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GENDER, FAITH AND FERTILITY: A COMPARATIVE STUDY OF RELIGIOUS RESPONSIBILITY AND REPRODUCTIVE CHOICES IN SELECTED PERI-URBAN AREAS OF NIGERIA

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ABSTRACT: Gender norms, religious beliefs, and socio-cultural expectations continue to shape fertility patterns in Nigeria. In peri-urban communities like Masaka, Uke, and Auta Balefi, where rural traditions meet urban influences, reproductive choices frequently reflect negotiations between faith-based commitments and socio-economic realities. Despite various reproductive health interventions, fertility rates remain relatively high, highlighting the persistent influence of religion and gender relations. However, there is limited comparative evidence on how different faith traditions shape reproductive decision-making in such transitional settings. Using mixed methods in three peri-urban communities (N=450), the study demonstrates that religious teachings and gender norms significantly influence reproductive decision-making, while education and economic pressures increasingly promote collaborative choices among partners. Guided by feminist theory, symbolic interactionism, and the sociology of religion, the study integrates household surveys with in-depth interviews, key informant interviews, and focus group discussions The study contributes to understanding how religion and gender intersect in shaping fertility choices and calls for culturally sensitive, gender-responsive reproductive health strategies that align with faith-based values.

Keywords: Faith, Fertility, Gender, Nigeria, and Reproductive-Choices

INTRODUCTION

Nigeria's fertility patterns reflect the interplay of social norms, religious beliefs, and gender roles. In peri-urban communities such as Masaka, Uke, and Auta Balefi, where rural traditions converge with urban influences, individuals navigate reproductive decisions shaped by socio-economic challenges and religious obligations. This intersection creates a distinctive reproductive landscape that warrants sociological inquiry from both comparative and contextual perspectives.

Although Nigeria's fertility rate has declined modestly from about 6.0 in 1990 to 5.3 in 2018, it remains among the highest globally (Olanrewaju et al., 2020). Scholars attribute this persistence to economic constraints, gendered domestic roles, and enduring cultural preferences for large families (Babalola et al., 2015). Pronounced religious and regional disparities also persist, with total fertility rates ranging from 6.3 to 6.7 in northern Muslim-majority areas and 4.3 to 4.7 in predominantly Christian southern regions (Babalola et al, 2015).

Religious affiliation profoundly influences reproductive behaviour, extending beyond mere demographic identity. Evidence from the Nigerian Urban Reproductive Health Initiative (NURHI) shows that family planning messages delivered by faith leaders significantly increased contraceptive use among women, demonstrating the moral authority of religion in shaping fertility outcomes **(**Babalola et al., 2018). Yet, in peri-urban Nigeria, fertility dynamics diverge from those in both rural and urban areas. Sedgh, Ashfor, and Hussain (2016) posit that women's contraceptive use in these settings is closely linked to fertility intentions but is often mediated by male authority, especially within religious households.

Both Christian and Muslim doctrines frequently reinforce patriarchal structures, privileging men in reproductive decision-making (Ganle et al., 2015). Feminist theory exposes these power asymmetries and highlights how gendered hierarchies within religion constrain women's autonomy. Symbolic interactionism complements this view by explaining how religious meanings and gender expectations are reproduced through everyday interactions within households. The sociology of religion provides an additional lens for understanding how institutional doctrines and clerical authority shape attitudes toward fertility and family planning.

Comparative studies indicate that even within groups of comparable socio-economic position, religious membership significantly impacts fertility norms and reproductive decisions. McQuillan (2004) posits that religion influences reproduction via several mechanisms, such as doctrinal authority, which delineates moral parameters concerning sexuality, contraception, and family size; institutional frameworks, which perpetuate these doctrines through clerical leadership and religious education; and identity formation, whereby individuals assimilate faith-based norms regarding gender roles and familial dynamics. In peri-urban Nigeria, where Christian and Muslim beliefs regularly coexist and compete, these factors are especially important in moulding communal values and personal choices regarding having children. In these contexts, faith-based norms converge with evolving socio-economic conditions and promising gender equality principles, resulting in a complicated conflict between entrenched patriarchal standards and contemporary desires for collaborative reproductive decision-making. Religion does not simply mirror cultural norms; it actively builds and maintains moral frameworks that influence fertility behaviour, shaping how couples see notions of family responsibility, divine providence, and women's autonomy in reproductive health.

This study investigates how religious teachings and gender relations interact to shape fertility preferences, contraceptive use, and reproductive decision-making within Christian and Muslim peri-urban communities in Nigeria. Anchored in feminist theory, symbolic interactionism, and the sociology of religion, it posits that religious doctrine and institutional authority mediate gendered bargaining over fertility decisions. The research aims to determine whether religion or gender exerts a stronger influence on reproductive choices while contributing empirical evidence to ongoing debates on gender, faith, and fertility in transitional peri-urban settings.

Statement of the Problem

Despite decades of reproductive health initiatives, Nigeria's fertility rates remain persistently high (Olanrewaju et al., 2020). The intersection of socio-economic transition and deeply rooted religious

and cultural norms continues to influence reproductive decision-making in peri-urban areas such as Masaka, Uke, and Auta Balefi, where rural traditions merge with urban modernity (Babalola, Bankole, & Fatusi, 2015). Religion applies a pivotal yet complex influence. While some religious leaders support contraceptive use under permissive doctrines (Babalola, Bankole & Fatusi, 2018), prevailing gender ideologies in both Islam and Christianity often privilege men as custodians of reproductive authority, thereby limiting women's agency (Isiugo-Abanihe, 1994). This dynamic sustains patriarchal control over family size and reproductive decisions.

However, there is limited comparative research examining how different religious traditions, particularly Islam and Christianity, mediate fertility decisions in peri-urban Nigeria. Most existing studies either neglect religion as a critical analytical factor or focus narrowly on rural-urban contrasts (McQuillan, 2004). Consequently, little empirical evidence explains how gender norms and religious obligations jointly shape fertility preferences, contraceptive use, and reproductive decision-making in peri-urban communities.

The present study addresses this gap through a comparative sociological analysis of reproductive choices and religious responsibilities in selected peri-urban communities. It explores how gender norms, religious beliefs, and socio-cultural expectations interact to influence fertility preferences and reproductive decision-making within Christian and Muslim households. Grounded in feminist, interactionist, and sociological perspectives, the study advances theoretical understanding of how religion and gender co-construct reproductive behaviour. It informs the design of culturally sensitive, gender-responsive reproductive health policies.

Objectives of the Study

The general objective of this study is to investigate the impact of gender dynamics and religious obligations on fertility desires, contraceptive utilization, and reproductive decision-making in certain peri-urban communities in Nigeria, while the specific objectives are to:

1. Assess how gender norms influence contraceptive use in peri-urban religious contexts
2. Compare fertility preferences between Christian and Muslim communities in Masaka, Uke, and Auta Balefi.
3. Assess how religious teachings and leadership affect reproductive decision-making within households.
4. Analyze variations in shared versus male-dominated reproductive decision-making across faith traditions.
5. recommend culturally sensitive, gender-responsive strategies for improving reproductive health outcomes in peri-urban Nigerian communities.

Theoretical Framework

This research employs feminist theory, symbolic interactionism, and the sociology of religion as foundational frameworks to examine the relationships between gender, faith, and fertility in peri-urban Nigeria. From a feminist theoretical standpoint, reproductive choices are situated within

unequal gender power dynamics that frequently favour male authority over female autonomy (Connell, 198 and Lorber, 2012).

In numerous Nigerian religious settings, men hold a preeminent role in fertility decision-making, especially within patriarchal Muslim and Christian groups (Isiugo-Abanihe, 1994). For instance, in certain regions of northern Nigeria, research indicates that women's access to contraceptive services frequently necessitates male agreement, even when women articulate a desire to space births (Babalola, Bankole & Fatusi, 2018). A comparable trend is evident in rural Afghanistan, where women's reproductive health choices predominantly depend on the approval of male relatives, influenced by dominant religious and cultural interpretations (Mashal et al., 2008). Feminist theory is essential for examining how structural inequities, worsened by religious doctrines, influence women's access to contraception, the management of family size, and their ability to contest or adhere to prevailing reproductive standards.

Feminist theory emphasizes structural disparities, whereas symbolic interactionism clarifies the mechanisms by which these inequities are perpetuated or challenged through everyday interpersonal encounters. Blumer (1969) asserts that meanings are socially constructed and perpetuated through social interaction. Consequently, in peri-urban Nigeria, couples, religious leaders, and community members ascribe meanings to fertility, contraception, and "religious responsibility" that influence individual choices. For instance, a husband's view of religious duties may cause him to strongly oppose family planning. This is shown in some Pentecostal churches in Lagos, where people think that using contraception means they do not trust God to provide (Oladeji, 2011). In some urban Muslim communities in Senegal, on the other hand, religious leaders reinterpret Islamic teachings to promote birth spacing for maternal health, leading couples to use contraception in certain situations (Browne,2012). These examples demonstrate how agreements at the micro level can either reinforce or alter established fertility norms in subtle ways.

The sociology of religion also examines how religious ideas and institutional practices influence behaviour, such as reproductive behaviour (McQuillan, 2004). Religious institutions not only express moral expectations for fertility but also serve as channels for disseminating these norms. In peri-urban areas with both Christian and Muslim populations, religious teachings on family planning, having children, and gender roles are not just ideas; they are things that people really do that affect the number of people in a certain area (Babalola et al., 2018). In Masaka, Nigeria, Catholic churches conduct marriage classes that prioritize natural family planning and dissuade hormonal or barrier methods. Concurrently, certain local mosques in Uke advocate Quranic passages that urge big families as a manifestation of divine favour. The Catholic Church's opposition to artificial contraception in the Philippines has similarly resulted in significant demographic changes, leading to elevated fertility rates in comparison to neighbouring Southeast Asian countries with more secular family planning policies.

REVIEW OF LITERATURE AND EMPIRICAL EVIDENCE

Global and Regional Evidence on Religion, Gender, and Fertility

Fertility remains a multidimensional phenomenon shaped by socio-cultural, religious, and economic factors across societies. Globally, religious institutions often serve as moral and social regulators of reproductive behaviour. In Catholic-dominated contexts such as the Philippines, religious opposition to contraception historically sustained high fertility rates (Abada & Tenkorang, 2012). Conversely, in Iran, fertility declined sharply when Islamic authorities endorsed family planning as compatible with religious duty (Abbasi-Shavazi, Hosseini-Chavosh, & McDonald 2009), showing that religious interpretations evolve with socio-economic change.

In sub-Saharan Africa, fertility remains among the highest globally, influenced by both pro-natalist norms and limited access to reproductive health services (United Nations, 2023). The Nigeria Demographic and Health Survey (NDHS, 2018) reports a total fertility rate of 5.3 births per woman, with marked variations by region, religion, and education. Women in the predominantly Muslim North have an average of between 6.3 and 6.7 births, while their counterparts in the Christian South have an average of between 4.3 and 4.7 (NDHS, 2018). These disparities highlight how religious affiliation intersects with socio-economic and cultural factors to shape fertility choices.

Studies further reveal that fertility patterns in peri-urban settings differ from those in both rural and urban contexts (Sedgh, Ashford, & Hussain, 2016). They found that women's contraceptive use in such transitional communities depends not only on fertility intentions but also on marital negotiations and male consent. This pattern aligns with findings from other African contexts (Kapiga et al., 2017; Orisaremi, 2020), where rapid urbanization, economic insecurity, and kinship pressures sustain traditional gender roles, even as exposure to modern family planning messages increases.

Despite extensive regional evidence, few comparative studies have examined how religious teachings and gendered power relations jointly shape fertility in peri-urban Nigeria, where rural cultural traditions intersect with urban aspirations. This gap underscores the need for a sociological analysis that integrates demography, religion, and gender to explain variations in reproductive decision-making.

Religion and Fertility: Doctrines, Institutions, and Local Realities

Religious belief and institutional authority significantly shape fertility norms by defining moral frameworks for reproduction. McQuillan (2004) emphasizes that religion influences fertility through three mechanisms: doctrinal teachings, institutional authority, and group identity. Across African societies, churches and mosques act as key social spaces where religious discourse reinforces pro-natalist ideals, framing children as divine blessings (Bongaarts, 2011; Agyei & Epema, 1992).

In Nigeria, this institutional influence is especially pronounced in peri-urban areas where faith provides social stability amid change. Studies show that the interpretations of religious leaders

regarding scripture have a greater impact on reproductive decisions than formal health messages (Okunowo & Adedini, 2021). For instance, in Nasarawa and Benue States, clerics who associate contraception with "Western corruption" discourage family planning, while others promote birth spacing for maternal health reasons consistent with faith teachings (Babalola et al., 2018).

Evidence from the Nigerian Urban Reproductive Health Initiative (NURHI) demonstrates that when faith leaders are engaged as advocates, contraceptive uptake among women increases substantially (Babalola et al., 2018). These findings emphasize the dual nature of religious influence, constraining when doctrines are rigid, yet enabling when messages are adapted to local realities.

Anthropological studies in peri-urban Nigeria (Smith, 2011; Orisaremi, 2020) reveal that Christian and Muslim communities both sustain patriarchal interpretations of reproduction, where men hold authority over decisions about family size and contraceptive use. In Auta Balefi, Masaka, and Uke, for example, fertility remains intertwined with social prestige and divine approval, while clerical teachings reinforce gendered expectations that women's worth is tied to motherhood. These intersections of faith, culture, and kinship make religion both a moral compass and a social regulator in matters of reproduction.

Despite growing empirical attention to faith-based engagement, few studies explore how religion functions simultaneously as a site of resistance and negotiation for women, particularly in peri-urban contexts undergoing cultural transition. This study contributes to filling that empirical and theoretical gap.

Gendered Decision-Making and Reproductive Negotiations

Feminist scholarship situates reproductive behaviour within structures of gendered power and inequality (Connell, 1987; Lorber, 2012). Across sub-Saharan Africa, studies show that women often require spousal consent to access contraceptives, even where services are available (Kapiga et al., 2017). In rural Pakistan and Tanzania, women's reproductive autonomy similarly depends on male approval, demonstrating the persistence of patriarchal interpretations of religious and cultural norms (Ali & Ushijima, 2005; Kapiga et al., 2017).

In Nigeria, similar patterns are observed. Isiugo-Abanihe (1994) and Izugbara and Ezeh (2010) found that men's control over reproductive decisions is supported by religious teachings that emphasize male authority and procreation. Field observations from Auta Balefi, Masaka, and Uke show that even when women want smaller families, decisions about birth spacing or contraception often need male approval, a negotiation framed with moral and spiritual language.

Symbolic interactionist perspectives explain these micro-level negotiations as processes of meaning-making. Couples frequently reinterpret religious ideals to justify personal choices, such as describing birth spacing as an act of stewardship or maternal protection rather than population control. These adaptive interpretations demonstrate how religion and gender norms are not merely prescriptive but actively negotiated in daily life (Blumer, 1969; Kaggwa, Diop & Storey, 2008).

Kinship systems further reinforce these dynamics. Anthropological evidence (Smith, 2010 and Layefa, Ezenagu & Esoso-Agbor, 2022) shows that extended families influence reproductive expectations, often discouraging contraceptive use in favour of lineage continuity. Among the Fulani and Gwari groups surrounding Uke, patrilineal authority and ideals of modesty (semteende) sustain gender hierarchies (Stenning, 1959; Dupire, 1970). Yet, socio-economic pressures increasingly compel couples to reinterpret these norms, revealing internal contradictions between tradition and modernity. Semteende can be translated roughly as "a sense of modesty, shame, or moral reserve." It embodies self-respect, dignity, and restraint, guiding individuals to behave honourably and avoid actions that bring shame to themselves or their family.

The reviewed literature thus exposes two enduring tensions: first, between religious doctrine and individual reproductive choice, and second, between patriarchal authority and women's evolving agency. Despite extensive studies on fertility determinants, comparative mixed-methods research examining how religion and gender interact within peri-urban Nigerian contexts remains limited. The present study addresses this gap by analysing how Christian and Muslim teachings, gender norms, and socio-economic realities jointly shape fertility preferences and reproductive decision-making in Masaka, Uke, and Auta Balefi.

METHODOLOGY

Research Design

A mixed-methods approach was employed to examine both the quantifiable patterns of fertility behaviour and the socio-cultural meanings behind gender and religious influences on reproductive decision-making in peri-urban Nigeria. Specifically, the study adopted a convergent mixed-methods design to explore how gender norms and religious obligations shape fertility preferences, contraceptive use, and reproductive decision-making among Christians and Muslims in three peri-urban communities such as Masaka, Uke, and Auta Balefi. Quantitative and qualitative data were collected concurrently, analyzed separately, and integrated during interpretation to strengthen validity and enrich understanding through triangulation**.**

A structured household survey was administered to 450 respondents aged 18–49 years (women and men of reproductive age). The sampling frame was derived from community enumeration lists provided by local councils. A multistage cluster sampling approach was adopted: first, neighborhoods were randomly selected; second, households were systematically chosen at fixed intervals; and third, one eligible respondent per household was randomly selected. The inclusion criteria comprised permanent residency (≥12 months) and informed consent, while the exclusion criteria included non-residents and those unable to complete the interview due to illness or absence. The final response rate was 91%.

The sample size (N = 450) was determined using Cochran's formula, with a 95% confidence level, a 5% margin of error, and an estimated prevalence of 50%, to ensure adequate power for subgroup analysis. The survey instrument captured socio-demographics, reproductive history, contraceptive behavior, gender norms, and religiosity.

Data Analysis

Quantitative data were analyzed in STATA 17 using descriptive statistics and logistic regression with adjusted odds ratios controlling for socio-demographic covariates. Binary logistic regression models estimated the likelihood of modern contraceptive use and fertility preference, reporting adjusted odds ratios (AORs) with 95% confidence intervals. Covariates controlled for included age, education, income, marital status, and religion. Model adequacy was assessed using variance inflation factors (VIF < 2.5) to test multicollinearity, Hosmer–Lemeshow goodness-of-fit, and events-per-variable (EPV) ratios to ensure robustness.

Qualitative Component

The qualitative strand consisted of 24 in-depth interviews, 12 key informant interviews, and 6 focus group discussions, purposively selected to ensure diversity in terms of gender, religion, and marital status. Interviews were conducted in English, Hausa, and Gwari, and were audio-recorded with the participants' permission. Translations and transcriptions were reviewed for consistency. Thematic analysis was conducted using Braun and Clarke's six-step framework in NVivo 12. Coding was guided by a codebook developed iteratively, with two trained coders achieving intercoder reliability (Cohen's $\kappa > 0.80$). Data saturation was confirmed when no new themes emerged.

Ethical Considerations

Ethical approval was obtained from the Bingham University Institutional Review Board (Approval No: BHU/ERC/25/H001). Oral informed consent was obtained from all participants after they were informed of the study aims, confidentiality assurances, and the voluntary nature of their participation. Pseudonyms were used, and all records were securely stored

RESULTS

Quantitative Findings

Table 1: Descriptive Characteristics of Respondents (N = 450)

Variable	Category	*n*	*%*
Gender	Male	220	48.9
	Female	230	51.1
Mean age (years)			33.6
Religion	Christian	251	55.8
	Muslim	199	44.2
Education level	No formal education	128	28.4
	Secondary	160	35.6
	Tertiary	162	36.0
Employment status	Informal sector	211	46.9
	Formal sector	149	33.1

	Unemployed	90	20.0
Current contraceptive use	Yes	160	35.6
	No	290	64.4

Source: Field Survey 2025

Note. N = 450. Percentages are based on valid responses

Table 1 presents the demographic and socio-economic characteristics of the respondents. The group had nearly equal numbers of men and women, with women making up 51.1% and men 48.9%. The average age was 33.6 years, indicating most individuals were of childbearing age. Among the respondents, 55.8% identified as Christians, and 44.2% as Muslims. Education levels were fairly evenly distributed, and most participants (46.9%) were employed in the informal sector. The use of birth control was low at 35.6%, consistent with long-term national trends (NDHS, 2018).

Table 2: Binary Logistic Regression Predicting Partner-Led Fertility Decision-Making (N = 450)

Predictor	**Odds Ratio *(OR)***	**95% *CI***	***p-value***
Gender (Male vs. Female)	2.41	1.62–3.58	< .001
Religion (Muslim vs. Christian)	1.56	1.05–2.33	.028
Location (Masaka vs. Auta Balefi)	1.17	0.73–1.86	.521
Location (Uke vs. Auta Balefi)	0.97	0.60–1.55	.886

Source: Field Survey 2025

Note: Model adjusted for age, education, and job position. The model fit is characterized by a Nagelkerke R^2 of .18, and the Hosmer–Lemeshow test yields a p-value of .412.

Table 2 presents the logistic regression model examining factors influencing partner-led fertility decisions. Adjusted results indicate that gender was a significant predictor, with males more than twice as likely as females to report partner-led fertility decisions (OR = 2.41, 95% CI [1.62, 3.58], $p < .001$). Religion also played a significant role, with Muslims more likely than Christians to report partner-dominated decisions (OR = 1.56, 95% CI [1.05, 2.33], $p = .028$). Changes in location were not statistically significant. No major confounders were identified, but exploratory models including gender-religion interaction terms showed that the effect of gender was slightly stronger among Muslims. This suggests an interaction effect that warrants further research.

Qualitative Analysis using Thematic Integration

The qualitative findings from in-depth interviews, focus group discussions, and key informant interviews highlighted the intersections of gender norms, religious obligations, and fertility

decision-making in Masaka, Uke, and Auta Balefi. Thematic analysis revealed five key themes. First, religious beliefs strongly shaped fertility preferences. Christians, particularly Pentecostals, drew from biblical injunctions like "be fruitful and multiply," while Muslims referenced Qur'anic verses and the Prophet's emphasis on building a strong ummah. While some Islamic leaders encouraged moderation in family size, many Christian groups viewed limiting children as challenging divine providence, affirming the role of religion as a moral authority (Durkheim, 1915/2001; Connell, 2009; Isiugo-Abanihe, 1994; Adegoke et al., 2022). Second, gender norms were central to contraceptive use, with men asserting authority as household heads, often leading to women's covert contraceptive use, corroborating earlier Nigerian findings (Hooks, 2000; Okigbo et al., 2017). Women's narratives, such as concealing contraceptives to avoid conflict, underscored both symbolic interpretations of contraception as mistrust or infidelity and the perception that it opposed God's will (Kabagenyi, Habaasa, & Rutaremwa, 2016).

Third, decision-making in couples was relational but often unequal, with women's views marginalized under male-dominant interpretations of doctrine. Muslim respondents often relied on their elders or clerics, while Christian couples described making prayerful decisions, although they were still influenced by patriarchal structures (Fapohunda & Orobaton, 2013). Fourth, faith leaders played decisive roles: some pastors endorsed modern contraception as a service to God, while others promoted only natural methods, aligning with evidence that clergy significantly shape congregational attitudes (Durkheim, 1915/2001; Kaler, 2001; Babalola et al., 2018). Fifth, gender, religion, and socio-economic conditions intersected to influence decisions. Couples with limited resources struggled to reconcile economic realities with community and religious expectations, reflecting the cumulative pressures of intersectionality (Crenshaw, 1989; Isiugo-Abanihe & Oke, 2011). These findings affirm that reproductive decisions in peri-urban Nigeria are not solely shaped by faith or gender alone but by their interaction with broader socio-economic constraints, producing complex negotiations of fertility, autonomy, and responsibility.

Qualitative–Quantitative Integration

Findings from mixed methods indicate that faith, gender, and socio-economic factors significantly influence fertility decisions in peri-urban Nigeria. Quantitative analysis (N=450) revealed that men were twice as likely as women to report partner-led reproductive decisions (AOR = 2.41, 95% CI [1.62–3.58], $p < .001$). Additionally, Muslims reported more male-dominated outcomes compared to Christians (AOR = 1.56, 95% CI [1.05–2.33], $p = .028$). Qualitative insights correspond with these findings. In Masaka, Uke, and Auta Balefi, where both genders associated fertility with divine will, supported by Christian and Muslim texts that offer moral justification for large families. Women's narratives emphasized disparities in negotiation power, with some individuals concealing contraceptive use to mitigate conflict. Changes influenced by education, urban exposure, and economic strain have facilitated joint decision-making among younger couples. The evidence indicates that fertility decisions are influenced not solely by religion or gender, but by their interplay with socio-economic changes. The complex negotiations indicate that reproductive health programs in peri-urban Nigeria should incorporate gender equality and religious engagement strategies to foster shared responsibility in fertility planning.

DISCUSSION

The convergence of evidence indicates that gender and religion, rather than spatial location, influence fertility decision-making in peri-urban Nigeria. The integration of mixed techniques suggests that quantitative data demonstrate statistical significance, while qualitative evidence clarifies the lived experiences and negotiations within homes. Feminist theory explicates the limitations imposed on women's reproductive agency by patriarchal religious frameworks (Connell, 2009), while symbolic interactionism shows how couples navigate fertility decisions within these moral limits.

Other possible causes, such as financial problems and educational differences, were also examined, but gender and religious interactions remained the strongest predictors. This study's findings closely correspond with the theoretical frameworks of feminist theory, symbolic interactionism, and the sociology of religion. Patterns observed in Masaka, Uke, and Auta Balefi indicate that gendered hierarchies and religious authority collaboratively influence reproductive behaviour, supporting feminist theories that reproductive autonomy is limited by unequal power dynamics (Raewyn Connell, 1987 and Judith Lorber, 2012).

In alignment with Herbert Blumer's (1969) symbolic interactionism, the data demonstrate how couples interpret and negotiate religious teachings in their daily lives, constructing meanings of fertility and contraception that encompass both faith and socio-economic realities. These micro-level negotiations illustrate that religion operates not only as a doctrinal influence but also as a lived social experience that shapes moral reasoning and decision-making. The findings align with Kevin McQuillan's (2004) sociology of religion, highlighting the role of religious institutions in mediating norms related to family size and reproductive behaviour, thereby reinforcing pro-natalist ideals through sermons, marriage classes, and clerical authority.

While financial strain and educational disparities also affect reproductive choices, gender and religious interactions are the primary predictors of fertility behaviour. This outcome supports empirical findings from Babalola, Bankole, Fatusi, and colleagues (2018) and Orisaremi (2020), emphasizing the necessity for interventions to extend beyond awareness campaigns to incorporate culturally relevant and faith-inclusive strategies. Future research should utilize stratified regression models (e.g., Christian versus Muslim sub-samples) and longitudinal data to investigate the changing intersections of gender, faith, and fertility in peri-urban Nigeria.

Conclusion

This study finds that enhancing reproductive health outcomes in peri-urban Nigerian communities necessitates faith-sensitive involvement, gender-equitable social structures, and access to accurate reproductive health information. Cooperation between religious leaders, health professionals, and municipal officials can help people, especially women, make reproductive decisions that are in line with their religion and real-life experiences.

Nevertheless, these results must be regarded with caution owing to specific methodological limitations. The cross-sectional survey methodology restricts causal inference, and potential social

desirability bias may have affected self-reported contraceptive use. Furthermore, the localized characteristics of the peri-urban study sites limit the applicability of the findings to wider populations. Subsequent study ought to utilize longitudinal and mixed-methods approaches to corroborate and enhance these findings.

Recommendations for Policy and Practice

Based on the study's results, the following specific, actionable recommendations are suggested to improve the relevance of policies and the implementation of programs:

1. Religion-Based Capacity Building

   There is a need for religious stakeholders to conduct pilot workshops for religious leaders, in collaboration with qualified health professionals, to teach family planning in a culturally appropriate and evidence-based manner. This can be achieved through sermons, premarital counseling, and community outreach. Indicators for monitoring should include the number of faith-based organizations that incorporate reproductive health messages and changes in how people in the congregation perceive contraception and their attitudes toward it.

2. Implementation of Gender-Sensitive Programs

   There is also a need for public health professionals and non-governmental organisations (NGOs) to formulate and implement gender-transformative reproductive health initiatives that engage both men and women. Evaluation metrics should keep track of how many men are involved, how many households make decisions together, and how many people in the target community start using contraception.

3. Interfaith Reproductive Health Committees

   There is a need for community leaders to set up interfaith reproductive health committees with religious leaders, women's groups, and health care workers. These committees should help keep the conversation going, break down cultural and doctrinal barriers, monitor fertility trends, and encourage community responsibility in reproductive health advocacy.

4. Integration into Local Health Frameworks.

   There is need for local government health authorities to make family planning counselling and services available on a voluntary and confidential basis within existing community structures like religious assemblies, market days, and cultural festivals. You may judge how well a program is doing by looking at how many people use its services and how much less stigma there is around using birth control.

5 Policy and Workforce Development

There is also a need for state and federal authorities to create and enforce reproductive health policies that take into account gender and religion, and require healthcare providers to get training in cultural competency. Regular reviews should assess how well policies are being implemented, the ease of accessing services, and user satisfaction, particularly in peri-urban and underserved areas.

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