousal dialogue, and empower women to make informed choices about their reproductive health. Without addressing these underlying socio-cultural and structural factors, FP programs in Delta North are unlikely to achieve significant and sustainable increases in contraceptive use or improvements in reproductive health outcomes.

Based on the findings of this study, the following recommendations are proposed to improve the adoption of family planning (FP) in Delta North Senatorial District: (a) *Engage Cultural and Religious Leaders as Change Agents:* Initiatives to promote FP should actively involve respected community leaders, traditional rulers, and religious figures. These individuals hold significant influence and can help reframe family planning in culturally and religiously acceptable terms. Sensitization campaigns should be designed to align FP with shared community values, such as maternal health, child welfare, and economic stability. (b) *Promote Gender-Transformative Interventions:* Programs should address entrenched gender norms by fostering more equitable spousal relationships and encouraging joint decision-making around reproductive health. Community-based education efforts must include men and boys to shift attitudes about masculinity, reproductive responsibility, and power dynamics within the household. (c) *Enhance Spousal Communication on FP:* Couples-focused interventions—such as peer group discussions, counseling, and media campaigns—should be implemented to improve communication between partners regarding FP. Increased dialogue can lead to more mutual understanding, reduced stigma, and higher contraceptive uptake. (d) *Empower Women through Education and Support Services:* Women's empowerment should be a cornerstone of FP programming. This includes improving access to education, economic opportunities, and targeted reproductive health services. Creating safe spaces for women to discuss FP and providing supportive counseling can strengthen their agency and decision-making power. (e) *Strengthen Health System Responsiveness*: While socio-cultural barriers are primary, service delivery issues also contribute to low FP uptake. Health facilities should ensure consistent availability of contraceptives, improve provider attitudes through training, and deliver respectful, non-judgmental care. Mobile clinics and community health workers can be leveraged to extend access to remote and underserved areas. (e) *Develop Context-Specific, Culturally Sensitive Messaging:* Information, education, and communication (IEC) materials should be tailored to local beliefs, languages, and values. Messaging that focuses on the benefits of FP for family wellbeing, economic resilience, and maternal/child health may be more effective than messages focused purely on population control. (f) *Monitor and Evaluate FP Programs with Community Input:* Continuous monitoring and feedback mechanisms should be integrated into FP programs to assess effectiveness and adapt to community concerns. Involving local stakeholders in program design, implementation, and evaluation enhances trust and relevance.

Summary

This study explored how cultural norms, religious beliefs, and gender dynamics influence the adoption of family planning (FP) in Delta North Senatorial District. Despite high awareness of modern contraceptives, actual use remains low due to deeply rooted socio-cultural barriers. Cultural values that prioritize large families, religious opposition to artificial contraceptives, and patriarchal gender relations all contribute to limited uptake. Women often lack autonomy in reproductive decisions, and poor spousal communication further hampers FP use. While healthcare access is a factor, sociocultural influences are the primary obstacles. The study emphasizes the need for holistic FP interventions that engage community leaders, address gender inequality, and empower women to make informed reproductive choices.

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