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Religious Orientation and Socioeconomic Status as Predictors of Attitude Toward Contraceptive Use among Married Couples

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Abstract

This article examined how religious orientation and socioeconomic status affect married couples' attitudes toward contraceptive use in Anambra State, Nigeria. A total of 397 married people took part in the study. Descriptive analysis showed a wide age span (*M*age= 42.46 years), various lengths of marriage, and a moderate spread in religiosity and socioeconomic class. Pearson correlation analysis showed a significant positive link between religious orientation and socioeconomic class (r= 0.216, p <.01), a small but statistically significant negative link between religious orientation and contraceptive attitude (r= 0.104, p <.05), and a non-significant link between socioeconomic class and contraceptive attitude (r= 0.064). Hierarchical multiple regression analysis was done in three models: Model 1 (demographics) explained 49.4 of the variation in contraceptive attitudes r^2= 0.506; Model 2 (adding religious orientation) raised the explained variation to 54.2, Δr^2= 0.037, with religious orientation having a significant negative effect β= 0.245, p <.001; Model 3 (adding socioeconomic status) bumped the explanatory power further to 59.2, r^2= 0.592, with socioeconomic status positively predicting contraceptive attitude β= 0.416, p <.001. The results shows that greater religiosity has the tendency to undermine positive views of contraception, but greater socioeconomic resources have the tendency to foster positive views of contraception. The combined influence of religious orientation and socioeconomic status indicates that reproductive health interventions in Nigeria should traverse the nexus of faith and economic context to shape contraceptive perceptions among married couples.
Key words: religious orientation, socioeconomic status, contraceptive attitude.

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Novelty and Significance

What is already known about the topic?

- Religious orientation and socioeconomic status are established determinants of reproductive health attitudes and behaviors in sub-Saharan Africa, though most studies rely on affiliation-based rather than orientation-based measures of religiosity.
- Higher socioeconomic status is consistently associated with greater knowledge of and positive attitudes toward modern contraceptive methods, particularly in Nigeria, where education, income, and occupation intersect with fertility decision-making.

What this paper adds?

- This study moves beyond religious affiliation to examine intrinsic vs. extrinsic religiosity as a predictor of contraceptive attitudes among married couples in Anambra State, Nigeria.
- This study shows the combined predictive value of religious orientation and socioeconomic status on contraceptive attitudes, providing evidence that reproductive health interventions in Nigeria must simultaneously address both the faith-based and material dimensions of family planning decision-making.

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Religion and socioeconomic conditions remain central to understanding reproductive behaviour, particularly in contexts where both domains exert strong normative and structural influence. Nigeria represents one such setting, characterized by deep religiosity alongside marked socioeconomic inequalities. Within this environment, religion functions not only as a system of belief but also as a moral framework and social regulator that shapes expectations around sexuality and childbearing. As noted by Adedini, Babalola, Akiode, Odiase, and Palamuleni (2018), religious institutions often articulate prescriptions for ideal sexual conduct and reproductive practices. In many cases, childbearing is interpreted as a divine blessing, which can foster resistance toward contraceptive use when it is perceived as interfering with God's will.

That said, this interpretation risks oversimplification. Religious influence is neither uniform nor static. While some doctrines discourage artificial contraception, empirical evidence suggests that religious messaging can also be mobilized to support family planning. For instance, Adedini *et alii* (2018), using a Measurement and Learning for Evaluation (MLE) dataset, found that exposure to religion-compatible messaging increased the likelihood of adopting modern contraceptive methods by approximately 70%. This introduces an important tension, religion can both constrain and enable contraceptive behaviour depending on how it is interpreted and communicated.

Alongside religion, socioeconomic status (SES) plays a critical role in shaping reproductive choices by influencing access to information, healthcare services, and decision-making autonomy. Individuals in lower socioeconomic strata often face structural barriers to family planning, including limited awareness and restricted access to services. Conversely, those in higher socioeconomic groups tend to have greater exposure to health information and improved capacity to utilize reproductive health services. Lamidi (2015) demonstrated that education, employment status, and household wealth significantly predict contraceptive uptake, while Ejembi, Dahiru, and Aliyu (2015) and Ukoji, Anele, and Imo (2022) further highlight the importance of both individual and community-level socioeconomic factors in explaining disparities in contraceptive practices.

However, even this relationship is not straightforward. Evidence from the Nigerian Demographic and Health Survey (Sani, Oluyomi, Wali, Ahmed, & Halane, 2025) indicates that higher levels of knowledge do not always translate into increased contraceptive use, particularly within highly religious communities. This suggests that attitudinal and normative factors may override purely informational or economic advantages. In a similar vein, Obasohan (2015) found that religion and ethnicity jointly predict contraceptive behaviour, with more restrictive cultural and religious environments associated with lower adoption of modern methods.

These dynamics are especially pronounced in specific socio-cultural contexts such as Anambra State in southeastern Nigeria, where strong religious commitments intersect with evolving economic realities. Within such settings, married individuals may experience competing pressures. On one hand, religious teachings, particularly within Christianity, may discourage artificial contraception. On the other, economic constraints, including the rising costs of healthcare and childrearing, create practical incentives for limiting family size. This tension places individuals in a complex decision-making position that cannot be fully explained by either religion or socioeconomic status in isolation.

Despite substantial research on religion and socioeconomic determinants of contraceptive use in Nigeria, several important gaps remain. First, much of the existing literature conceptualizes religion in terms of affiliation (e.g., Christian, Muslim, traditional) rather than examining variations in religiosity itself. This overlooks differences in how individuals internalize and practice their faith.

The *Religious Orientation Theory* proposed by Allport and Ross (1967) addresses this limitation by distinguishing between intrinsic religiosity, where religion is internalized

and lived as an end in itself, and extrinsic religiosity, where religion is used instrumentally for personal or social gain.

Secondly, large-scale datasets such as the NDHS provide valuable population-level insights but often fail to capture the psychological and interpretive dimensions of religious experience. As a result, the mechanisms through which religiosity shapes attitudes toward contraception remain underexplored. Third, there is limited attention to how religiosity and socioeconomic status interact, rather than operate independently, in influencing reproductive decision-making.

The present study addresses these gaps by integrating Religious Orientation Theory with socioeconomic perspectives to examine attitudes toward contraceptive use. Prior research suggests that individuals with intrinsic religious orientation tend to exhibit greater moral consistency and are more likely to align their behaviour with religious teachings (Donahue, 1985; Maltby, 2002). In contrast, those with extrinsic orientation may adopt a more pragmatic approach, weighing social, economic, and health considerations. Applied to reproductive behaviour, this implies that intrinsic religiosity may be associated with less favourable attitudes toward contraception, whereas extrinsic religiosity may allow for greater flexibility.

Socioeconomic status, conceptualized through education, income, and occupation (Adler *et alii*, 1994), further shapes individuals' capacity to act on these attitudes. While higher SES is generally associated with increased fertility control (Shapiro & Tambashe, 1994), its effects may be moderated by the strength and nature of religious commitment. For instance, Odulami (2022) and Wusu (2015) demonstrate that strong religious norms can limit contraceptive uptake even among relatively advantaged groups.

Attitudes toward contraceptive use, as conceptualized within the Theory of Planned Behavior (Ajzen, 1991), reflect individuals' evaluations of the acceptability and desirability of engaging in contraceptive practices. Importantly, knowledge alone does not determine these attitudes, as belief systems and moral frameworks often serve as intervening variables (Nsubuga, Sekandi, Sempeera, & Makumbi, 2016; Sanjayanthan *et alii*, 2026).

Taken together, this study conceptualizes reproductive decision-making as a product of both structural capacity and interpretive frameworks. Religious orientation provides the lens through which individuals interpret reproductive choices, while socioeconomic status determines the extent to which those choices can be enacted. It is therefore proposed that religious orientation moderates the relationship between socioeconomic status and attitudes toward contraceptive use. Specifically, individuals with higher socioeconomic status may exhibit more favourable attitudes toward contraception, but this relationship is expected to weaken or reverse among those with strong intrinsic religious orientation.

This study aims to explore how religious orientation and socioeconomic status interact to affect married couples' attitudes toward contraceptive use in Anambra State, Nigeria. The basis of this study is established through the lens of Religious Orientation theory. The study focused specifically on three objectives: To determine if religious orientation is a significant predictor of married couples' attitudes toward contraception; To assess how socioeconomic status influences attitudes toward contraception; and to analyze how religious orientation and socioeconomic status interact to predict attitudes toward contraception.

Method

Participants

The target population consisted of married men and women residing in Anambra State. The inclusion criteria were established as being legally married and living with

his spouse; having resided in the state for at least 1 year; and signing the informed consent. An attempt was made to ensure that the sample reflected a broad socioeconomic distribution, guaranteeing the representation of participants from low-income, middle-income, and high-income groups, considering that demographic diversity improves the external validity and generalizability of the results. A total of 397 married adults (53.1% females) participated in the study.

Instruments and Measures

Data were collected using standardized and validated instruments organized into four sections: demographic information, religious orientation, socioeconomic status, and contraceptive attitude.

Demographic Information. This section contained items on age, gender, marital duration, number of children, level of education, occupation, type of marriage, religious affiliation, and denomination. These variables provided background data for describing the sample and controlling for demographic influences in statistical analysis.

Religious Orientation Scale (Allport & Ross, 1967). This 21-item instrument measured intrinsic and extrinsic religious orientation. Respondents rated each statement on a 5-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5). Sample items included "My whole approach to life is based on my religion" and "What religion offers me most is comfort in times of trouble." Higher scores indicated stronger religious orientation. The scale showed good internal consistency in this study (Cronbach's α= 0.84).

Status Scale (Saleem, 2019). The scale assessed participants' educational attainment, occupation, and income. Scores were summed and categorized into five levels, ranging from low to high socioeconomic class. The scale showed a Cronbach's α of 0.81 in this study, indicating acceptable reliability.

Contraceptive Attitude Scale (Aksu, Aksoy, Gurcuoglu, & Erenel, 2022). This 25-item instrument measured participants' perceptions and attitudes toward contraceptive use. Responses were rated on a 4-point scale from Strongly Disagree (1) to Strongly Agree (4). Higher scores reflected more positive attitudes toward contraception. The scale's internal consistency reliability in this study was α= 0.86.

Design

This study adopted a quantitative cross-sectional survey design. This design was considered most appropriate because the research aimed to obtain data from a relatively large group of married couples at a single point in time to determine the predictive influence of religious orientation and socioeconomic status on attitude toward contraceptive use.

Procedure

The study employed a multi-stage sampling procedure to ensure adequate representation of participants across the senatorial zones. At the first stage, three local government areas (LGAs) were purposively selected from each zone based on accessibility and the presence of active religious institutions. At the second stage, two communities were randomly chosen from each LGA, giving a total of nine communities. Within each community, participants were recruited through churches, community health centers, community meetings, and family networks.

Prior to data collection, the researchers explained the objectives of the study to potential participants, emphasizing that participation was entirely voluntary, responses would be kept confidential, and data would be used solely for academic purposes. A

structured questionnaire was administered face-to-face to participants who met the inclusion criteria while returned the questionnaires after filling it out themselves. Assistance was provided to those with limited literacy skills. Ethical integrity was maintained throughout the research process. Confidentiality and anonymity were strictly observed; no identifying information was recorded. Participants were informed that they could withdraw at any stage without penalty.

Data Analysis

Data were analyzed using the *Statistical Package for the Social Sciences* (SPSS, Version 25). To summarize the demographic characteristics of the participants and the main study variables, descriptive statistics such as mean, standard deviation, skewness, and kurtosis were used. The relationships between religious orientation, socioeconomic status, and attitude toward contraception were determined using Pearson's correlation coefficient. Likewise, to assess the predictive power of religious orientation and socioeconomic status on attitude toward contraception, controlling for demographic factors, a hierarchical multiple regression analysis was performed. Statistical significance was set at $p < .05$.

RESULTS

Participants' ages ranged from 28 to 69 years (M= 42.46, SD= 10.34). A total of 397 participants were included in the final analysis after screening for completeness of responses. Descriptive statistics for all variables in the study are shown in Table 1.

Table 1. Descriptive Statistics of Participants' Demographic data.

	N	*Mi-Max*	*M* (*SD*)	Skewness (*SE*)	Kurtosis (*SE*)
Age	397	28-69	42.46 (10.340)	.894 (.122)	.277 (.244)
Marital Duration	397	0-20	8.38 (5.897)	.490 (.122)	-1.025 (.244)
Number of Children	397	0-5	2.69 (1.423)	-.077 (.122)	-1.050 (.244)
Socioeconomic Class	397	1-5	3.25 (1.461)	-.360 (.122)	-1.223 (.244)
Religious Orientation	397	42-76	56.60 (6.860)	.616 (.122)	1.622 (.244)
Contraceptive Attitude	397	49-98	70.25 (10.777)	.310 (.122)	.713 (.244)

Notes: *Mi-Max*= Minimun-Maximun; *SD*= Standard Deviation; *SE*= Standard Error.

Pearson correlation analysis was conducted to examine the relationships among religious orientation, socioeconomic status, and contraceptive attitude (see Table 2). Religious orientation was positively correlated with socioeconomic status (r= 0.216, $p < .01$). Religious orientation was negatively correlated with contraceptive attitude (r= -0.104, $p < .05$). The correlation between socioeconomic status and contraceptive attitude was not statistically significant (r= -0.064, $p > .05$). The relationship among religious orientation, socioeconomic class, and contraceptive attitude among participants is found in Table 2.

Table 2. Correlations among Religious Orientation, Socioeconomic class, and Contraceptive attitude.

	Religious Orientation	Socioeconomic Class
Religious Orientation	--	
Socioeconomic Class	.216**	--
Contraceptive Attitude	-.104*	-.064

*= Significant at .05 (2-tailed); **= Significant at .01 (2-tailed).

A hierarchical multiple regression analysis was conducted to examine the extent to which religious orientation and socioeconomic status predicted contraceptive attitude after controlling for demographic variables (see Table 3).

Table 3. Hierarchical Multiple Regression Predicting Contraceptive Attitude from Demographics, Religious Orientations, and Socioeconomic Status.

	Model	β	t	p	95% CI for β		CS		r	r^2	Δr^2	Durbin Watson
					LB	UP	Tolerance	VIF				
	(Constant)		20.223	.000	56.931	69.192						
	Gender	.088	1.851	.065	-.118	3.893	.570	1.756				
	Age	.025	.410	.682	-.099	.152	.341	2.932				
	Marital Duration	.637	6.709	.000	.823	1.505	.142	7.051				
	Number of children	-.588	-6.130	.000	-5.881	-3.025	.139	7.195				
1	Education Level	.403	5.446	.000	2.301	4.901	.233	4.288	.712	.506	.494	
	Occupation	-.098	-1.600	.110	-1.447	.149	.342	2.921				
	Religious Affiliation	-.470	-5.860	.000	-6.479	-3.224	.198	5.040				
	Denomination	.933	8.941	.000	4.996	7.812	.117	8.521				
	Type of Marriage	.034	.571	.568	-2.295	4.172	.354	2.826				
	Contraceptive use	-.598	-13.479	.000	-9.046	-6.743	.649	1.541				
	(Constant)		14.798	.000	80.968	105.781						
	Gender	.067	1.459	.145	-.500	3.381	.566	1.768				
	Age	-.092	-1.471	.142	-.225	.032	.301	3.321				
	Marital Duration	.570	6.167	.000	.709	1.373	.139	7.178				
	Number of children	-.421	-4.321	.000	-4.640	-1.738	.125	7.979				
2	Education Level	.290	3.892	.000	1.279	3.892	.215	4.653	.736	.542	.529	
	Occupation	-.245	-3.779	.000	-2.472	-.780	.283	3.531				
	Religious Affiliation	-.370	-4.648	.000	-5.428	-2.201	.188	5.325				
	Denomination	.702	6.423	.000	3.341	6.289	.100	10.030				
	Type of Marriage	.221	3.280	.001	2.418	9.654	.263	3.803				
	Contraceptive use	-.645	-14.771	.000	-9.642	-7.376	.624	1.602				
	Religious Orientation	-.245	-5.465	.000	-.524	-.247	.590	1.694				
	(Constant)		11.397	.000	61.833	87.616						
	Gender	.049	1.134	.258	-.778	2.897	.564	1.774				
	Age	.004	.072	.943	-.121	.130	.285	3.509				
	Marital Duration	.452	5.073	.000	.506	1.145	.134	7.458				
	Number of children	-.622	-6.436	.000	-6.151	-3.272	.114	8.790				
	Education Level	.408	5.632	.000	2.370	4.913	.203	4.933				
3	Occupation	.068	.888	.375	-.547	1.448	.182	5.491	.769	.592	.579	2.166
	Religious Affiliation	-.581	-7.148	.000	-7.642	-4.345	.161	6.220				
	Denomination	1.119	9.334	.000	6.063	9.298	.074	13.528				
	Type of Marriage	.051	.743	.458	-2.284	5.059	.228	4.382				
	Contraceptive use	-.738	-16.987	.000	-10.868	-8.613	.563	1.776				
	Religious Orientation	-.201	-4.686	.000	-.449	-.183	.577	1.733				
	Socioeconomic Status	.416	6.850	.000	2.190	3.954	.288	3.478				

Notes= β= Beta coefficient; *CI*= Confidence Interval; *CS*= Collinearity Statistics; DV= Contraceptive Attitude; LB= Lower Bound; t= t-test value; r= correlation coefficient; r^2= coefficient of determination; UB= Upper Bound; *VIF*= Variance Inflation Factor.

In Model 1, demographic variables (gender, age, marital duration, number of children, education level, occupation, religious affiliation, denomination, type of marriage, and contraceptive use) were entered. The model was significant and accounted for 50.6% of the variance in contraceptive attitude (R^2= 0.506, Adjusted R^2= 0.494). Significant predictors included marital duration (β= 0.637, p <.001), education level (β= 0.403, p <.001), denomination (β= 0.933, p <.001), number of children (β= -0.588, p <.001), religious affiliation (β= -0.470, p <.001), and contraceptive use (β= -0.598, p <.001).

In Model 2, religious orientation was added. The model accounted for 54.2% of the variance (R^2= 0.542, Adjusted R^2= 0.529). Religious orientation was a significant predictor (β= -0.245, t= -5.465, p <.001).

In Model 3, socioeconomic status was entered alongside religious orientation. The model accounted for 59.2% of the variance in contraceptive attitude (R^2= 0.592, Adjusted R^2= 0.579). Socioeconomic status was a significant predictor (β= 0.416, t= 6.850, p <.001). The change in explained variance from Model 2 to Model 3 was significant (ΔR^2= 0.037, p <.001).

Discussion

This study examined how religious orientation and socioeconomic status interact to shape married couples' attitudes toward contraceptive use in Anambra State, Nigeria, guided by Religious Orientation Theory. Specifically, it sought to determine whether religious orientation predicts contraceptive attitudes, assess the role of socioeconomic status, and examine the combined influence of both factors. The findings address each of these objectives and are discussed below in relation to the existing literature, theoretical expectations, and the limitations that circumscribe their interpretation.

The first objective concerned the predictive role of religious orientation. Consistent with expectations derived from Religious Orientation Theory (Allport & Ross, 1967), religious orientation emerged as a significant negative predictor of contraceptive attitudes, such that more strongly religious individuals tended to hold less favorable views toward contraceptive use. This finding aligns with a well-established pattern in the Nigerian literature. Osuafor and Mturi (2013) similarly found that the contraceptive behavior of married women in Nigeria was more strongly shaped by religious values than by other social factors, with the direction of association varying by denomination. At a broader regional level, a qualitative synthesis of evidence from Sub-Saharan Africa found that both Muslim and Christian respondents frequently cited religious belief as a source of concern about contraceptive use, viewing it as incompatible with divinely sanctioned reproductive norms (Turner, 2021). The present findings extend this pattern to the domain of attitudes rather than behavior alone and situate it within a sample drawn from a state where religion exerts particularly strong social influence. It is worth noting, however, that the relationship between religious orientation and contraceptive attitudes does not imply that religion functions simply as a barrier. The data suggests a more nuanced picture: religious values shape the lens through which couples evaluate contraception, but they do not uniformly prohibit openness to family planning. Some religious leaders actively promote birth spacing, even while expressing reservations about specific contraceptive technologies. This points to the potential for religiously sensitive communication strategies as a pathway for change, rather than treating religious conviction as a fixed obstacle.

Turning to the second objective, socioeconomic status was found to be a significant positive predictor of contraceptive attitudes, with higher levels of education, income, and occupational standing associated with more favorable orientations toward contraception. This is consistent with the findings of researchers who document the positive relationship between socioeconomic empowerment and reproductive autonomy (Ekholuenetale, Owobi, & Shishi, 2022; Andeskebtso & Ugochukwu, 2023). Education, as a central component of socioeconomic status, appears to broaden access to information about modern contraceptive options and to reduce susceptibility to restrictive normative influences (Okunlola, 2022). Income and occupational prestige reinforce this effect by improving access to healthcare services and by shifting the cost-benefit calculus of family planning in favor of fertility control. The financial pressures associated with raising children in Nigeria provide a plausible pathway through which higher economic standing translates into greater openness to contraception, as wealthier couples may be more motivated to weigh and manage the economic implications of family size. The finding from Okunlola (2022) that wealth index and socioeconomic standing are primary predictors of modern contraceptive uptake in Nigeria lends further support to the pattern observed here.

The third objective concerned the combined and interactive influence of both predictors. The hierarchical regression analysis showed that religious orientation and socioeconomic status together accounted for a substantial proportion of variance in contraceptive attitudes beyond what demographic variables alone could explain, and that both predictors remained significant in the fully specified model. This joint contribution is

theoretically meaningful. As Ajzen (1991) argues within the Theory of Planned Behavior, attitudes are shaped by both personal beliefs and perceived behavioral control, the latter of which is closely tied to material resources. The present findings suggest that these two forces (faith commitment and economic circumstance) operate simultaneously and, to some extent, in tension. Individuals with higher socioeconomic standing may possess the material resources and informational access that support favorable contraceptive attitudes, yet strong intrinsic religious orientation can attenuate this positive association. Conversely, lower socioeconomic status, combined with strong embeddedness in religiously conservative communities, may compound the barriers to accepting contraception. The interaction of these forces underscores the inadequacy of purely economic or purely faith-based explanations of reproductive attitudes in the Nigerian context, and points to the value of integrated analytical frameworks.

These findings carry implications for how reproductive health research and programming in Nigeria might be conceptualized, though it is essential to interpret them with appropriate caution. The study is correlational in design, which means that no causal inferences can be drawn from the data. The observed associations between religious orientation, socioeconomic status, and contraceptive attitudes describe co-variation at a single point in time; they do not establish that changes in religiosity or socioeconomic standing would produce corresponding changes in attitudes. The theoretical mechanisms proposed here (moderation, mediation, and interactive effects) remain hypotheses to be tested in longitudinal and experimental designs. Furthermore, the findings are drawn from a convenience sample of married adults in Anambra State, a predominantly Igbo-Christian region. It is not known whether the patterns observed here would generalize to other states, ethnic groups, or religious communities in Nigeria, or to other sub-Saharan African contexts.

Several methodological limitations should be noted. First, although the sample size is adequate for the main regression models, it limits the statistical power required to detect subtle subgroup differences (e.g., interactions between intrinsic and extrinsic religious orientations across socioeconomic status levels). Second, all data were collected through self-report, raising the possibility of socially desirable responding, particularly on sensitive topics such as contraceptive attitudes and religiosity. Participants may have moderated their expressed attitudes in light of perceived community norms, which would tend to attenuate observed associations. Third, the cross-sectional design precludes any assessment of how attitudes may change over time in response to shifting religious engagement, economic mobility, or exposure to family planning interventions.

These limitations point to a clear agenda for future research. Longitudinal designs tracking couples over time would allow researchers to examine whether and how changes in religious orientation or socioeconomic circumstances predict shifts in contraceptive attitudes, and would enable the identification of causal pathways rather than static associations. Multi-state or nationally representative samples would improve the generalizability of findings and allow for the examination of regional, ethnic, and denominational variation. Mixed-method approaches incorporating in-depth interviews or focus group discussions would complement survey data by illuminating the psychological mechanisms and interpersonal dynamics through which religion and socioeconomic status shape reproductive decision-making within couples. There is also a need for studies that examine the role of religious leaders and faith-based institutions more directly, given the suggestive but indirect evidence in the present data that religion operates as a social as well as an individual-level influence.

To conclude, this study provides evidence that religious orientation and socioeconomic status are each independently associated with married couples' attitudes toward contraceptive use in Anambra State, Nigeria, and that their combined contribution

to explaining attitudinal variation is substantial. The findings are consistent with Religious Orientation Theory (Allport & Ross, 1967) and with the broader literature on the social determinants of reproductive health in Nigeria, while extending both by focusing on psychological orientation rather than simple religious affiliation, and on attitudes rather than behavior alone. The results reinforce the view that reproductive health in faith-saturated, socioeconomically heterogeneous societies cannot be adequately understood through a single explanatory lens. At the same time, the correlational nature of the evidence, the bounded geographic scope of the sample, and the reliance on self-report measures counsel restraint in translating these findings into programmatic prescriptions. What the study does justify is the call for a richer, more contextually grounded research base -one that takes seriously both the spiritual commitments and the material realities that shape how couples in Nigeria approach questions of family planning.

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