

Sexual Knowledge and Contraceptive use among Christians in Lagos State, Nigeria: A Cross-Sectional Study

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Abstract

Sexual knowledge and contraceptive use remain critical public health concerns in Nigeria, particularly among religious communities where moral and doctrinal teachings may influence reproductive health behaviours. Despite high unmet need for family planning, contraceptive prevalence remains low among Christians in Lagos State, suggesting potential gaps between knowledge, attitudes, and practices. This study assessed sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria, and examined the associations between these dimensions and socio-demographic, religious, and doctrinal factors. A descriptive cross-sectional survey was employed with 600 Christian adults aged 18–49 years recruited from 30 churches across five local government areas in Lagos State using multistage sampling. Data were collected using a structured questionnaire adapted from the Demographic and Health Survey (DHS) family planning module and the Sexual Health Literacy Assessment Tool. Sexual knowledge was measured with 25 items on reproduction, contraception, STIs, and fertility (scored 0–25). Contraceptive use was assessed via self-reported current use of modern methods (condoms, pills, injectables, implants, IUDs, sterilisation). Data were analysed using descriptive statistics, chi-square tests, and multiple logistic regression, controlling for age, gender, education, income, marital status, denominational affiliation, and religious attendance. Participants demonstrated moderate sexual knowledge ($M = 16.8$, $SD = 4.2$ out of 25), with 62% correctly identifying at least three modern contraceptive methods and 54% knowing at least three fertility signs. Contraceptive use was low: only 34% reported current use of modern methods, with condoms (18%) and oral contraceptive pills (12%) being most common. Knowledge was significantly higher among university-educated participants ($M = 19.2$) than those with secondary education or less ($M = 14.6$; $t = 9.34$, $p < 0.001$). Contraceptive use was significantly associated with higher knowledge (adjusted OR = 2.18, 95% CI: 1.56–3.05, $p < 0.001$), younger age (18–29 years: aOR = 1.67, $p = 0.018$), university education (aOR = 2.34, $p = 0.001$), and lower religious attendance (less than weekly: aOR = 1.89, $p = 0.006$). Denominational affiliation was significant: Pentecostal/evangelical Christians were less likely to use contraception than mainline Protestants (aOR = 0.58, $p = 0.004$) and Catholics (aOR = 0.62, $p = 0.012$), controlling for covariates. Christians in Lagos State demonstrate moderate sexual knowledge but low contraceptive use, with significant variations by education, age, religious attendance, and denominational affiliation. Findings suggest that doctrinal teachings and religious norms mediate the knowledge–practice relationship, highlighting the need for faith-sensitive family planning interventions, pastoral training on reproductive health, and integration of contraceptive education within church-based health programmes.

Keywords: Sexual Knowledge; Contraceptive Use; Family Planning; Religious Affiliation; Doctrinal Teachings.

I. INTRODUCTION

Sexual knowledge and contraceptive use remain critical public health concerns in Nigeria, particularly among religious communities where moral and doctrinal teachings may influence reproductive health behaviours. In Nigeria, an estimated 23% of women aged 15–49 have an unmet need for family planning, yet contraceptive prevalence remains low at approximately 12% among married women and 18% among all women of reproductive age (National Population Commission [NPC] & ICF, 2019; National Agency for the Control of AIDS [NACA], 2023). Lagos State, Nigeria's most populous state with over 20 million residents and a predominantly Christian population (approximately 60% Christian, 40% Muslim and other), reflects this trend: despite urban advantages (e.g. better health infrastructure, higher education levels), contraceptive prevalence remains suboptimal, particularly among Christians (Lagos State Ministry of Health, 2022; Odebiyi et al., 2021).

Christians in Lagos State face unique vulnerabilities: early sexual debut (median age 17–18 years), high fertility desires (mean desired children: 4–5), limited access to youth-friendly reproductive health services, and pervasive religious and moral norms surrounding contraception (Izugbe & Odebiyi, 2020; Ogunbameru, 2020). Despite decades of family planning programmes,

including mass media campaigns, community outreach, and church-based health initiatives, knowledge gaps, doctrinal ambivalence, and low uptake of modern contraceptive methods persist (Singh et al., 2021; World Health Organization, 2022).

Sexual knowledge and contraceptive use are critical determinants of reproductive health outcomes. The Health Belief Model and Social Cognitive Theory posit that accurate knowledge shapes risk perceptions, attitudes influence behavioural intentions, and self-efficacy enables preventive action (Bandura, 1986; Ajzen, 1991). However, among Christians in Nigeria, the relationship between knowledge and contraceptive use remains complex: high knowledge does not always translate into contraceptive uptake, suggesting that doctrinal teachings, religious norms, and pastoral guidance mediate these relationships (Izugbe & Odebiyi, 2020; Odebiyi et al., 2021).

Global evidence on sexual knowledge and contraceptive use among religious communities comes primarily from sub-Saharan Africa, Asia, and Latin America, with studies consistently finding that knowledge is moderate, attitudes are mixed (high unmet need but significant religious ambivalence), and contraceptive use is suboptimal (UNAIDS, 2023; World Health Organization, 2022). However, evidence from urban Nigeria, particularly among Christians in Lagos State, remains limited, with most studies focusing on rural populations or specific denominations (e.g. Catholics, Pentecostals).

This study addresses this gap by assessing sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria. Specifically, the research examines: (1) levels of sexual knowledge and contraceptive use; (2) associations between knowledge, religious factors, and contraceptive use; and (3) socio-demographic and doctrinal predictors of contraceptive use. Findings contribute to scholarly understanding of reproductive health in urban African religious contexts and offer actionable recommendations for faith-sensitive family planning interventions, pastoral training, and church-based health programmes.

Statement of the Problem

Despite decades of family planning programmes in Nigeria, Christians in Lagos State continue to demonstrate low contraceptive use, with estimates suggesting only 30–35% of Christian women aged 15–49 use modern methods, compared to 40–45% among Muslims and 50–55% among adherents of traditional religions (NPC & ICF, 2019; Lagos State Ministry of Health, 2022). This disparity persists despite high awareness of contraception (over 85% have heard of at least one modern method) and widespread availability of family planning services in urban areas (Odebiyi et al., 2021; Izugbe & Odebiyi, 2020).

The disconnect between awareness and contraceptive use suggests that knowledge alone is insufficient; doctrinal teachings, religious norms, pastoral guidance, and denominational affiliations play critical mediating roles (World Health Organization, 2022; UNAIDS, 2023). However, empirical research on the knowledge–religion–practice nexus among Christians in Lagos State remains scarce. Most studies focus on specific denominations (e.g. Catholics, Pentecostals) or rural populations, limiting generalisability to the broader Christian population in urban Lagos (Odebiyi et al., 2021; Izugbe & Odebiyi, 2020).

Furthermore, global evidence on sexual knowledge and contraceptive use among religious communities comes primarily from sub-Saharan Africa, Asia, and Latin America, with limited representation from urban Nigeria (UNAIDS, 2023; World Health Organization, 2022). Whether global patterns (moderate knowledge, mixed attitudes, suboptimal use) hold in highly urbanised, religiously diverse contexts like Lagos remains empirically untested. Comparative evidence is needed to determine whether knowledge, religious factors, and socio-demographic variables operate similarly across urban and rural contexts, informing both local interventions and global theory.

Addressing these gaps is urgent, given the social, health, and economic implications of low contraceptive use among Christians in Nigeria. Unintended pregnancies contribute to maternal mortality, unsafe abortions, and economic hardship, while high fertility rates strain household resources and limit women's educational and economic opportunities (Singh et al., 2021; World Health Organization, 2022). This study responds by providing robust empirical evidence on sexual knowledge and contraceptive use among Christians in Lagos State, offering actionable recommendations for faith-sensitive family planning interventions, pastoral training, and church-based health programmes.

Empirical Research Questions

This study was guided by the following empirical research questions:

1. What is the level of sexual knowledge among Christians in Lagos State, Nigeria?
2. What is the prevalence of modern contraceptive use among Christians in Lagos State, Nigeria?
3. Is there a statistically significant relationship between sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria?

4. Is there a statistically significant relationship between religious attendance and contraceptive use among Christians in Lagos State, Nigeria?
5. Is there a statistically significant relationship between denominational affiliation and contraceptive use among Christians in Lagos State, Nigeria?
6. Do sexual knowledge, religious attendance, and denominational affiliation significantly predict contraceptive use after controlling for socio-demographic variables (age, gender, education, income, marital status) among Christians in Lagos State, Nigeria?

Objectives

General Objective

The general objective of this study was to assess sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria.

Specific Objectives

1. To assess the level of sexual knowledge among Christians in Lagos State, Nigeria.
2. To evaluate the prevalence of modern contraceptive use among Christians in Lagos State, Nigeria.
3. To examine the bivariate relationship between sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria.
4. To examine the bivariate relationship between religious attendance and contraceptive use among Christians in Lagos State, Nigeria.
5. To examine the bivariate relationship between denominational affiliation and contraceptive use among Christians in Lagos State, Nigeria.
6. To determine whether sexual knowledge, religious attendance, and denominational affiliation significantly predict contraceptive use after controlling for socio-demographic variables (age, gender, education, income, marital status) among Christians in Lagos State, Nigeria.

Hypotheses

Based on the research questions and theoretical frameworks, the following hypotheses were tested:

- H₁: Christians in Lagos State will demonstrate moderate sexual knowledge (mean score 50–70% of total).
- H₂: Christians in Lagos State will demonstrate low contraceptive use (less than 40% current use of modern methods).
- H₃: There will be a statistically significant positive relationship between sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria.
- H₄: There will be a statistically significant negative relationship between religious attendance and contraceptive use among Christians in Lagos State, Nigeria.
- H₅: There will be a statistically significant relationship between denominational affiliation and contraceptive use among Christians in Lagos State, Nigeria.
- H₆: Sexual knowledge, religious attendance, and denominational affiliation will significantly predict contraceptive use after controlling for socio-demographic variables among Christians in Lagos State, Nigeria.

II. LITERATURE REVIEW

Conceptualising Sexual Knowledge and Contraceptive Use

Sexual knowledge encompasses factual understanding of human reproduction, contraceptive methods, fertility signs, STIs, and reproductive health (World Health Organization, 2022). Contraceptive use refers to the current use of modern methods (condoms, oral contraceptive pills, injectables, implants, intrauterine devices, sterilisation) to prevent pregnancy (National Population Commission & ICF, 2019).

Global research conceptualises sexual knowledge and contraceptive use as interconnected but distinct dimensions: knowledge shapes attitudes through cognitive pathways (e.g. risk perceptions, outcome expectations), attitudes influence behavioural intentions, and self-efficacy enables preventive action (Bandura, 1986; Ajzen, 1991). However, the knowledge–practice nexus is complex: high knowledge does not always translate into contraceptive use, suggesting that structural barriers (e.g. cost, access, provider attitudes) and cultural factors (e.g. religion, gender norms, ethnic identity) mediate these relationships (Izugbe & Odebiyi, 2020; Odebiyi et al., 2021).

Empirical Evidence from Nigeria

Nigeria: Limited studies on sexual knowledge and contraceptive use among Christians in Nigeria focus primarily on specific denominations (e.g. Catholics, Pentecostals) or rural populations. A study in Southwest Nigeria found that Christian women demonstrated moderate knowledge (60% correct responses) but low contraceptive use (28%) (Odebiyi et al., 2021). Another study in Lagos State reported that 76% of Christians expressed willingness to use contraception, but only 32% were current users, suggesting a knowledge–practice gap (Izugbe & Odebiyi, 2020).

Ethnographic Observations: Ethnographic research in Lagos reveals that Christians navigate complex reproductive landscapes shaped by denominational affiliation, pastoral guidance, and socioeconomic status. Among mainline Protestant communities (e.g. Anglican, Methodist, Baptist), contraception is generally accepted within marriage for family spacing, with pastors often endorsing responsible parenthood (in Yoruba: *ìdílẹ̀ tó dára*; in Igbo: *ezinụlọ dị mma*) (Adepoju, 2019; Ogunbameru, 2020). Among Pentecostal/evangelical communities, contraception is more contested, with some pastors discouraging use as ‘interference with God’s plan’ (in Yoruba: *ídiwọ̀n fún èròngbà Qlórùn*; in Igbo: *mgbochi maka atumatụ Chineke*), while others endorse use for health and economic reasons (Smith, 2021). Among Catholic communities, official doctrine opposes artificial contraception, permitting only natural family planning methods (e.g. rhythm, withdrawal), though lay Catholics often use modern methods discreetly (Umar, 2022).

Sociological Interpretations: From a sociological perspective, sexual knowledge and contraceptive use among Christians are shaped by structural forces (e.g. poverty, gender inequality, healthcare access) and cultural meanings (e.g. morality, religion, denominational doctrine) (Bourdieu, 1984; Foucault, 1978). In Lagos, Christians’ reproductive behaviours are not merely individual choices but are embedded within broader social structures and religious narratives that shape risk perceptions, doctrinal compliance, and contraceptive action (Giddens, 1991; Archer, 1995). Ethnographic observations reveal that Christians navigate these structures through creative strategies (e.g. discreet contraceptive use, selective pastoral consultation, reliance on secular health providers) but these strategies are often insufficient to ensure consistent contraceptive action (Adepoju, 2019; Ogunbameru, 2020).

Empirical Evidence from Africa

Sub-Saharan Africa: Comparative evidence from sub-Saharan Africa is similarly mixed. A multi-country study across 10 African nations found that sexual knowledge was moderate (60–70% correct responses), contraceptive use was suboptimal (30–40% among Christians), and religious factors (e.g. attendance, denominational affiliation) significantly predicted use (UNAIDS, 2023; World Health Organization, 2022). Qualitative research in Kenya, Tanzania, and Uganda revealed that doctrinal teachings, pastoral guidance, and denominational norms mediate the knowledge–practice relationship.

South Africa: In contrast, South African research has begun to examine the knowledge–religion–practice nexus among Christians. A study among university students found that knowledge predicted positive attitudes towards contraception, but religious attendance and denominational affiliation did not predict use, suggesting that structural barriers (e.g. access, cost) override religious factors (World Health Organization, 2022).

Overall, African evidence suggests that knowledge is moderate, contraceptive use is suboptimal among Christians, and religious factors mediate the knowledge–practice relationship, but the relationships between these dimensions remain empirically unclear, particularly in urban contexts like Lagos.

Empirical Evidence from AsiaIndia: Studies in India consistently find that sexual knowledge is moderate (55–65% correct responses), contraceptive use is suboptimal (25–35% among Christians), and religious factors (e.g. attendance, denominational affiliation) significantly predict use (UNAIDS, 2023). A national survey found that knowledge predicted positive attitudes towards contraception, but religious attendance and denominational affiliation did not predict use, suggesting that structural barriers (e.g. access, gender norms) override religious factors.

Philippines: In contrast, the Philippines’ predominantly Catholic context has resulted in lower knowledge (50–60% correct responses), more religious ambivalence, and lower contraceptive use (20–30% among Catholics) among Christians (World Health Organization, 2022).

Asian evidence suggests that sexual knowledge and contraceptive use vary significantly by context, with successful family planning programmes (e.g. Thailand, Indonesia) achieving better outcomes than countries with weaker programmes or strong religious opposition (e.g. Philippines, India).

Empirical Evidence from Latin America/Brazil: Studies consistently find that sexual knowledge is moderate (60–70% correct responses), contraceptive use is moderate (35–45% among Christians), and religious factors (e.g. attendance, denominational affiliation) significantly predict use (UNAIDS, 2023). A national survey found that knowledge predicted positive attitudes towards contraception, and religious attendance predicted lower use, but structural barriers (e.g. access, cost) mediated these relationships.

Mexico: A multi-state study found that knowledge was higher in urban areas (70–80% correct responses) than rural areas (50–60%), but contraceptive use was similarly suboptimal among Christians, suggesting that knowledge alone is insufficient without structural enablers (World Health Organization, 2022).

Latin American evidence highlights the complexity of the knowledge–religion–practice nexus: knowledge and religious factors matter, but structural barriers (e.g. access, cost, gender norms) often override cognitive and religious factors.

Empirical Evidence from Europe and North America

Europe: Europe’s comprehensive sexual education and universal healthcare systems result in higher knowledge (75–85% correct responses), more positive attitudes towards contraception, and better contraceptive use (50–60% among Christians) (UNAIDS, 2023; World Health Organization, 2022).

United States: In the US, knowledge is high (80–90% correct responses), but contraceptive use varies significantly by religious affiliation. Evangelical Christians demonstrate lower contraceptive use than mainline Protestants and Catholics, reflecting doctrinal differences (UNAIDS, 2023).

European and North American evidence suggests that comprehensive sexual education, universal healthcare, and structural enablers (e.g. free contraception, confidential services) result in better knowledge and contraceptive use outcomes than low- and middle-income contexts.

Theoretical Frameworks

Health Belief Model (HBM): HBM posits that contraceptive use is shaped by perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Bandura, 1986). Applied to contraception, knowledge shapes perceived susceptibility and severity, attitudes shape perceived benefits and barriers, and self-efficacy enables contraceptive action.

Social Cognitive Theory (SCT): SCT suggests that knowledge, attitudes, and practices are shaped by reciprocal interactions between personal factors (knowledge, self-efficacy), behavioural patterns, and environmental influences (Bandura, 1986, 2001). Applied to contraception, knowledge and attitudes shape contraceptive use, but structural barriers (e.g. access, cost) and religious factors (e.g. doctrine, pastoral guidance) mediate these relationships.

Theory of Planned Behaviour (TPB): TPB suggests that attitudes, subjective norms, and perceived behavioural control shape behavioural intentions and actual behaviour (Ajzen, 1991). Applied to contraception, knowledge shapes attitudes and subjective norms, while perceived behavioural control (e.g. access, self-efficacy) enables contraceptive action.

These frameworks predict that knowledge should predict contraceptive use, but the strength of these relationships varies by context (stronger in contexts with structural enablers, weaker in contexts with structural barriers and religious opposition).

Gaps in the Literature

Despite extensive global research on sexual knowledge and contraceptive use among religious communities, several empirical gaps remain:

- Limited urban Nigerian evidence: Most studies focus on rural populations or specific denominations (e.g. Catholics, Pentecostals), with urban Lagos underrepresented despite high unmet need for family planning.
- Knowledge–religion–practice nexus empirically unclear: Few studies examine the relationships between knowledge, religious factors, and contraceptive use, particularly in urban African Christian contexts.
- Doctrinal and denominational variations underexplored: Most studies focus on individual-level factors (knowledge, attitudes) without examining doctrinal teachings and denominational variations.

- Contextual variation: It remains empirically unclear whether global patterns (moderate knowledge, suboptimal use, religious mediation) hold in highly urbanised, religiously diverse contexts like Lagos.
- Ethnographic and sociological insights missing: Few studies incorporate ethnographic observations or sociological interpretations of reproductive health behaviours among Nigerian Christians, limiting understanding of cultural meanings and religious structures.

This study addresses these gaps by assessing sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria, contextualised within global evidence, theoretical frameworks, ethnographic observations, and sociological interpretations.

Theoretical Framework

Three complementary theoretical frameworks: the Health Belief Model (HBM) guided this study, Social Cognitive Theory (SCT), and the Theory of Planned Behaviour (TPB), supplemented by sociological structuration theory (Giddens, 1991) and cultural capital theory (Bourdieu, 1984).

Health Belief Model (HBM)

The Health Belief Model posits that contraceptive use is shaped by perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Bandura, 1986). Applied to contraception, knowledge shapes perceived susceptibility and severity, attitudes shape perceived benefits and barriers, and self-efficacy enables contraceptive action.

Social Cognitive Theory (SCT)

Social Cognitive Theory suggests that knowledge, attitudes, and practices are shaped by reciprocal interactions between personal factors (knowledge, self-efficacy), behavioural patterns, and environmental influences (Bandura, 1986, 2001). Applied to contraception, knowledge and attitudes shape contraceptive use, but structural barriers (e.g. access, cost) and religious factors (e.g. doctrine, pastoral guidance) mediate these relationships.

Theory of Planned Behaviour (TPB)

The Theory of Planned Behaviour suggests that attitudes, subjective norms, and perceived behavioural control shape behavioural intentions and actual behaviour (Ajzen, 1991). Applied to contraception, knowledge shapes attitudes and subjective norms, while perceived behavioural control (e.g. access, self-efficacy) enables contraceptive action.

Sociological Structuration Theory

Structuration theory posits that social structures (e.g. gender norms, religious institutions, healthcare systems) and individual agency (e.g. knowledge, attitudes, practices) are mutually constitutive: structures shape agency, and agency reproduces or transforms structures (Giddens, 1991). Applied to contraception, Christians' reproductive behaviours are shaped by structural forces (e.g. poverty, gender inequality, healthcare access) and religious meanings (e.g. morality, doctrine, denominational affiliation), but Christians also exercise agency in navigating these structures.

Cultural Capital Theory

Cultural capital theory suggests that individuals' knowledge, attitudes, and practices are shaped by their cultural resources (e.g. education, language, social networks) (Bourdieu, 1984). Applied to contraception, Christians with higher cultural capital (e.g. university education, urban residence, English proficiency) demonstrate better knowledge, more positive attitudes, and more consistent contraceptive use than those with lower cultural capital.

These frameworks predict that knowledge should predict contraceptive use, but the strength of these relationships varies by context (stronger in contexts with structural enablers, weaker in contexts with structural barriers and religious opposition).

III. METHODOLOGY

Research Design

A descriptive cross-sectional survey design was employed to assess sexual knowledge and contraceptive use among Christians in Lagos State, Nigeria. This design was deemed appropriate for assessing prevalence, describing patterns, and testing associations between knowledge, religious factors, and contraceptive use at a single point in time.

Setting

The study was conducted in 30 churches across five local government areas (LGAs) in Lagos State, Southwest Nigeria: Lagos Mainland, Surulere, Ikeja, Agege, and Oshodi-Isolo. These LGAs were selected to represent diverse urban contexts (commercial, residential, industrial) and high population density. Lagos State is predominantly Yoruba-speaking, with significant Igbo, Hausa, and other ethnic communities, reflecting Nigeria's multicultural landscape (National Population Commission, 2022).

Participants and Sampling

The target population comprised Christian adults aged 18–49 years attending the selected churches. A multistage sampling technique was employed:

1. Stage 1: Five LGAs were randomly selected from Lagos State.
2. Stage 2: Six churches were randomly selected from each LGA (30 churches total), stratified by denominational affiliation (10 mainline Protestant, 10 Pentecostal/evangelical, 10 Catholic).
3. Stage 3: 20 Christian adults were purposively selected from each church based on inclusion criteria: (a) aged 18–49 years, (b) self-identified Christian, (c) attending the selected church for at least 6 months, and (d) provided informed consent.

The final sample consisted of 600 Christian adults. This sample size exceeded the minimum requirement for multiple logistic regression analysis with 5–7 predictors (approximately 10 events per predictor variable) and provided adequate power (>0.80) to detect medium effect sizes (odds ratio = 1.5) at $\alpha = 0.05$.

Instruments

Sexual Knowledge Scale

Sexual knowledge was measured using a 25-item researcher-developed Sexual Knowledge Scale, adapted from the Demographic and Health Survey (DHS) family planning module and validated in African contexts (National Population Commission & ICF, 2019; World Health Organization, 2022). Items assessed factual knowledge of human reproduction (e.g. ovulation, fertilisation, implantation), contraceptive methods (e.g. condoms, pills, injectables, implants, IUDs, sterilisation), fertility signs (e.g. cervical mucus, basal body temperature, calendar method), STIs (e.g. transmission, prevention, symptoms), and reproductive health (e.g. antenatal care, postnatal care, family planning). Each correct response was scored 1, and incorrect or ‘don’t know’ responses were scored 0, yielding a total score ranging from 0 to 25 (higher = greater knowledge). The scale demonstrated acceptable internal consistency in this sample (Cronbach’s $\alpha = 0.84$).

Contraceptive use

Contraceptive use was assessed via a single-item self-report measure, adapted from the DHS family planning module and validated in African contexts (National Population Commission & ICF, 2019; World Health Organization, 2022). Participants were asked: ‘Are you currently using any method to prevent pregnancy?’ Response options included: (1) no method, (2) modern method (condom, oral contraceptive pill, injectable, implant, IUD, sterilisation), (3) traditional method (rhythm, withdrawal, herbal remedies). For analysis, contraceptive use was dichotomised as ‘modern method’ vs. ‘no method/traditional method’.

Religious Factors

Religious attendance was measured via a single-item self-report measure: ‘How often do you attend church services?’ Response options included: (1) less than once a month, (2) once a month, (3) 2–3 times a month, (4) weekly, (5) more than weekly. For analysis, religious attendance was dichotomised as ‘weekly or more’ vs. ‘less than weekly’.

Denominational affiliation was measured via a single-item self-report measure: ‘What is your denominational affiliation?’ Response options included: (1) mainline Protestant (Anglican, Methodist, Baptist, Presbyterian), (2) Pentecostal/evangelical, (3) Catholic, (4) other Christian. For analysis, denominational affiliation was categorised as ‘mainline Protestant’, ‘Pentecostal/evangelical’, ‘Catholic’, and ‘other Christian’.

Demographic and Control Variables

A researcher-designed demographic questionnaire collected data on age, gender, education, income (monthly household income in Nigerian Naira), marital status (married/cohabiting, single, divorced/separated), and socioeconomic status (wealth index constructed from household assets). These variables were included as controls in regression models based on prior evidence of their association with contraceptive use (National Population Commission & ICF, 2019; UNAIDS, 2023).

Procedure

Ethical approval was obtained from the Lagos State Ministry of Health, Health Research Ethics Committee (Approval No: LSMH/REC/XXX/2025). Permission was sought from church leaders, and informed consent was obtained from all participants prior to data collection. Trained research assistants administered questionnaires in private rooms within church premises or participants’ homes, ensuring confidentiality and minimising social desirability bias. Questionnaires were available in English, Yoruba, and Igbo to ensure accessibility for diverse ethnic communities. Data collection occurred over eight weeks (April–May 2025), with an average completion time of 20–25 minutes per participant.

Data Analysis

Data were analysed using IBM SPSS Statistics version 28. Descriptive statistics (means, standard deviations, frequencies, percentages) were computed for all variables. Pearson correlation coefficients and chi-square tests were calculated to examine bivariate associations between sexual knowledge, religious factors, and contraceptive use. Multiple logistic regression was conducted to test the predictive power of sexual knowledge, religious attendance, and denominational affiliation on contraceptive use (modern method vs. no method/traditional method), controlling for age, gender, education, income, and marital status. Assumptions of linearity, absence of multicollinearity, and adequate sample size were verified prior to analysis. Effect sizes were reported as adjusted odds ratios (aOR) with 95% confidence intervals (CI). Statistical significance was set at $p < 0.05$ (two-tailed).

¹Ethical Considerations

Participation was voluntary, and respondents could withdraw at any time without penalty. Anonymity was ensured through the use of identification codes rather than names. Given the sensitivity of contraception as a topic within religious communities, participants were provided with contact information for counselling and family planning services in case the questionnaire raised emotional distress or interest in services. All data were stored securely and accessible only to the research team.

Findings

Descriptive Statistics

The sample comprised 600 Christian adults with a mean age of 29.7 years ($SD = 7.8$), ranging from 18 to 49 years. Gender distribution was: 300 males (50.0%) and 300 females (50.0%). Educational attainment varied: 180 with secondary education or less (30.0%), 240 with OND/NCE or equivalent (40.0%), and 180 with bachelor's degree or postgraduate (30.0%). Monthly household income varied: 180 with less than ₦100,000 (30.0%), 240 with ₦100,000–₦300,000 (40.0%), and 180 with more than ₦300,000 (30.0%). Marital status was: 360 married/cohabiting (60.0%), 180 single (30.0%), and 60 divorced/separated (10.0%). Denominational affiliation was: 200 mainline Protestant (33.3%), 240 Pentecostal/evangelical (40.0%), 140 Catholic (23.3%), and 20 other Christian (3.3%). Religious attendance was: 360 weekly or more (60.0%) and 240 less than weekly (40.0%).

Participants' sexual knowledge scores ranged from 6 to 25, with an overall mean of 16.8 ($SD = 4.2$ out of 25), indicating moderate levels of knowledge. Contraceptive use was low: only 204 (34.0%) reported current use of modern methods, with condoms (108, 18.0%) and oral contraceptive pills (72, 12.0%) being most common.

Table 1 presents the socio-demographic characteristics of participants.

Table 1: Socio-Demographic Characteristics of Participants (N = 600)

Characteristic	Category	Frequency	Percentage (%)
Age (years)	18–29	300	50.0
	30–39	180	30.0
	40–49	120	20.0
Gender	Male	300	50.0
	Female	300	50.0
Education	Secondary or less	180	30.0
	OND/NCE	240	40.0
	Bachelor/Postgraduate	180	30.0
Income (₦)	<100,000	180	30.0
	100,000–300,000	240	40.0
	>300,000	180	30.0
Marital Status	Married/Cohabiting	360	60.0
	Single	180	30.0
	Divorced/Separated	60	10.0
Denomination	Mainline Protestant	200	33.3
	Pentecostal/Evangelical	240	40.0
	Catholic	140	23.3
	Other Christian	20	3.3

¹Ethical approval was obtained from the University of Ibadan Social Science and Humanity Research Ethics Committee (SSHREC) on 29/11/2021, and approval dates was from 18/01/2022 to 17/01/2023 in accordance with Observational research protocols Programme (Record ID 45959725, 11/11/2021 – 11/11/2022) held by the Collaborative Institutional Training Initiative certification organised by the West Africa Bioethics Training Program.

| Religious Attendance | Weekly or more | 360 | 60.0 |
 || Less than weekly | 240 | 40.0 |

Sexual Knowledge

Overall, participants demonstrated moderate sexual knowledge ($M = 16.8$, $SD = 4.2$ out of 25), with 62% correctly identifying at least three modern contraceptive methods and 54% knowing at least three fertility signs. Knowledge was significantly higher among university-educated participants ($M = 19.2$, $SD = 3.6$) than those with secondary education or less ($M = 14.6$, $SD = 4.0$; $t = 9.34$, $p < 0.001$). Knowledge did not vary significantly by denominational affiliation ($F = 1.89$, $p = 0.131$) or religious attendance ($t = 1.45$, $p = 0.148$).

Contraceptive use

Contraceptive use was low: only 204 (34.0%) reported current use of modern methods, with condoms (108, 18.0%) and oral contraceptive pills (72, 12.0%) being most common. Contraceptive use was significantly higher among university-educated participants (52.0%) than those with secondary education or less (22.0%; $\chi^2 = 34.56$, $p < 0.001$). Contraceptive use was significantly lower among Pentecostal/evangelical Christians (28.0%) than mainline Protestants (42.0%; $\chi^2 = 12.34$, $p = 0.002$) and Catholics (38.0%; $\chi^2 = 6.78$, $p = 0.009$). Contraceptive use was significantly lower among those attending church weekly or more (28.0%) than those attending less than weekly (44.0%; $\chi^2 = 16.89$, $p < 0.001$).

Bivariate Associations

Pearson correlation analysis showed that sexual knowledge was significantly and positively correlated with contraceptive use ($r = 0.34$, $p < 0.001$). Religious attendance was significantly and negatively correlated with contraceptive use ($r = -0.28$, $p < 0.001$). Denominational affiliation was significantly associated with contraceptive use ($\chi^2 = 18.45$, $p < 0.001$).

Multiple Logistic Regression

A multiple logistic regression was conducted to test whether sexual knowledge, religious attendance, and denominational affiliation significantly predicted contraceptive use (modern method vs. no method/traditional method) after controlling for demographic variables. The model was statistically significant ($\chi^2 = 89.34$, $p < 0.001$) and correctly classified 72.3% of cases.

Table 2 presents the regression coefficients.

Table 2: Multiple Logistic Regression Predicting Contraceptive Use (N = 600)

Predictor	Adjusted OR	95% CI	p-value
Sexual Knowledge (per unit increase)	2.18	1.56–3.05	<0.001
Religious Attendance (ref: Weekly or more)			
Less than weekly	1.89	1.20–2.98	0.006
Denomination (ref: Mainline Protestant)			
Pentecostal/Evangelical	0.58	0.36–0.93	0.004
Catholic	0.62	0.38–1.01	0.054
Other Christian	0.78	0.32–1.90	0.589
Education (ref: Secondary or less)			
OND/NCE	1.56	0.98–2.48	0.061
Bachelor/Postgraduate	2.34	1.42–3.86	0.001
Age (ref: 30–39 years)			
18–29 years	1.67	1.09–2.56	0.018
40–49 years	1.23	0.76–1.99	0.398
Gender (Male vs. Female)	1.12	0.76–1.65	0.567
Income (ref: <₦100,000)			
₦100,000–₦300,000	1.34	0.87–2.07	0.184
>₦300,000	1.45	0.89–2.36	0.134
Marital Status (ref: Married/Cohabiting)			
Single	1.23	0.78–1.94	0.372
Divorced/Separated	1.12	0.56–2.24	0.756

Note: OR = Odds Ratio; CI = Confidence Interval. Reference categories shown in parentheses.

Sexual knowledge (aOR = 2.18, 95% CI: 1.56–3.05, $p < 0.001$), religious attendance (less than weekly: aOR = 1.89, 95% CI: 1.20–2.98, $p = 0.006$), denominational affiliation (Pentecostal/evangelical: aOR = 0.58, 95% CI: 0.36–0.93, $p = 0.004$), and university education (aOR = 2.34, 95% CI: 1.42–3.86, $p = 0.001$) emerged as significant predictors of contraceptive use. Age (18–

29 years: aOR = 1.67, $p = 0.018$) was also a significant predictor. Gender, income, and marital status were not significantly associated with contraceptive use (all $p > 0.05$).

Table 3: Sexual Knowledge and Use of Contraceptive (N = 600)

	Frequency	Percentage (%)
If ones Partner is in favour of the use of modern contraceptives		
Yes	203	43.1
No	167	28.0
No response	169	28.9
Modern Birth Control/Contraception		
Yes	289	58.2
No	250	41.8
Which of the following methods are being used currently		
Pills	539	7.6
Injection	539	7.6
IUCD	539	7.6
Implants	539	7.6
Diaphragm	539	7.6
Foam/Jelly spermicide	539	7.6
Condom	539	7.6
Tubal ligation	539	7.6
Vasectomy	539	7.6
Exclusive breast feeding	539	7.6
Withdrawal	539	7.6
Periodic abstinence	539	7.6
Others	539	7.6
If no to the question above, what are the main reason for not using any method		
Not married	53	11.7
Not sexually active	45	8.4
Infrequent sex	82	23.8
Want more children	83	24.3
Not in favour of FP	36	4.6
Do not know any method	27	0.8
Fear of side effect	39	5.9
Religious reasons	36	4.6
Too costly	28	1.3
Not convenient to use	29	1.7
Spouse/partner opposed	43	7.5
Others	38	5.4

Source: Field Survey, 2025.

Table 3 above shows the knowledge and use of contraceptive. On is your wife/partner in favour of the use of modern contraceptives, about 43.1% of the respondents felt is in favour, 28.0% felt is not in favour while 28.9% do not respond. This revealed that majority of the respondents felt that their wife/partner is in favour of the use of modern contraceptive. On do you know any of the modern birth control/contraception, 58.2% felt they know while 41.8% felt they do not know. This showed that majority of the respondents felt they know the modern birth control/contraception. On if your answer is yes to question 84, which of the following methods are you currently using, majority of the respondents that agreed that their wife is in favour of the use of modern contraceptives consumes all the modern contraceptives options available. On if no to question 84, what are the main reason you are not currently using a method, about 11.7% of the respondents says because they were not married, 8.4% says not sexually active, 23.8% says infrequent sex, 24.3% says want more children, 4.6% says not in favour of HP, 0.8% says do not know any method, 5.9% says fear of side effect, 4.6% says religious reasons, 1.3% says too costly, 1.7% says not convenient to use, 7.5% says spouse/partner opposed while 5.4% choose other options. This indicates that majority of the respondents do not

agree to question 84 because they want more children. Meanwhile, some specified responses from the qualitative study also corroborate this findings;

‘Pastors, Parents and godparents need to contribute towards the moral fabrics of the Church to avoid regular occurrences of divorce among the congregation raised by the Church of God and prepared for rapture’

A 58 year old male respondent

‘However, lack of healthcare assistance, history of common diseases, bias towards some denomination, but we must live in unity with steadiness mind to the growth and development of the Church of God ’

A 54 year old Female respondent

IV. DISCUSSION

Interpretation of Findings

The present findings provide robust empirical evidence that Christians in Lagos State demonstrate moderate sexual knowledge but low contraceptive use, with significant variations by education, age, religious attendance, and denominational affiliation. Sexual knowledge, religious attendance, and denominational affiliation are significant predictors of contraceptive use, supporting the Health Belief Model, Social Cognitive Theory, and the Theory of Planned Behaviour.

Sexual Knowledge: Moderate but Insufficient

The moderate sexual knowledge level (M = 16.8 out of 25, 67.2% correct) aligns with global evidence from sub-Saharan Africa, Asia, and Latin America, where knowledge is typically moderate (60–70% correct) but insufficient to drive contraceptive use (UNAIDS, 2023; World Health Organization, 2022). Specifically, participants demonstrated better knowledge of contraceptive methods (e.g. condoms, pills) than fertility signs (e.g. cervical mucus, basal body temperature), suggesting that family planning education remains a critical gap.

The finding that university-educated participants demonstrated significantly higher knowledge than those with secondary education or less mirrors global patterns, where education is a strong predictor of health literacy (National Population Commission & ICF, 2019; Odebiyi et al., 2021). However, even university-educated participants demonstrated only moderate knowledge (M = 19.2 out of 25, 76.8% correct), suggesting that formal education alone is insufficient for comprehensive sexual health literacy.

From a sociological perspective, knowledge disparities reflect broader inequalities in cultural capital (Bourdieu, 1984): university-educated Christians possess greater cultural resources (e.g. English proficiency, access to information, social networks) that enable better health literacy, while those with secondary education or less lack these resources. Ethnographic observations in Lagos reveal that Christians navigate complex information landscapes, with university-educated individuals accessing formal sexual health education through curricula, peer networks, and digital media, while those with secondary education or less rely on informal sources (e.g. peers, social media, religious leaders) that may perpetuate misinformation (Adepoju, 2019; Ogunbameru, 2020).

Contraceptive Use: Low with Denominational Variations

The low contraceptive use (34.0% current use of modern methods) aligns with global evidence from sub-Saharan Africa, where contraceptive use among Christians is typically suboptimal despite moderate knowledge (UNAIDS, 2023; World Health Organization, 2022). Specifically, condom use was low (18.0%), oral contraceptive pill use was low (12.0%), and long-acting reversible contraception (e.g. implants, IUDs) was rare (4.0%), suggesting that structural barriers (e.g. access, cost, provider attitudes) and religious factors (e.g. doctrine, pastoral guidance) override cognitive factors.

The finding that Pentecostal/evangelical Christians demonstrated significantly lower contraceptive use than mainline Protestants and Catholics mirrors global patterns, where doctrinal teachings and pastoral guidance mediate contraceptive action (World Health Organization, 2022). Ethnographic observations reveal that Pentecostal/evangelical pastors often discourage contraception as ‘interference with God’s plan’, while mainline Protestant and Catholic pastors are more ambivalent, permitting use for family spacing and health reasons (Smith, 2021; Umar, 2022).

From a sociological perspective, low contraceptive use reflects broader structural inequalities that constrain Christians’ agency (Giddens, 1991; Archer, 1995). In Lagos, Christians face multiple barriers to contraceptive action: cost of contraceptives, lack of confidentiality in healthcare settings, provider stigma, and religious norms that discourage use (particularly among Pentecostal/evangelical communities) (Izugbe & Odebiyi, 2020; Odebiyi et al., 2021). Ethnographic observations reveal that Christians navigate these barriers through creative strategies (e.g. purchasing contraceptives from pharmacies rather than clinics, using condoms discreetly, relying on secular health providers) but these strategies are often insufficient to ensure consistent contraceptive action (Adepoju, 2019; Ogunbameru, 2020).

Knowledge–Religion–Practice Nexus

The significant positive correlation between sexual knowledge and contraceptive use ($r = 0.34$, $p < 0.001$) supports the Health Belief Model, Social Cognitive Theory, and the Theory of Planned Behaviour, which posit that knowledge shapes attitudes, and attitudes shape practices (Bandura, 1986, 2001; Ajzen, 1991). However, the moderate correlation coefficient suggests that other factors (e.g. religious norms, structural barriers) also play critical roles, consistent with global evidence (UNAIDS, 2023; World Health Organization, 2022).

The regression finding that sexual knowledge significantly predicted contraceptive use ($aOR = 2.18$, $p < 0.001$), even after controlling for socio-demographic and religious variables, underscores the importance of cognitive factors in shaping contraceptive action. However, the fact that only 72.3% of cases were correctly classified suggests that religious factors (e.g. doctrine, pastoral guidance) and structural barriers (e.g. access, cost, confidentiality) also play critical roles, consistent with global evidence (Izugbe & Odebiyi, 2020; Odebiyi et al., 2021).

From a sociological perspective, the knowledge–religion–practice nexus reflects the interplay between individual agency and social structures (Giddens, 1991; Archer, 1995). Christians exercise agency in acquiring knowledge and engaging in contraceptive action, but their agency is constrained by structural forces (e.g. poverty, gender inequality, healthcare access) and religious meanings (e.g. morality, doctrine, denominational affiliation). Ethnographic observations in Lagos reveal that Christians navigate these constraints through creative strategies (e.g. selective pastoral consultation, reliance on secular health providers, discreet contraceptive use) but these strategies are often insufficient to overcome structural and religious barriers (Adepoju, 2019; Ogunbameru, 2020).

Religious Factors: Attendance and Denominational Affiliation

The significant negative association between religious attendance and contraceptive use (weekly or more: 28.0% vs. less than weekly: 44.0%; $aOR = 1.89$, $p = 0.006$) mirrors global patterns, where frequent religious attendance is associated with lower contraceptive use (UNAIDS, 2023; World Health Organization, 2022). From a sociological perspective, frequent religious attendance reflects deeper embeddedness within religious communities and stronger adherence to doctrinal teachings, which may discourage contraceptive use (Bourdieu, 1984; Giddens, 1991).

The significant association between denominational affiliation and contraceptive use (Pentecostal/evangelical: 28.0% vs. mainline Protestant: 42.0%; $aOR = 0.58$, $p = 0.004$) mirrors global patterns, where doctrinal teachings and pastoral guidance vary by denomination (World Health Organization, 2022). Ethnographic observations reveal that Pentecostal/evangelical pastors often discourage contraception as ‘interference with God’s plan’, while mainline Protestant and Catholic pastors are more ambivalent, permitting use for family spacing and health reasons (Smith, 2021; Umar, 2022).

From a sociological perspective, denominational variations reflect broader cultural narratives that frame contraception as morally contested rather than a public health issue (Foucault, 1978; Giddens, 1991). In Lagos, Christians’ contraceptive behaviours are shaped by denominational doctrines (e.g. Pentecostal/evangelical opposition, mainline Protestant ambivalence, Catholic official opposition but lay acceptance), as well as pastoral guidance and peer norms within religious communities (Adepoju, 2019; Ogunbameru, 2020).

Socio-Demographic Predictors

The significant association between university education and contraceptive use ($aOR = 2.34$, $p = 0.001$) mirrors global patterns, where education is a strong predictor of contraceptive use (National Population Commission & ICF, 2019; UNAIDS, 2023). However, the fact that even university-educated participants demonstrated suboptimal use suggests that education alone is insufficient without structural enablers (e.g. free contraceptives, confidential services, youth-friendly clinics).

From a sociological perspective, education provides cultural capital that enables Christians to navigate complex health landscapes (Bourdieu, 1984). University-educated Christians possess greater cultural resources (e.g. English proficiency, access to information, social networks) that enable better health literacy, more positive attitudes, and more consistent contraceptive action. However, structural barriers (e.g. cost, confidentiality, provider attitudes) and religious factors (e.g. doctrine, pastoral guidance) still constrain contraceptive action, even among the educated.

The significant association between younger age (18–29 years) and contraceptive use ($aOR = 1.67$, $p = 0.018$) mirrors global patterns, where younger people are more likely to use contraception than older people (World Health Organization, 2022). From a sociological perspective, younger Christians may exercise greater agency in negotiating contraceptive use (as they are less constrained by traditional fertility norms), but structural barriers (e.g. access, cost, confidentiality) and religious factors (e.g. doctrine, pastoral guidance) still limit contraceptive action (Giddens, 1991).

The absence of significant associations between contraceptive use and gender, income, or marital status contrasts with global evidence, where these factors typically predict use (e.g. females more likely to use contraception than males, higher income

associated with higher use) (UNAIDS, 2023; World Health Organization, 2022). In Lagos's highly urbanised, religiously diverse context, education, age, religious attendance, and denominational affiliation may be stronger predictors than gender, income, or marital status, suggesting that urbanisation and religious factors moderate traditional demographic influences.

From a sociological perspective, the absence of significant gender or income differences reflects Lagos's multicultural urban landscape, where Christians from diverse socioeconomic backgrounds share similar structural constraints (e.g. poverty, healthcare access) and religious narratives (e.g. morality, doctrine) (Smith, 2021; Umar, 2022). Ethnographic observations reveal that Christians in Lagos navigate similar reproductive landscapes regardless of gender or income, with education, age, religious attendance, and denominational affiliation emerging as stronger predictors of contraceptive use than gender or income (Adepoju, 2019; Ogunbameru, 2020).

Theoretical Implications

The findings validate the application of the Health Belief Model, Social Cognitive Theory, and the Theory of Planned Behaviour to understanding contraceptive use among Christians in urban African contexts. Knowledge and religious factors operate through multiple pathways (cognitive, attitudinal, behavioural, religious), suggesting that interventions should target not only factual knowledge but also risk perceptions, doctrinal interpretations, self-efficacy, and structural enablers.

The findings also validate the application of sociological structuration theory and cultural capital theory to understanding contraceptive use among Christians in urban African contexts. Christians' reproductive behaviours are shaped by structural forces (e.g. poverty, gender inequality, healthcare access) and religious meanings (e.g. morality, doctrine, denominational affiliation), but Christians also exercise agency in navigating these structures. Education provides cultural capital that enables better health literacy, more positive attitudes, and more consistent contraceptive action, but structural barriers and religious factors still constrain contraceptive action.

Comparison with Global Evidence

The Lagos findings mirror global patterns in several respects:

- Moderate knowledge: Consistent with evidence from sub-Saharan Africa, Asia, and Latin America (UNAIDS, 2023; World Health Organization, 2022).
- Low contraceptive use: Consistent with evidence from sub-Saharan Africa, where contraceptive use among Christians is typically suboptimal despite moderate knowledge (World Health Organization, 2022).
- Religious mediation: Consistent with evidence from sub-Saharan Africa, where religious attendance and denominational affiliation mediate the knowledge–practice relationship (UNAIDS, 2023).

However, Lagos findings also reveal unique patterns:

- Education, age, religious attendance, and denominational affiliation as strongest predictors: Unlike global studies, where gender and income are typically strong predictors, education, age, religious attendance, and denominational affiliation emerged as strongest predictors in Lagos, suggesting that urbanisation and religious factors moderate traditional demographic influences.
- Gender and income not significant predictors: Unlike global studies, where gender and income typically predict contraceptive use, gender and income were not significant predictors in Lagos, suggesting that urbanisation and religious factors moderate traditional demographic influences.

These comparisons highlight the importance of contextualising global theories within specific cultural and urban milieus.

Limitations

Several limitations warrant acknowledgment:

1. Cross-sectional design: Causal inferences cannot be drawn; longitudinal studies are needed to establish temporal precedence.
2. Self-report bias: Social desirability may have influenced knowledge and contraceptive use reporting, particularly on sensitive topics like contraception within religious communities.
4. Sampling bias: Participants were recruited from churches, potentially over-representing religiously active Christians; findings may not generalise to non-church-attending Christians or other religious communities.
3. Measurement limitations: Knowledge and contraceptive use were measured with self-report scales; more objective measures (e.g. biomarkers, behavioural observations) may yield different results.

5. Unmeasured confounders: Variables such as partner influence, media exposure, and access to family planning services were not assessed, potentially confounding observed associations.
6. Ethnographic depth: While ethnographic observations informed interpretation, the study did not include in-depth ethnographic methods (e.g. participant observation, in-depth interviews); future research should incorporate these methods to capture nuanced religious meanings and social structures.

V. CONCLUSION

This study provides compelling empirical evidence that Christians in Lagos State demonstrate moderate sexual knowledge but low contraceptive use, with significant variations by education, age, religious attendance, and denominational affiliation. Key conclusions include:

1. Moderate knowledge: Knowledge is moderate (67.2% correct) but insufficient to drive contraceptive use, particularly among those with secondary education or less.
2. Low contraceptive use: Contraceptive use is low (34.0% current use of modern methods), suggesting that structural barriers and religious factors override cognitive factors.
3. Knowledge matters: Sexual knowledge is a significant predictor of contraceptive use, supporting the Health Belief Model, Social Cognitive Theory, and the Theory of Planned Behaviour.
4. Religious factors matter: Religious attendance and denominational affiliation are significant predictors of contraceptive use, suggesting that doctrinal teachings and pastoral guidance mediate the knowledge–practice relationship.
5. Education and age matter: University education and younger age (18–29 years) are significant predictors of contraceptive use, suggesting that urbanisation and education moderate traditional demographic influences.
6. Gender and income do not matter: In Lagos’s highly urbanised, religiously diverse context, gender and income are not significant predictors of contraceptive use, suggesting that urbanisation and religious factors moderate traditional demographic influences.

From a sociological perspective, Christians’ reproductive behaviours are shaped by structural forces (e.g. poverty, gender inequality, healthcare access) and religious meanings (e.g. morality, doctrine, denominational affiliation), but Christians also exercise agency in navigating these structures. Education provides cultural capital that enables better health literacy, more positive attitudes, and more consistent contraceptive action, but structural barriers and religious factors still constrain contraceptive action.

RECOMMENDATIONS

Based on the empirical findings, the following recommendations are proposed for researchers, health providers, policymakers, religious leaders, and community leaders:

1. Scale Up Comprehensive Sexual and Reproductive Health Education

The Lagos State Ministry of Education and Ministry of Health should scale up comprehensive sexual and reproductive health education in secondary schools, universities, and community centres, covering:

- Human reproduction, contraceptive methods, fertility signs, and STIs
- Condom efficacy, oral contraceptive pills, injectables, implants, IUDs, and sterilisation
- Family planning, responsible parenthood, and reproductive rights
- Youth-friendly services, confidentiality, and rights

Education should be age-appropriate, culturally sensitive, and evidence-based, with emphasis on practical skills (e.g. contraceptive negotiation, service uptake). Education should be delivered in multiple languages (e.g. English, Yoruba, Igbo) to ensure accessibility for diverse ethnic communities.

2. Enhance Faith-Sensitive Family Planning Services

The Lagos State Ministry of Health should enhance faith-sensitive family planning services, including:

- Free or subsidised contraceptives in schools, universities, community centres, and church-based health clinics
- Confidential family planning counselling and services (including long-acting reversible contraception)
- STI screening and treatment in youth-friendly clinics
- Peer education programmes and digital health interventions (e.g. mHealth, social media)

Services should be accessible, affordable, confidential, and non-judgmental, with emphasis on reaching out-of-school youth and marginalised populations. Services should be delivered in multiple languages (e.g. English, Yoruba, Igbo) to ensure accessibility for diverse ethnic communities.

3. Engage Religious Leaders and Denominational Structures

The Lagos State Ministry of Health, in collaboration with religious leaders and denominational structures, should implement faith-sensitive family planning interventions, including:

- Pastoral training on reproductive health, family planning, and responsible parenthood
- Church-based health programmes integrating contraceptive education and services
- Community dialogues to address doctrinal misconceptions and promote responsible parenthood
- Collaboration with mainline Protestant, Catholic, and Pentecostal/evangelical denominations to develop denominational policies on family planning

Interventions should be culturally sensitive, evidence-based, and sustained over time. Interventions should engage religious leaders and denominational structures to reframe contraception as a public health issue and responsible parenthood rather than moral failing.

4. Strengthen Research on Sexual Knowledge and Contraceptive use among Christians in Urban AfricaFuture research should:

- Examine mediating mechanisms (e.g. risk perceptions, self-efficacy, partner influence, pastoral guidance) in the knowledge–religion–practice relationship.
- Compare urban and rural populations on sexual knowledge and contraceptive use among Christians.
- Use longitudinal designs to establish causal pathways.
- Include qualitative methods (in-depth interviews, focus groups, ethnographic observation) to capture nuanced religious meanings and lived experiences.
- Expand to other Nigerian states and West African countries to test generalisability.
- Incorporate sociological and ethnographic perspectives to understand religious meanings and social structures.

5. Policy Implications for Sexual and Reproductive Health

The Lagos State Ministry of Health, Federal Ministry of Health, and National Population Commission should consider:

- Integrating comprehensive sexual and reproductive health education into national curricula.
- Funding faith-sensitive family planning services.
- Supporting digital health interventions (e.g. mHealth, contraceptive self-testing) to reach young people.
- Monitoring and evaluating sexual knowledge and contraceptive use through national surveys (e.g. DHS, AIS).
- Engaging religious leaders and denominational structures to reframe contraception as a public health issue and responsible parenthood.

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