RELIGIOUS AND CULTURAL CONSTRUCTIONS OF SEXUALITY AND THEIR IMPLICATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH IN NIGERIA

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ABSTRACT
Sexuality is a biological, social and cultural phenomenon whose meanings are shaped by institutions, relationships and systems of social regulation. In Nigeria, religious beliefs, cultural expectations and gender relations influence understandings of premarital sex, marriage, fertility, contraception, abortion, sexual consent and reproductive responsibility. This review examines how these constructions affect sexual and reproductive health (SRH), using Social Norms Theory as its principal analytical lens. Evidence from Nigerian studies indicates that norms surrounding chastity, family honour, early marriage, fertility, partner authority and gendered responsibility can shape whether individuals disclose sexual activity, seek contraception, and negotiate safer sex or access SRH services. At the same time, religious and cultural values can have protective effects by encouraging fidelity, responsible parenthood, social responsibility and stable family relationships. The central argument is that religion and culture should not be treated as uniform or inherently harmful determinants of SRH. Their effects are mediated by social norms, gendered power, stigma, socioeconomic conditions, education, spousal communication and health-system practices. The review therefore advocates culturally responsive and gender-transformative interventions that engage religious and traditional institutions while protecting autonomy, informed choice and access to evidence-based care. It further argues that sustainable improvement in SRH requires attention to the social environments in which reproductive decisions are made, rather than relying solely on the provision of commodities or information.

Keywords: adolescents, culture, gender norms, religion, sexual and reproductive health, social norms

INTRODUCTION
Sexuality is an important dimension of social life because societies establish expectations about relationships, acceptable sexual conduct, marriage, reproduction and gender. Individuals do not make sexual and reproductive decisions in social isolation. Family members, peers, religious authorities, partners, traditional institutions, schools and health professionals communicate standards about what is considered respectable, permissible or deviant. These

expectations can influence behaviour directly through advice and indirectly through approval, disapproval, stigma and anticipated sanctions.

Sexual and reproductive health is consequently both a health issue and a sociological issue. Access to information and services is shaped by education, economic resources, geography, gender relations and the social meanings attached to sexual behaviour. In settings where sexuality is closely associated with morality, family honour, marriage and fertility, people may experience tension between personal needs and collective expectations.

Nigeria provides a particularly important setting for examining these relationships because of its religious, ethnic and cultural diversity. Christianity and Islam are major religious traditions, while indigenous beliefs and practices continue to influence family organisation, marriage and gender relations. These institutions do not operate independently of broader social change. Urbanisation, education, migration, digital communication and changing family patterns continually reshape how sexuality is understood and negotiated.

Recent Nigerian evidence demonstrates the importance of normative environments. Taiwo et al. (2023), for example, found that adolescent access to and utilisation of SRH services in northern Nigeria was shaped by social expectations concerning chastity, family honour, early marriage and pregnancy outside marriage. Similarly, Agu et al. (2022) documented gendered beliefs among adolescents in south-eastern Nigeria, including expectations that boys should initiate sex and that girls bear primary responsibility for avoiding pregnancy. Such findings demonstrate that knowledge of SRH does not necessarily translate into behaviour when individuals anticipate social consequences.

Gendered power is another important mechanism. Ilori et al. (2023) found a significant association between sexual autonomy and modern contraceptive use among Nigerian women. This suggests that reproductive behaviour cannot be understood only in terms of availability or awareness of contraceptive methods. The capacity to negotiate sexual relations and participate in reproductive decisions is itself socially structured.

The purpose of this review is therefore to critically examine how religious and cultural constructions of sexuality shape SRH in Nigeria, with particular attention to contraception, adolescent sexuality, abortion stigma, female genital mutilation/cutting (FGM/C), reproductive decision-making and health-seeking behaviour. The paper also considers how these social processes can be addressed without dismissing the cultural and religious identities of Nigerian communities.

REVIEW METHODOLOGY

This article adopts a narrative sociological review design. It synthesises the Nigerian empirical and institutional evidence identified in the original manuscript and uses Social Norms Theory to organise the analysis. The evidence base includes peer-reviewed studies addressing adolescent sexuality, gender norms, contraception, reproductive autonomy, abortion stigma, health-worker attitudes and social norms, together with national and international institutional evidence relevant to Nigerian SRH.

The review is interpretive rather than a statistical meta-analysis. Studies were examined for recurring explanations of how social expectations influence sexual and reproductive behaviour. Particular attention was given to the mechanisms linking religion and culture with behaviour: perceived expectations, social approval and sanctions, gendered authority, stigma, partner negotiation and the practices of health institutions. The approach allows findings from different Nigerian settings to be compared while recognising that Nigerian culture is heterogeneous and that social norms vary across communities, age groups, gender and socioeconomic contexts.

The review has an important limitation. Because it is based on a narrative synthesis rather than a systematic review protocol, it does not claim to provide an exhaustive inventory of all Nigerian literature on sexuality and SRH. Its contribution is instead conceptual and interpretive: it connects contemporary Nigerian evidence to a sociological explanation of how norms and institutions shape reproductive behaviour.

THEORETICAL FRAMEWORK: SOCIAL NORMS THEORY

The analysis is anchored in Social Norms Theory, associated with the work of Perkins and Berkowitz (1986). The approach emphasises that behaviour is influenced not only by personal attitudes but also by perceptions of what members of a relevant social group do and approve of. Individuals may conform to expectations because they anticipate social approval, avoid disapproval or seek to maintain belonging. This is especially relevant to sexuality, an area in which communities frequently establish strong expectations concerning marriage, sexual initiation, fidelity and reproduction.

In the Nigerian context, norms are communicated and reinforced by parents, spouses, peers, religious institutions, traditional authorities and community networks. A young woman may know that contraception can prevent unintended pregnancy yet avoid seeking it because she believes that doing so would reveal premarital sexual activity. A married woman may wish to space births but perceive that contraceptive use requires spousal approval. An adolescent may recognise the importance of consent but encounter gender expectations that define boys as initiators and girls as responsible for resisting sexual advances. These situations illustrate the difference between knowledge and the social conditions under which knowledge can be translated into action.

Mandal et al. (2022) provide direct evidence of this mechanism in Nigeria. Their structural equation modelling study identified social norms concerning delaying first pregnancy, spacing or limiting pregnancies, and contraceptive use when husbands disagree. The findings indicate that family-planning norms are associated with modern contraceptive use and that the strength of these relationships varies across settings and types of norms.

The theory also avoids reducing individuals to passive recipients of culture. Social norms can be accepted, negotiated or resisted. This is important for policy because religious leaders, parents, community leaders, health workers and young people can participate in normative change. The objective is not simply to replace cultural values but to distinguish values that support dignity, responsibility and wellbeing from expectations that produce coercion, stigma or unequal access to health.

A major strength of Social Norms Theory is therefore its capacity to connect macro-level institutions with interpersonal behaviour. It explains how broad religious and cultural ideas become practical expectations through everyday interaction. It also supports interventions that change reference-group expectations rather than placing the entire burden of behaviour change on individuals.

CONCEPTUAL FRAMEWORK

The review conceptualises sexuality as socially constructed through the interaction of religion, culture and gender. Religion may provide moral frameworks concerning sexual relationships, marriage and family responsibility. Culture establishes expectations surrounding family honour, fertility, marriageability and gender roles. Gender structures the distribution of authority within sexual and reproductive relationships. These influences are mediated by social norms and are expressed through stigma, perceived approval, partner negotiation and institutional practices.

The analytical pathway can be represented as follows: religion + culture + gender → social norms and expectations → autonomy, knowledge, stigma and partner negotiation → reproductive decision-making → SRH behaviour and outcomes. The framework recognises that individuals possess agency but exercise that agency within social structures.

RELIGIOUS CONSTRUCTIONS OF SEXUALITY

Religion is an important source of sexual morality in Nigeria. Religious teachings may emphasise abstinence, marital fidelity, modesty, responsible parenthood and commitment within marriage. Such values can support SRH when they encourage respectful relationships, reduce exposure to some forms of sexual risk and promote responsibility for family wellbeing. The social contribution of religion should therefore not be reduced to its restrictive dimensions.

The concern arises when moral regulation is accompanied by silence, shame or condemnation rather than accurate health information. Adolescents may be strongly encouraged to abstain from sex while receiving limited opportunities to discuss contraception, sexually transmitted infections, consent or how to obtain confidential care. In such circumstances, moral expectations may coexist with limited practical guidance.

Social Norms Theory suggests that the key issue is not simply whether a religious teaching exists, but how it is interpreted and enforced within a community. If young people anticipate condemnation for asking about contraception, they may avoid health facilities or rely on peers and informal sources. The same process can affect adults whose reproductive preferences differ from perceived expectations.

A sociologically balanced interpretation therefore recognises both protective and restrictive effects. Religious institutions can be partners in SRH improvement when they promote accurate information, healthy relationships, non-violence, responsible parenthood and respect for individual dignity. Their influence becomes particularly significant when religious leaders help reduce stigma and legitimise constructive conversations about health.

CULTURAL CONSTRUCTIONS OF SEXUALITY

Culture influences sexuality through shared meanings about virginity, marriage, fertility, family honour, masculinity and femininity. These meanings are not uniform across Nigeria, but they can shape expectations about when sexual activity is acceptable and who has authority over reproductive decisions. Cultural norms are maintained through everyday interaction and may be reinforced by praise, shame, gossip, exclusion or other social responses.

Evidence from adolescents in south-eastern Nigeria illustrates the gendered character of some of these expectations. Agu et al. (2022) found that many adolescents considered premarital sex unacceptable and supported abstinence, while substantial proportions also believed that boys should initiate sex and that girls bear responsibility for preventing pregnancy. These findings demonstrate how apparently protective norms can coexist with unequal expectations about sexual responsibility.

In northern Nigeria, Taiwo et al. (2023) similarly found that norms surrounding chastity, family honour, early marriage and pregnancy outside marriage influenced adolescents' access to and utilisation of SRH services. The significance of these findings lies in the social mechanism: adolescents may possess information about contraception but avoid using services when doing so threatens their social standing or reveals behaviour considered unacceptable.

Cultural practices should consequently be examined critically rather than categorised as simply good or bad. Cultural expectations can provide social cohesion and support responsible family life, yet they may also become harmful when they limit autonomy, normalise coercion or impose unequal reproductive responsibilities.

Cultural sensitivity in health programming should therefore mean understanding local meanings while protecting health, dignity and informed choice.

The 2024 Nigeria Demographic and Health Survey provides a contemporary national evidence base for interpreting reproductive behaviour within its wider demographic and health context (Federal Ministry of Health and Social Welfare of Nigeria et al., 2025). National data are particularly useful because they prevent isolated community findings from being treated as representative of all Nigerian populations.

A further implication is that social change should involve community actors. Parents, elders, youth groups, religious leaders and traditional institutions can participate in dialogue about changing expectations. Agu et al. (2024) also illustrates the potential of community-embedded interventions to influence attitudes and beliefs concerning adolescent SRH in Ebonyi State.

GENDER, SEXUALITY AND REPRODUCTIVE DECISION-MAKING

Gender is a central mechanism through which sexuality is socially regulated. In many contexts, men are expected to demonstrate sexual initiative and household authority, whereas women are assigned greater responsibility for sexual respectability, pregnancy and childcare. These expectations can produce unequal reproductive responsibilities and constrain women's ability to negotiate contraception, refuse unwanted sex or determine the timing and number of pregnancies.

Ilori et al. (2023) found that sexual autonomy was significantly associated with modern contraceptive use among Nigerian women. The finding is sociologically important because it demonstrates that access to a method is not equivalent to the ability to use it. Reproductive autonomy depends partly on power within relationships and on whether women can participate meaningfully in decisions concerning sex and fertility.

Mandal et al. (2022) further demonstrate that family-planning norms concerning pregnancy spacing, limiting births and contraceptive use when husbands disagree are associated with contraceptive behaviour. These findings suggest that programmes focused only on women may overlook the interpersonal structures through which reproductive choices are negotiated.

Men should therefore be included in family-planning and SRH programmes, but male involvement should be framed around shared responsibility rather than control over women's reproductive choices. A gender-transformative approach challenges the assumption that pregnancy prevention is primarily a woman's duty and encourages men and women to share responsibility for contraception, STI prevention, communication and parenting.

Gender norms also affect adolescents. Agu et al. (2022) found that sex was commonly perceived as something boys should initiate, while girls were more likely to be seen as responsible for avoiding pregnancy. Such expectations may reduce girls' negotiating power and place boys under pressure to demonstrate masculinity through sexual initiation. Effective interventions should therefore address the relational dynamics behind sexual behaviour rather than treating adolescents as homogeneous recipients of information.

Health institutions may reproduce these inequalities. Mbachu et al. (2025) found that health workers in youth-friendly primary health centres in Ebonyi State held some adverse gender attitudes concerning sexuality and reproductive behaviour. This evidence demonstrates that social norms can operate inside health systems as well as in households and communities.

IMPLICATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH

Contraception and Family Planning

Contraceptive behaviour is influenced by knowledge, availability, cost, fertility intentions, partner communication and social expectations. Akinyemi et al. (2023) examined Nigerian men and found that perceptions of family planning are relevant to understanding non-use and contraceptive behaviour. Ayo-Bello and Quinn-Walker (2025), in a systematic review of quantitative studies, similarly identified individual, socioeconomic, spousal, community and healthcare factors among the determinants of modern contraceptive use among Nigerian women.

These findings caution against attributing contraceptive non-use to religion alone. Social norms may operate alongside education, wealth, place of residence, fertility preferences and service accessibility. Programmes that provide commodities without addressing the meanings attached to contraception may therefore have limited effects. Effective family-planning strategies should include couple communication, accurate counselling and community-level engagement while protecting voluntary choice.

Adolescent Sexuality

Adolescent sexuality is highly sensitive because many Nigerian communities place strong moral expectations on unmarried young people. Parents may consider direct discussions of sex inappropriate, producing silence that can leave adolescents dependent on peers, social media or other informal sources. The result can be a gap between formal moral instruction and the practical knowledge required to prevent unintended pregnancy and STIs.

Agu et al. (2022) and Taiwo et al. (2023) show that adolescents' sexual behaviour is embedded in gender and social norms. The policy implication is that sexuality education should extend beyond biological facts to include consent, communication, contraception, STI prevention, gender equality, healthy relationships and pathways to confidential services.

Agu et al. (2024) provides further support for community-embedded approaches. The study examined changes in attitudes and beliefs about adolescent SRH in Ebonyi State and highlights the value of interventions that work within community contexts rather than assuming that information alone will alter behaviour.

Youth-friendly services are equally important. Adolescents who expect judgement may delay care even when services are technically available. Confidentiality, respectful communication and provider training are therefore components of SRH quality, not optional additions.

Abortion and Reproductive Stigma

Abortion is another area where moral, religious, cultural and health considerations intersect. Strong moral judgements can generate stigma toward women who seek abortion and toward providers who offer abortion-related care. Okonofua et al. (2024) documented experiences of abortion stigma among health providers in Nigeria, demonstrating that stigma can affect healthcare workers as well as patients.

From a social-norm perspective, stigma is sustained when communities attach negative meanings to particular behaviours and when individuals anticipate sanctions for violating expectations. Fear of judgement can discourage timely healthcare seeking and can contribute to concealment. Addressing abortion-related SRH therefore requires attention to both service provision and the normative environment surrounding reproductive decisions.

Female Genital Mutilation/Cutting

FGM/C illustrates how cultural expectations can regulate women's bodies and sexuality. In communities where the practice persists, it may be associated with femininity, purity, marriageability, social acceptance or perceived religious obligation. UNFPA's Nigeria country snapshot identifies cultural norms and perceived religious obligations among the drivers of FGM/C while also documenting progress toward elimination (United Nations Population Fund, 2025).

The SRH implications include physical complications, sexual difficulties and reproductive-health risks. Because the practice is socially embedded, legal prohibition alone may not transform the expectations that sustain it. Community dialogue, survivor-centred services, education and engagement with traditional and religious leaders can contribute to normative change.

The Nigerian case also demonstrates why social change should not be equated with cultural rejection. Community actors can reinterpret values in ways that preserve social identity while rejecting practices that undermine health and bodily autonomy. This principle is consistent with a human-centred approach to sustainable social development.

Maternal and Reproductive Health-Seeking

Religious and cultural expectations may also influence where and when women seek reproductive and maternal healthcare. Decisions can involve spouses, parents, elders and other influential actors. Where these actors control mobility, finances or permission to seek care, delays may occur. Conversely, community institutions can serve as channels for health education, referral and mobilisation.

The appropriate strategy is therefore partnership rather than simple exclusion of community institutions. Religious and traditional leaders can support messages that encourage timely care, informed decision-making and respectful treatment while health workers address provider-side stigma and gender bias.

REVIEW FINDINGS AND CRITICAL ANALYSIS

The reviewed evidence indicates that religious and cultural constructions of sexuality have neither uniformly positive nor uniformly negative effects on SRH. Their consequences depend on the specific expectations they promote, the social groups that enforce them and the degree of power individuals have to negotiate those expectations. Norms that support fidelity, responsibility, respectful relationships and family wellbeing can be protective. Norms that produce silence, stigma, coercion or unequal gender responsibility can be restrictive.

First, the evidence shows that social norms mediate the relationship between values and behaviour. Taiwo et al. (2023) demonstrates how expectations surrounding chastity and family honour can shape adolescent access to services, while Mandal et al. (2022) shows that family-planning norms are associated with contraceptive use. These findings support the central proposition that reproductive behaviour is partly a product of the social environment.

Second, the evidence highlights the importance of agency and power. Ilori et al. (2023) links sexual autonomy with contraceptive use, indicating that women require not only information and commodities but also the capacity to negotiate sexual and reproductive decisions. Gender-transformative interventions should consequently address interpersonal power rather than treating women as isolated users of health services.

Third, the review challenges cultural homogenisation. Nigeria contains diverse ethnic, religious, linguistic and socioeconomic communities. A norm observed in one setting should not automatically be presented as a universal Nigerian cultural rule. Akinyemi et al. (2023),

Ayo-Bello and Quinn-Walker (2025), Agu et al. (2022) and Taiwo et al. (2023) collectively demonstrate variation in the factors associated with reproductive behaviour across populations and settings.

Fourth, health institutions are themselves social institutions. Mbachu et al. (2025) shows that adverse gender attitudes can be held by health workers, meaning that service delivery can reproduce the same norms that programmes seek to change. This is particularly important for adolescents and other clients who may already fear judgement.

Finally, the evidence suggests that sustainable SRH improvement requires multi-level action. Individual knowledge is necessary but insufficient. Change must occur simultaneously at interpersonal, community and institutional levels. This is where the sociological contribution of the paper lies: SRH outcomes are shaped not only by services but also by the social relations through which people decide whether and how to use those services.

DISCUSSION

The principal contribution of this review is to reposition religious and cultural influences from the category of fixed causes into a framework of socially produced and potentially changeable norms. Religion and culture matter because they shape what communities expect, reward and sanction. The same institution can therefore produce different health effects depending on the interpretation of its teachings and the social relations through which those teachings are enacted.

This perspective has implications for culturally responsive policy. Cultural responsiveness should not mean accepting every existing practice, nor should health programming assume that Westernised models can simply be transferred into Nigerian communities. Instead, interventions should identify local reference groups, understand how norms are communicated and work with influential actors to strengthen expectations that support health and autonomy.

A second implication concerns communication. Public-health messages are often designed around the assumption that individuals make rational choices once they receive sufficient information. The evidence reviewed here suggests a more complex process. Individuals may understand the health benefits of contraception and still avoid it if they fear that family members or partners will interpret use as evidence of sexual impropriety. Correct information must therefore be accompanied by an enabling normative environment.

A third implication concerns sustainable social development. Sustainable innovation in the humanities and social sciences is not restricted to technological invention. It also includes innovative ways of transforming institutions, relationships and social practices. Community dialogue, gender-transformative programming, youth participation and respectful provider training can be understood as forms of social innovation because they seek durable changes in the conditions that produce health inequalities.

The review also identifies a tension between social cohesion and individual autonomy. Communities require shared values, but shared values can become restrictive when conformity is prioritised over wellbeing. The policy challenge is therefore not to eliminate norms but to create normative environments in which dignity, consent, equality and informed reproductive choice are socially supported.

There are limitations to the evidence. Much of the cited Nigerian literature is geographically specific, and the available studies vary in design and population. The review does not establish causal relationships between religious affiliation and SRH outcomes. Instead, it identifies mechanisms supported by the reviewed studies. Future research should examine how religion, gender, age, class, education, urban-rural residence and socioeconomic position intersect in shaping sexuality and health-seeking behaviour.

RECOMMENDATIONS

Strengthen Comprehensive Sexuality Education

Sexuality education should combine accurate information with consent, communication, contraception, STI prevention, gender equality and healthy relationships. Programmes should be culturally contextualised without withholding essential health information.

Adopt Gender-Transformative SRH Interventions

Interventions should challenge unequal expectations concerning sexual initiation, pregnancy prevention and reproductive responsibility. Both boys and girls should be encouraged to understand shared responsibility and respectful negotiation.

Engage Religious Leaders as Partners

Religious leaders can promote responsible parenthood, healthy relationships, non-violence, respect for consent and accurate health information. Engagement should focus on building supportive norms rather than using religious authority to police individual health-seeking.

Engage Parents and Community Leaders

Parents, elders, youth representatives and traditional institutions should participate in structured dialogue about adolescent SRH, contraception, harmful stigma and changing expectations. Community-based approaches are more likely to be sustainable when influential reference groups participate.

Improve Youth-Friendly Services

Health facilities should provide confidential, respectful and non-judgemental services for adolescents and young people. Provider training should address stigma and gender bias, including assumptions about sexuality and contraceptive use.

Promote Sexual and Reproductive Autonomy

Women and girls should be supported to participate meaningfully in decisions concerning sex, contraception and fertility. Programmes should address barriers created by unequal relationship power.

Include Men without Reinforcing Male Dominance

Male participation should promote shared reproductive responsibility, communication and supportive partnership rather than control over women's reproductive choices. Evidence concerning Nigerian men indicates the importance of understanding men's perceptions of family planning (Akinyemi et al., 2023).

Strengthen Community Responses to Harmful Practices

FGM/C and other harmful practices require coordinated legal, educational, community and survivor-centred responses. Religious and traditional leaders should be engaged in norm transformation.

Strengthen Health-Worker Training

Provider training should address adverse gender norms and stigma because health workers can reproduce community expectations within clinical encounters (Mbachu et al., 2025).

Support Context-Specific Nigerian Research

Future research should avoid treating Nigerian culture as homogeneous. Studies should examine how religion interacts with gender, age, class, education, geography and socioeconomic status and should evaluate which community-based strategies produce durable normative change.

CONCLUSION

Religious and cultural constructions of sexuality have significant implications for sexual and reproductive health in Nigeria. They influence understandings of sexual morality, marriage, fertility, contraception, adolescent sexuality, abortion and reproductive decision-making. However, their effects cannot be explained by religious affiliation or culture alone. The reviewed evidence demonstrates that religion and culture operate through social norms, gender relations, family expectations, stigma, sexual autonomy and health-system practices.

Social Norms Theory provides a useful sociological explanation because it shows how shared expectations become behavioural pressures through approval, disapproval and anticipated sanctions. It also highlights the possibility of change. Individuals and communities can negotiate existing expectations, while institutions can support norms that promote dignity, equality, informed choice and healthy relationships.

Improving SRH in Nigeria therefore requires more than expanding services or transferring information to individuals. It requires attention to the social environments in which decisions are made. Religious and traditional institutions should be engaged as partners, harmful norms should be critically challenged, and health workers should be trained to provide respectful and non-judgemental care. A culturally responsive, gender-transformative and socially informed approach offers a stronger pathway toward sustainable improvements in sexual and reproductive health.

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