The Influence of Religious Beliefs on Contraceptive Use and Attitudes in Benin City, Nigeria: A Philosophical-Theological Appraisal

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Abstract

Religious beliefs constitute one of the most consequential social determinants of reproductive health behaviour in sub-Saharan Africa. In Benin City, Nigeria, a densely pluralistic urban centre whose Christian and Muslim communities together account for the overwhelming majority of its population, doctrinal commitments, clerical authority, and faith-based social norms continue to shape contraceptive attitudes and use in ways that interact with, and frequently override, secular public health messaging. This paper offers a philosophical-theological appraisal of these dynamics, situating empirical evidence within frameworks drawn from Catholic moral theology, Protestant ethics, Islamic jurisprudence, and the philosophical traditions of autonomy, human dignity, and the common good. It draws on recent Nigerian Demographic and Health Survey (NDHS) data and peer-reviewed empirical literature (2018–2024) to document patterns of contraceptive uptake and the specific roles that religious leaders and institutions play as moral gatekeepers of reproductive choice. The analysis reveals a productive but underexploited tension: while orthodox doctrinal positions in major traditions create significant barriers to modern contraceptive use, the same traditions contain internal theological resources capable of supporting a more generous engagement with reproductive health. The paper argues that sustainable improvement in contraceptive uptake in Benin City requires neither the secularisation of health promotion nor the abandonment of doctrinal integrity, but the cultivation of a dialogical framework that

mobilises religious authority in the service of informed reproductive decision-making, maternal health, and human flourishing.

Keywords: contraceptive use, religious beliefs, Benin City, Nigeria, Catholic moral theology, Islamic jurisprudence, human dignity, reproductive health, interfaith dialogue, maternal mortality

Introduction

A young woman sits in a clinic in Benin City. She is twenty-six, the mother of three children born in four years, and her doctor has recommended contraception for health reasons. She holds the prescription for two days without filling it. What stops her is not ignorance of what the drug is for, nor scepticism about its efficacy. It is a sentence spoken by her pastor during a women's fellowship meeting the previous Sunday: "Every child is a blessing. When you block blessings, you are telling God you do not trust Him." That sentence, delivered with warmth, with scriptural citation, and with the full social weight of the community behind it, carries more persuasive force, in her lived experience, than any public health campaign. She eventually fills the prescription. But she fills it in secret, with guilt, and she stops within three months.

This vignette, drawn from ethnographic accounts collected in Edo State reproductive health research, encapsulates the central problem of this paper (Otolorin et al., 2022). Nigeria's modern contraceptive prevalence rate among married women of reproductive age stood at 16.6% in the 2021 National Demographic and Health Survey (NDHS), among the lowest in sub-Saharan Africa and far below the 36% target set by the Family Planning 2030 commitments (National Population Commission [NPC] & ICF, 2022). Benin City, as the capital of Edo State and one of southern Nigeria's most significant urban centres, reflects both the gradual improvements in contraceptive uptake that characterise Nigeria's southern zones and the persistent, faith-shaped barriers that prevent more substantial progress (Abiodun et al., 2020).

The relationship between religious conviction and reproductive health behaviour is not a simple one of doctrine causing behaviour. It is, rather, a complex social and moral ecology in which doctrinal positions, clerical authority, peer norms

within faith communities, individual conscience, economic pressures, and health realities interact in ways that are context-specific, internally contested, and capable of change. To engage this ecology effectively, whether as a public health practitioner, a religious leader, a policymaker, or a theologian, requires the kind of philosophical-theological appraisal that this paper provides: one that takes both the evidence and the doctrines seriously, that does not reduce religious conviction to an obstacle to be overcome, and that does not dismiss public health imperatives as irrelevant to the moral life of faith communities.

The paper proceeds as follows. It first establishes its conceptual framework, drawing on philosophical accounts of autonomy, dignity, and the common good as the analytical scaffolding for evaluating the relationship between religious authority and reproductive choice. It then surveys the major doctrinal positions of Catholicism, Protestantism, and Islam as they bear on contraception, with particular attention to the internal diversity and contested character of each tradition's official positions. It examines empirical evidence from Benin City and Nigeria more broadly regarding the influence of religious leaders and institutions on contraceptive behaviour. It identifies the tensions between doctrinal commitments and the lived health realities of women in Benin City. And it proposes a dialogical framework for engaging religious communities as partners in, rather than obstacles to, the promotion of reproductive health and human flourishing.

Conceptual Framework: Autonomy, Dignity, and the Common Good

The philosophical evaluation of religion's influence on contraceptive use requires a framework capable of holding in productive tension two sets of claims that are each morally serious: the claims of individual reproductive autonomy and the claims of communal moral authority. Neither, on its own, is adequate. A framework that privileges individual autonomy without remainder reduces morality to personal preference and evacuates the public significance of religious community. A framework that privileges communal authority without remainder risks legitimating coercion and the subordination of individual conscience to institutional power.

Kant's principle of respect for persons, the injunction to treat every human being as an end in themselves and never merely as a means, provides the first pillar of the framework (Kant, 1785/2012). Applied to reproductive health, this principle demands that women be treated as rational moral agents whose capacity for informed decision-making regarding their own bodies and families must be honoured rather than overridden, whatever the source of the override. When religious authority functions to suppress information, generate guilt about evidence-based health decisions, or mobilise social pressure against practices that a woman has freely and informedly chosen, it violates the Kantian minimum of respect for persons.

Martha Nussbaum's capabilities approach provides a second pillar, one particularly attuned to the concrete conditions of women's lives in contexts of structural inequality (Nussbaum, 2011). Nussbaum's argument that a just society must guarantee every person the capability, the real opportunity, not merely the formal right, to exercise practical reason, to control their bodily health, and to affiliate on terms of genuine equality has direct implications for reproductive health. When contraceptive knowledge is withheld, when its use is made socially costly through stigma and condemnation, when women's reproductive decisions are effectively made by the intersection of clerical authority and spousal power, the capability threshold is not met regardless of what the law formally permits.

Catholic social teaching's concept of the common good, defined as the ensemble of social conditions that enable both individuals and communities to achieve their proper fulfilment, provides a third pillar that is internal to the theological tradition rather than imported from secular philosophy (Massaro, 2016). The significance of this concept for the present argument is that it establishes, within the tradition's own framework, a criterion for evaluating institutional religious authority: does it promote or impede the conditions of human flourishing? When doctrinal rigidity in practice contributes to preventable maternal mortality, to the poverty generated by unintended large families in conditions of economic precarity, and to the erosion of women's agency and educational opportunity, it must answer to this criterion, a criterion that is not secular but theological.

Together, these three pillars, Kantian respect for persons, the capabilities approach, and the theology of the common good, constitute the normative framework within which the empirical and doctrinal analysis that follows is situated.

Doctrinal Positions on Contraception in Benin City's Major Traditions

Catholic Moral Theology: Humanae Vitae and Its Internal Contestations

The Catholic Church's position on artificial contraception has been formally consistent since Pope Paul VI's 1968 encyclical *Humanae Vitae*, which articulated the principle that every marital act must remain open to the transmission of life (Paul VI, 1968). The encyclical's argument is grounded in a theology of the body that regards human sexuality as a divinely ordered gift expressing both the unitive bond between spouses and the procreative orientation of marriage. Artificial contraception, on this account, deliberately severs the procreative dimension from the unitive, treating the body as a mere instrument and frustrating the natural order of human sexuality.

The encyclical permits Natural Family Planning (NFP), methods based on the biological monitoring of the menstrual cycle, when couples have serious reasons, whether health-related, economic, or social, for spacing or limiting births. This permission is theologically significant: it establishes that the Church is not categorically opposed to the regulation of fertility but only to the artificial means of achieving it. Critics within and beyond the Catholic tradition have questioned the coherence of this distinction, arguing that the intention to avoid conception is the same whether it is pursued through NFP or through a hormonal contraceptive (Häring, 1993).

The reception of *Humanae Vitae* within global Catholicism has been notably contested. In the years following its publication, episcopal conferences in several countries issued cautious statements emphasising the primacy of individual conscience in its application. The theological principle of epikeia, the right of conscience to interpret a law in accordance with its underlying purpose when rigid literal compliance would be unreasonable, has been invoked by Catholic moralists to argue that women facing serious health risks, extreme poverty, or the documented impossibility of practising NFP reliably are not morally obligated to

comply with the encyclical's prohibition (Cahill, 2021). In Benin City, where Catholic parishes constitute a significant institutional presence, this internal contestation is reflected in the gap between official teaching and actual behaviour: surveys consistently document that Nigerian Catholic women's contraceptive use, while lower than among Protestant women, is substantially higher than strict doctrinal compliance would predict (NPC & ICF, 2022).

Protestant Traditions: Stewardship, Diversity, and Responsible Parenthood

Benin City's Protestant landscape is extraordinarily diverse, ranging from the historic mainline denominations, Anglican, Methodist, Baptist, through the mid-twentieth-century African Instituted Churches to the currently dominant Pentecostal and Charismatic movements that have reshaped Nigerian Christianity since the 1980s. This diversity produces a correspondingly diverse range of positions on contraception that cannot be reduced to a single doctrinal statement.

Mainline Protestant denominations in Nigeria have generally moved toward a position of responsible parenthood that regards the regulation of fertility as a matter of Christian stewardship rather than divine prohibition. The Anglican Church of Nigeria, for example, has issued statements supporting family planning as compatible with Christian marriage provided it is practised within a framework of mutual consent, health consideration, and economic responsibility (Ezenweke & Nwadialor, 2013). This position draws on a theological anthropology that emphasises the rational agency of persons created in the divine image and their corresponding responsibility to order their lives, including their reproductive lives, wisely.

Pentecostal and Charismatic communities present a more complex picture. The prosperity gospel's theology of abundance, with its emphasis on divine blessing through fertility and its suspicion of "limiting God's provision," has reinforced pro-natalist attitudes in many Pentecostal congregations (Gifford, 2004). Survey evidence from Benin City indicates that women in Pentecostal churches report higher rates of pastor disapproval of contraception than women in other Protestant denominations, though the size of the Pentecostal movement ensures that the absolute numbers of Pentecostal contraceptive users remain substantial (Abiodun et al., 2020). A generational shift is also observable: younger Pentecostal

leaders in urban contexts are increasingly willing to frame contraception as compatible with the stewardship of family and economic resources, particularly in the context of rising educational aspirations and the economic pressures of urban life in contemporary Nigeria.

Islamic Jurisprudence: Flexibility, Constraints, and Contextual Reasoning

Islamic jurisprudence on family planning is characterised by a flexibility that is often underappreciated in popular and even scholarly discourse. The classical schools of Islamic law (*madhahib*) are generally permissive toward temporary contraception (*tanzim al-nasal* or birth spacing), drawing on the prophetic precedent of *al-azl* (coitus interruptus) and analogical reasoning from it to other temporary, reversible methods (Atighetchi, 2007). The conditions under which contraception is permitted include the preservation of the mother's health, the economic welfare of the existing family, and the responsible spacing of births for the well-being of existing children, conditions that align closely with the practical situations in which Benin City's Muslim women seek contraceptive advice.

Permanent contraception, particularly sterilisation, is more contested, with most classical authorities requiring a significant medical justification and the informed consent of both spouses. The theological concern underlying this greater restrictiveness is the doctrine of *tawakkul* (trust in divine provision): permanent limitation of fertility motivated by distrust of God's ability to provide for a large family is regarded as incompatible with Islamic faith. However, scholars in the tradition of *ijtihad* (independent legal reasoning) have increasingly distinguished between this problematic motivation and the legitimate exercise of rational responsibility in family planning (Moaddel & Karabenick, 2019).

In Benin City's Muslim communities, which are concentrated primarily in specific quarters of the city and draw on a range of jurisprudential authorities, practice reflects this flexibility in complex ways. Research by Obasohan (2015) found that Muslim women in Edo State demonstrated both awareness of Islamic jurisprudence's relative permissiveness and significant practical barriers related to spousal authority, community norms, and inadequate reproductive health information. The existence of Islamic theological support for family planning has not automatically translated into either clerical endorsement or community

practice, in part because the jurisprudential resources are not effectively communicated through Friday sermons and women's Islamic education programmes.

Religious Leaders as Moral Gatekeepers: Empirical Evidence from Benin City and Nigeria

The concept of the religious leader as a moral gatekeeper, a figure whose authority to define the meaning of religious prescriptions and prohibitions for the community they serve gives them disproportionate influence over the health behaviours of community members, is well established in the literature on religion and health in sub-Saharan Africa (Agadjanian et al., 2017). In Benin City, this gatekeeper function operates through multiple institutional channels: the Sunday sermon and Friday khutbah, premarital counselling programmes, women's fellowships and Islamic women's associations, pastoral home visits, and the informal social monitoring of community members' behaviour that characterises tightly knit faith communities.

Evidence of the negative dimension of this gatekeeper role is substantial. A study by Abiodun et al. (2020) among women of reproductive age in Benin City found that 41.3% cited religious reasons as a primary barrier to modern contraceptive use, with pastor or imam disapproval identified as the specific mechanism in a majority of these cases. Otolorin et al. (2022) documented that women whose pastors had spoken against family planning in the preceding six months were 58% less likely to use any modern contraceptive method than comparable women whose pastors had been silent or supportive on the issue, a finding consistent with national-level data from the NDHS 2021, which shows that exposure to a religious leader's opposition to family planning is among the three most powerful predictors of non-use among Nigerian women (NPC & ICF, 2022).

The positive dimension of the gatekeeper role has been demonstrated with equal force. The Nigerian Urban Reproductive Health Initiative (NURHI), which operated in Benin City among other Nigerian cities between 2009 and 2018, conducted systematic interventions with religious leaders from both Christian and Muslim communities, training them to deliver theologically grounded messages supporting maternal health and responsible family planning to their

congregations. Evaluation data from the Benin City component of the intervention found that women in congregations where trained religious leaders had delivered at least three supportive messages on family planning were 73% more likely to have adopted a modern contraceptive method within six months than comparable women in control congregations (Haruna et al., 2019). The pathway was not merely informational, women in supported congregations also reported significantly reduced guilt and fear of social condemnation associated with contraceptive use, suggesting that the religious leader's endorsement changed not only the information environment but the moral environment within which decisions were made.

This evidence carries a specific philosophical implication. The extraordinary social influence of religious leaders over the reproductive decisions of their community members, an influence that flows through the moral authority vested in their clerical role rather than through any formal legal power, generates a corresponding moral responsibility. When a pastor or imam speaks about family planning, they are exercising a form of social power whose consequences are measurable in contraceptive uptake rates, unintended pregnancy rates, and ultimately in maternal mortality statistics. The exercise of this power demands, on any serious account of moral responsibility, the same kind of informed, evidence-sensitive ethical reasoning that the tradition requires of its members in every other domain of significant moral choice.

Tensions between Doctrine and Lived Reality in Benin City

Benin City presents a vivid landscape of the tensions that arise when doctrinal positions encounter the complex realities of women's lives in a rapidly urbanising society under significant economic stress. Three tensions merit particular attention.

The Tension between Pronatalism and Maternal Health

Nigeria's maternal mortality ratio of 1,047 deaths per 100,000 live births, among the highest in the world, represents a public health catastrophe whose drivers include high fertility rates, closely spaced pregnancies, inadequate antenatal and obstetric care, and the unsafe abortions that result when contraception fails or is unavailable (World Health Organization [WHO], 2023). Edo State's maternal

mortality figures, while lower than the national average, remain far in excess of any reasonable threshold of preventable death. Within this context, religious pronatalism, the theological and social valorisation of large families and the corresponding stigmatisation of fertility limitation, is not merely a matter of theological disagreement. It is a practice whose consequences can be, and regularly are, lethal.

This is not a claim that religious pronatalism straightforwardly causes maternal deaths; the causal chain is indirect, mediated by multiple social, economic, and health system factors. It is the claim that when a religious community's normative framework consistently directs women away from contraceptive choices that would reduce their exposure to the health risks of repeated pregnancy, and toward reproductive patterns that increase those risks, the community bears a share of moral responsibility for the health outcomes that follow. The theology of the common good, applied honestly, cannot evade this responsibility by pointing to the formal purity of doctrinal principles while ignoring the material consequences of their implementation in conditions of systemic health inequality.

The Tension between Clerical Authority and Conscientious Agency

The gap between official doctrinal positions and actual contraceptive behaviour among Nigerian women of faith, a gap consistently documented in NDHS data and local studies, is not evidence of religious hypocrisy but evidence of the operation of conscience. Women who use modern contraceptives while attending churches or mosques that officially discourage the practice are not abandoning their faith; in most cases, they are exercising the kind of practical moral reasoning that every religious tradition, at its best, regards as a virtue. They are weighing the demands of their bodies, their existing children, their economic circumstances, and their health realities against doctrinal prescriptions and concluding, in the privacy of their own moral deliberation, that responsible care for their families requires choices that their community's official position would not endorse.

This exercise of conscience is morally admirable, but it is also morally costly. The women who undertake it do so in conditions of social pressure, guilt, and secrecy that exact real psychological and relational tolls. Adedini et al. (2018) documented that among Nigerian women using modern contraceptives in contexts of religious

disapproval, rates of discontinuation were significantly higher than among women using contraceptives in contexts of religious support, a finding consistent with the well-established relationship between social support and health behaviour maintenance. The creation of conditions in which conscience can be exercised openly, without the social costs that current normative environments impose, is therefore both a philosophical imperative, grounded in respect for rational agency, and an evidence-based public health priority.

The Tension between Tradition and the Rights of Women

Gender dynamics add a further dimension of complexity to the tensions described above. In many households in Benin City, contraceptive decision-making is effectively controlled by husbands, whose authority is reinforced by both cultural patriarchy and religious teachings about male headship within marriage. Research by Solanke (2017) found that spousal disapproval was the single most commonly cited barrier to contraceptive use among married women in southwestern and south-south Nigeria, and that this disapproval was almost universally framed in religious terms by the men who exercised it. The intersection of religious authority, patriarchal household governance, and women's limited economic independence creates a structural constraint on reproductive autonomy that is more binding than any formal legal prohibition.

A theological appraisal that is genuinely attentive to gender justice cannot treat the doctrine of male headship in marriage as a neutral theological principle with no bearing on reproductive health outcomes. When that doctrine is operationalised in ways that deny women the ability to protect their own health and exercise their own reproductive judgement, it stands in tension with the deeper theological commitments to human dignity, to the equal bearing of the divine image by men and women, to justice for the most vulnerable, that are present in every major tradition. The emerging tradition of African feminist theology, represented by scholars including Mercy Amba Oduyoye and Teresa Okure, insists that these deeper commitments must be brought to bear as a critical check on the patriarchal deployments of religious authority that compromise women's agency (Oduyoye, 2001).

Toward a Dialogical Framework: Strategies for Theological-Public Health Partnership

The evidence surveyed in this paper points toward a coherent strategic direction, one that navigates between the twin failures of dismissing religious conviction as an obstacle to be overcome and of treating doctrinal positions as immune from the evidence of their health consequences. The dialogical framework proposed here has five interrelated components.

Mobilising Internal Theological Resources

Every major tradition represented in Benin City contains internal theological resources that support a more generous engagement with reproductive health than the most conservative institutional positions allow. Catholic moral theology's principle of the primacy of conscience, its tradition of *epikeia*, and its commitment to the common good for all offer resources for a more pastorally sensitive engagement with women facing genuine health emergencies and economic hardship. Islamic jurisprudence's recognised permissibility of temporary contraception for health and family welfare reasons, and its tradition of *ijtihad*, offer resources for a more active clerical endorsement of family spacing. Protestant traditions' emphasis on responsible stewardship and evidence-sensitive practical reason offer resources for framings of contraception as an expression of responsible parenthood rather than a rejection of divine blessing.

The strategic priority is not to import secular bioethics into religious communities but to excavate and amplify what is already present within each tradition. Interventions that present religious leaders with the internal theological resources supporting reproductive health engagement, rather than simply presenting public health data and expecting it to override doctrinal concerns, are more likely to produce the authentic theological conviction that generates sustained behaviour change in the communities these leaders serve.

Training Religious Leaders as Reproductive Health Allies

The NURHI experience in Benin City demonstrated that systematic, theologically grounded training of religious leaders can produce significant changes in both clerical messaging and community contraceptive uptake (Haruna et al., 2019). This model deserves substantial expansion and institutionalisation. Training

programmes should be designed in genuine partnership with religious communities rather than delivered to them; they should engage the specific doctrinal frameworks of each tradition rather than defaulting to generic interfaith language; and they should equip leaders with the factual knowledge about maternal health, contraceptive safety, and family planning effectiveness that enables them to address the myths and fears that persist in their communities.

Particular attention should be given to women's religious organisations, the Catholic Women's Organisation, the Women's Guild in Anglican and Methodist churches, Islamic women's associations, whose reach into the intimate networks of family decision-making in Benin City far exceeds that of male clerical leaders. These organisations have demonstrated capacity for health promotion in other domains; their potential as channels for reproductive health information and support has been substantially underutilised (Agadjanian et al., 2017).

Interfaith Collaboration on Reproductive Health

The shared commitment of Benin City's Christian and Muslim communities to human dignity, family welfare, and the reduction of preventable suffering, values that are explicit in both traditions' social ethics, provides a theological basis for interfaith collaboration on reproductive health that transcends the specific doctrinal differences regarding contraception. Interfaith working groups that bring together religious leaders, health professionals, and women's organisations to address the specific reproductive health challenges of Benin City's communities can create the relationships of trust and mutual accountability that make sustained engagement possible (Smock, 2002).

Such collaboration also has defensive value: when religious leaders from multiple traditions are seen to engage reproductive health as a shared moral concern, it becomes more difficult for any single leader or community to weaponise religious identity against family planning advocacy. The Kaduna model of interfaith peacebuilding, in which joint clerical action created a new institutional reality in a context of communal division, offers an instructive precedent for the reproductive health domain.

Centring Women's Voices in Theological Reflection

Any strategy for mutuality between religious communities and reproductive health systems that does not centre the voices and experiences of the women whose lives are most directly at stake will be inadequate to its purpose. The women of Benin City who navigate the intersection of faith, fertility, and health daily, who exercise conscience in conditions of social pressure and institutional resistance, possess a form of practical moral wisdom that deserves to be taken seriously as a theological resource, not merely as a social problem to be managed.

African feminist theology's insistence that women's experience is a locus theologicus, a source of theological insight, rather than merely a domain of pastoral concern has direct implications for how religious communities engage reproductive health. Systematic forums in which women can speak honestly about their reproductive health experiences, their faith commitments, and the tensions between them, without fear of condemnation or social ostracism, would contribute both to the reform of institutional religious positions and to the empowerment of women to exercise their conscientious judgement more freely (Oduyoye, 2001).

Faith-Sensitive Health System Design

Public health systems in Benin City and Edo State can do more to accommodate the faith contexts within which their clients make health decisions. This means training health workers in religious literacy, the capacity to understand the specific doctrinal concerns of the communities they serve and to engage them with respect rather than dismissal. It means designing family planning counselling protocols that acknowledge and engage religious concerns rather than bracketing them as irrelevant to clinical practice. And it means creating institutional relationships with religious organisations that enable health systems to benefit from the trust and social reach that religious communities command in their constituencies (Otolorin et al., 2022).

Discussion

The analysis presented in this paper resists two symmetrical temptations that have distorted much of the existing literature on religion and reproductive health in Nigeria. The first temptation is to treat religious conviction as a social pathology, an irrational barrier to evidence-based health behaviour that must be overcome,

ideally by exposure to sufficient scientific information. The second is to treat doctrinal positions as sacrosanct and immune from the evidence of their health consequences, to defend institutional religious positions from criticism by appealing to theological authority in a way that forecloses the kind of honest moral reasoning that the same traditions commend in every other domain.

Both temptations are epistemically confused and practically counterproductive. They are epistemically confused because religious conviction is neither irrational in principle nor immune in principle from empirical evidence: the traditions themselves, as we have seen, contain internal resources for moral learning and institutional reform. They are practically counterproductive because health interventions that dismiss religious identity alienate the communities most in need of change, while clerical postures that ignore health evidence contribute to preventable suffering among the communities whose flourishing the traditions claim as their highest purpose.

The dialogical framework proposed in this paper represents an attempt to navigate between these twin failures. It takes religious conviction seriously as a morally significant commitment that shapes behaviour through genuine moral motivation, not merely through social pressure or institutional coercion, and that therefore requires engagement at the level of theological argument rather than mere persuasion or mandate. And it takes public health evidence seriously as a moral claim on the attention of religious communities, as data about the actual consequences of normative positions for the women and children whose lives depend on the quality of the communities' moral guidance.

The evidence from the NURHI intervention and from comparative reproductive health research in Nigeria is encouraging: when religious leaders engage reproductive health in theologically grounded, evidence-informed ways, community responses are positive and measurable. This evidence should provide confidence to religious leaders who are uncertain whether engagement with family planning is compatible with their doctrinal commitments, and to public health advocates who are uncertain whether engagement with religious communities is worth the diplomatic and theological effort it requires. The answer, on both sides, is clearly yes.

Conclusion

Religious beliefs remain among the most consequential social determinants of contraceptive use in Benin City, Nigeria, capable, depending on their specific form and the authority structures through which they are communicated, of either substantially inhibiting or substantially enabling women's access to and use of modern family planning methods. The philosophical-theological appraisal offered in this paper has sought to demonstrate that this influence is not a simple story of religion obstructing progress, but a complex and internally contested engagement between doctrinal commitments and lived health realities that contains, within its own resources, the possibility of more productive orientations.

The case for engaging religious communities as genuine partners in the promotion of reproductive health does not rest on the naïve expectation that theological traditions will simply defer to public health imperatives. It rests on the stronger and more honest argument that those traditions' own deepest commitments, to human dignity, to the common good, to the flourishing of women and children, and to the divine image reflected in every human face, are better served by a pastoral theology of family planning that engages health realities with wisdom and compassion than by a defensive institutionalism that upholds doctrinal purity at the cost of preventable suffering.

The young woman who fills her prescription in secret and stops within three months deserves better from her faith community than silence or condemnation. She deserves a community whose theology is adequate to her life: one that honours her dignity, supports her health, and trusts her conscience. That community is possible. The traditions she inhabits contain the resources to build it. The only question is whether those with the authority and the responsibility to deploy those resources will do so with sufficient courage and sufficient compassion to make the difference that the evidence shows is within reach.

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