EXPLORING BARRIERS TO FAMILY PLANNING IN SELECTED COASTAL COMMUNITIES OF LAGOS STATE: IMPLICATIONS FOR POPULATION CONTROL AND QUALITY OF LIFE

[1]EFE GRACE OLORUNTOBA, [2]RAPHEAL ABIODUN OLAWEPO

[1]Department of Geography and Planning, Faculty of Social Sciences, Lagos State University, Lagos, Nigeria

[2]Department of Geography and Environmental Management, Faculty of Social Sciences, University of Ilorin, Ilorin, Nigeria

Abstract: **Aim: To examine the barriers to family planning in selected coastal communities in Lagos State and its implication for population control and quality of life.**

Methodology: This investigation deployed a survey designed to explore the socio-cultural beliefs, economic constraints, geographic barriers and systemic healthcare weaknesses that limit people in selected coastal communities of Lagos from assessing family planning and its implication on population and quality of life. The .study aims to determine if there is a significant relationship between the socio-demographic status of the inhabitants in the study area and their level of acceptance of modern family planning methods.

Results: A total of 400 sexually active people aged between 15 - 49 years were included in the analysis across seven coastal communities in Lagas State and includes Badagry, Epe, Eti-Osa, Ojo, Ikorodu, Apapa and Amuwo-Odofin Local Government Areas. A structured questionnaire titled "Barriers to family planning" was designed to obtain data from the respondents. The data gathered was analyzed using both descriptive and inferential statistical methods. Of the 400 respondents, 86.3% were aged between 21 and 40 years old, 62.5% were married, 54.25% were into fishing, 47.3% had incomes between 50,000 - 100,000 monthly, 54% were Christians, 44.25% had a primary school leaving certificate and 68.7% had above five children. Findings from the study reveal that over 30% of the responses shows that their religion is against the use of contraceptives with 50% accounting for the fear of side effects. Discontinued use of family planning options was commonly reported. This was associated with the side effects like increase in weight, breast enlargement, uncontrollable bleeding, feeling of weakness and dizziness.

Conclusion: This underscores the need for a holistic approach by healthcare providers to educate residents of coastal communities about the benefits and safety of family planning methods. Given the significant concerns about the fear of side effects of family planning options, this study therefore recommends improvement in access to accurate family planning information and that individuals undergo proper medication screening to determine the most suitable family planning method for their body system. This would not only help alleviate their fears but promote informed choices and enhance the acceptance and sustained use of family planning methods within coastal communities of Lagos State and the broader population. On the long run, this would support efforts to reduce unwanted pregnancies thereby contributing to improved quality of life among the residents of the coastal communities of Lagos State.

Keywords: **Family Planning, Contraceptive use, Barriers, Population control, Quality of life and Coastal Communities.**

1. INTRODUCTION

The issue of family planning all over the world has attracted attention due to its importance in decision making about population growth and development concerns (Okedare & Olawepo, 2000). The phenomenal rise in the population of Nigeria; the most populous country in Africa has created a ripple effect on its high level of insecurity, strains on education, poor healthcare delivery, high unemployment/underemployment rates and acute shortage of food and dwelling units (Adedeji, 2023; Adesola et al., 2024). In absolute terms, Nigeria's population has been on the increase since 1960 with the consequential growth of its population witnessing an unmatched change in its social, economic and technological development (Fotso et al., 2011). Therefore, as Nigeria's population continue to increase, there is an urgent need for effective family planning.

Family planning (FP) are strategies that allows individuals and couples to control the number, spacing and timing of their births (WHO, 2024). According to United Nations Population Fund (2013), FP is the right of couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. FP keeps the prospective parents healthy and without a child until a time of their choice (Odusola, 2015). Additionally, Micheal et al., (2021) sees FP as a fundamental aspect of reproductive health that helps individuals or couples to plan and control their fertility through various contraceptive methods. Salvini (2024) opine that these contraceptive methods could either be traditional (exclusive breastfeeding, withdrawal, rhythm, billings) or modern (birth control pills, condoms,intrauterine devices, sterilization procedures).

Numerous studies highlighted the persistent low uptake of FP options particularly amongst the marginalized communities in Nigeria. For instance, in a study of an examination of the use of modern contraceptive methods in Nigeria by Oyo-Ita et al., (2015), only 15% of Nigeria women were using modern contraception with significant disparities observed between the urban and rural populations. Findings from their study reveal that FP in the rural areas was hindered by limited healthcare infrastructure, socio-cultural resistance and lack of awareness of the existing FP services. Similarly, a comprehensive national survey conducted by the Nigerian Demographic and Health Survey (NDHS, 2013) reveal the contraceptive prevalence rate of 15% with urban and rural areas recording 22% and 12% respectively. Adedini et al., (2020) on assessment of contraceptive use across different Nigerian states attribute the findings to a combination of cultural and religious factors in which the northern Nigeria being predominantly Muslim; view family planning as skepticism. Findings from the NDHS reveal the alarming rate at which sexually active people discontinue the use of contraception due to ts side effects, partner opposition or fertility concerns.

Studies on sexual and reproductive health issues in Nigeria have therefore proffered ways of promoting the acceptance of small family size and the improvement in the standard of living and quality of human life especially for mothers and infants. However, despite the substantial increase in awareness of family planning programs, there still exists a high degree of culture-based resistance in Nigerian rural communities (Ekpenyong et al., 2018). According to Okereke & Obonyo (2013), Nigeria has about 31 million women of child bearing age and maternal mortality is estimated to be more than twice as high as the rural areas at 828 deaths per 100,000 live births than in the urban areas estimated at 351 deaths per 100,000 live births. Regional variations abound in maternal figure across Nigeria as high maternal mortality rates in the rural part of the country significantly impacts on the national maternal mortality rate estimated at 545 deaths per 100,000 live births which is among the highest in the world (Aigbe, 2000). These figures underscore the heightened vulnerability of women in rural settings as 1 in every 120 births results in maternal deaths (Nigeria Economic Summit Group, NESG, 2023).

A variety of factors have been identified as the leading causes of low utilization of family planning services: including poor socio-economic status, partner involvement, lack of accessibility, varying cultural beliefs and perceptions, high rate of illiteracy and the desire for large family size (Forty et al., 2021; Sarnak e al., 2021; Mushy et al., 2020 and Nakirijja, 2018). Additionally, education is observed as a powerful indirect determinant of fertility level and a direct determinant of adoption of family planning services (Uzoma Aja-Okorie, 2013). Olusanya (2013) in his study on educational factors in human fertility observed that the level of educational attainment of an individual plays an important role in an ideal family size. Hence, there is a tendency for education to affect the norms and values of one's culture and this will determine the acceptance of family planning practices. Esan (2015) observed that educated couples tend to practice family planning more than their uneducated counterparts. This is because career oriented women are compelled to reduce the effect of successive pregnancies and consequent childbearing on her career. Awoyemi *et al.,* (2011), found that a larger percentage (56.5%) of households whose heads had tertiary education seek more family planning service while a higher percentage (57.9%) of

households whose heads do not have any form of formal education do not in any way see the relevance of family planning. This also corroborates the study carried out by Hasan et al., (2025) who observe that the utilization of contraceptives increases with advancement in educational attainment.

Religion is one of the most important variables in discussions around adoption of family planning services. For instance, Katalay et al., (2020) observed that Islam and Catholism religious teachings and practices greatly discourage the use of family planning methods. Similarly, Najimudeen (2020) contend that Islamic theology in the United Arab Republic argue that the primary end of marriage is procreation and it is a sin against nature and biological disposition to prevent conception. He further buttresses this fact by positing that contraceptive prevalence rate among Muslim countries are relatively low compared to rest of the world. In his submission, Katalay et al., (2020) opine that Catholics believe that the health of women will suffer for selfish reasons and hence see the promotion of artificial birth control practices as humanly and psychologically disastrous to the population but accept fertility awareness method to be the most appropriate for fertility control.

A notable study on involvement of men in contraceptive use by Olugbenga et al., (2017) found that men's attitude to women's sexuality is one of the primary cultural barriers to women's use of contraceptives. The author further opine that men's dual role as custodians of the interest of their lineage and providers for their families render their wives dependent on them for almost everything. This suggests that family planning in households is significantly influenced by male attitudes and power dynamics. Adugnaw et al., (2011) admit that in matters relating to reproduction, decisions about when to have the next baby, when to stop childbearing and the number of children to have are usually taken by men. Adelekaan et al., (2014) observe that men's attitude toward family planning over the years had not been encouraging and their high knowledge of contraception has usually not been translated into real practice. This fact has been buttressed by Feyisetan & Bankole (2012) who carried out a study among females in Nigeria found out that four out of every five married women who are not using any form of modern contraceptives as a means of birth control, gave their husbands objection as their reason. In a country like Nigeria where there is an ever-increasing population growth with projections of 400million by 2050, addressing the barriers to family planning adoption is not only critical to economic and environmental stability but also, to the sustainable development of the nation (United Nations Department of Economic and Social Affairs, UNDESA, 2016).

The objectives of this study include:

● To determine if there is a significant relationship between the socio-demographic status of the respondents and their level of acceptance of modern family planning methods

● To explore the socio-cultural barriers to utilization of family planning in selected coastal communities in Lagos State, and

● To evaluate the effects of low family planning practice on population growth and quality of life in the study area.

2. ETHICAL CONSIDERATION

Ethical clearance for this study was obtained from the Health Research and Ethics committee of the Lagos State University Teaching Hospital. Permission to conduct the study was obtained from the Chairman and the Medical Officer of Health (MOH) of the local government area. Anonymity of participants was maintained at all times by not using any identifiers or personal information in the questionnaires. The researchers contacted community heads through letters and thereafter made arrangements for actual visits. A self administered questionnaire was hand delivered to the community heads for them to trust the authenticity of the purpose of the research work. There was an assurance of confidentiality of person before the start of the research.

The research involved a group of voluntary research assistants and provision made for the safety of the research assistants who were made to wear floating jackets branded with tags indicating that they are on research assignment. The nearest health facilities were informed to carry along a First Aid kit in case of any emergency or eventuality. The family planning service providers in the LGAs were duly informed before the commencement of the research so as to guarantee the security of the research assistants. The researcher seek consent and obtained a written permission from the representatives/authorities of the health centers in the LGAs in the study area.

Setting, sampling and design

Lagos State, according to 2006 census, has a population of 9.014 million. However, according to World Bank (2023), the city of Lagos is expected to hit the 24.5 million population mark and thus become one of the most populous cities in the world by the year 2030. As a cosmopolitan city, the state attracts Nigerians from all ethnic, religious, social and economic backgrounds as well as foreigners (National Population Commission, 2006). In Nigeria, interest in unwanted pregnancy, sexual behavior and reproductive health is keen with concerns in perceived levels of teenage pregnancy, illicit sexual activities, incidence of illegally induced abortion and the economic and social repercussions of early childbearing and large family size. Access to appropriate family planning options by the residents of coastal communities is crucial to the achievement of the Millennium Development Goals of reducing maternal and child mortality.

The area of Lagos constitutes of two major regions: the Island, which is the original city and the Mainland, which is made up by rapidly growing settlements. The environment is characterized as coastal with wetlands, sandy barrier islands, beaches, low-lying tidal flats and estuaries (Aina, 1994).

Table 1: Local Government Areas in Lagos State and their respective land and water area.

LOCAL GOVERNMENT AREA	LAND MASS SQ KM	WATER AREA IN SQ KM
AGEGE	17	Nil
AJEROMI/IFELODUN	13	0.9
ALIMOSHO	137.8	Nil
AMUWO/ODOFIN	153	26.1
APAPA	25.5	13
BADAGRY	363	80
EPE	641	324
ETI-OSA	154.1	145
IBEJU-LEKKI	643	10
IFAKO/IJAIYE	43	Nil
IKEJA	49.92	Nil
IKORODU	200	145
KOSOFE	74.4	10
LAGOS/ISLAND	5.2	4.06
LAGOS/MAINLAND	19.62	Nil
MUSHIN	14.05	Nil
OJO	163	19
OSHODI/ISOLO	41.98	Nil
SHOMOLU	12.1	2.5
SURULERE	27.05	Nil
TOTAL	2797.72	779.56

Source: Lagos State Lands Bureau (2015).

There are twelve (12) LGAs covered by the coast around Lagos State, but for the benefit of this study; only the LGAs that have above 10km water coverage were sampled namely: Badagry, Epe, Eti-Osa, Ojo, Ikorodu, Apapa and Amuwo-Odofin (see Table 1). In all, seven (7) LGAs in Lagos State were sampled. These LGAs were selected for the study in order for the researcher to capture the peculiarities of the communities that stem basically from the coastlines which define the context of this study.

The inclusion criteria includes sexually active individuals between the ages of 15 -59 years, currently residing within coastal communities. Participants younger or older than the aforementioned age bracket were excluded accordingly. The study's survey was developed by administering 400 questionnaires with twenty open-ended questions.

3. DATA REQUIRED AND DATA COLLECTION METHODS

The data required for this work are from primary and secondary sources, the major source is the primary data which include the administration of questionnaire. The sample frame for this study was obtained from seven (7) local government area (Apapa, Amuwo-Odofin, Badagry, Epe, Eti-Osa, Ikorodu and Ojo) in Lagos State coastal area. A total of four hundred questionnaires (400) were administered to 5% of the total houses in each coastline with one family per household used as the target population using the systematic-random sampling method.

The survey was conducted under two distinctive domains including (i) the demographics section containing age, sex, marital status, educational level, type of occupation, monthly income and family size (ii) a section highlighting several factors determining the access to family planning options, barrier, partner involvement, perceived benefits and perceived risk factors. The aforementioned items used multiple questions or a dichotomous yes/no format.

Method of data analysis

The data for the study was collected and analyzed by tallying scores for the responses given to the items in the survey instrument. The data was then summarized in a tabular form. After collection of the data, data cleaning was done in order to determine inaccurate, incomplete or unreasonable data and then improve the quality through corrections of detected errors and omissions. After cleaning, the data was coded and entered in the computer for analysis.

Data analysis procedures that were employed involved both quantitative and qualitative procedures. Quantitative data derived from the demographic section and other closed questions was analyzed using descriptive statistic such as percentages and frequencies. Qualitative data generated from the open-ended questions in research instruments were organized in themes and patterns, categorized through content analysis then tabulated. The data analysis required the use of computer spreadsheet and for this reason; the statistical package for social sciences (SPSS) was used. The multiple logistic regression models were fitted to investigate the adjusted effects of access to family planning on range of sexual and reproductive health behaviour among both sexually active married and unmarried individuals, after controlling for demographic and socio-economic confounding variables.

The obtained data were analyzed using both descriptive (presented as frequencies and tables) and inferential statistics with Statistical package for social sciences (SPSS version 20). These were examined using a forward stepwise multiple regression analysis $Y = a + b_1x_1 + b_2x_2 + b_3x_3 \ldots\ldots b_{nxn} + e.$

4. RESULTS

Socio-demographic characteristics of respondents

Of 400 sexually active individuals responding to the invitation to participate in the study, there was a 100% response rate. The socio-demographic profile of respondents indicated that a good number of the respondents were between the age group of 21 - 30 years (53.3%) and 31 - 40 years (33%). The table also revealed that many of the respondents, 62.5% (250) were married and of the Christian religion 216 (54%). About 111 respondents (27.7%) and 39 (9.8%) for singles and divorced/widowed respectively with 72 (18%) having no formal education at all. while 177 (44.25%) had primary education, are into fishing (54.2%) and earn between 50,000 - 10,000 (47.3%).

Table 2: Socio-demographic characteristics of respondents

Variables	Frequency (%) n = 400
Age group (years)	
15 - 20	20 (8.0%)
21 - 30	213 (53.3%)
31 - 40	132 (33.0%)
41 - 50	35 (8.7%)
Religion	
Christianity	216 (54%)
Muslims	130 (32.5%)

Traditionalists	53 (13.25%)
Others	1 (0.25%)
Marital status	
Married	250 (62.5%)
Single	111 (27.7%)
Divorced	11 (2.8%)
Widowed	28 (7.0%)
Level of education	
No formal education	72 (18%)
Primary	177 (44.25%)
Secondary	120 (30%)
Tertiary	31 (7.75%)
Occupation	
Civil servants	29 (7.25%)
Petty trading	86 (21.5%)
Fishing	217 (54.25%)
Artisans	68 (17%)
Family size	
None	17 (4.3%)
One	39 (9.7%)
2 - 5	69 (17.3%)
Above 5	275 (68.7%)
Monthly income	
Less than 50,000	68 (17.2%)
Between 50,000 - 100,000	190 (47.3%)
Over 100,000	142 (35.5%)

275 (68.7%) of the respondents have over 5 children while 17 (4,3%) had none yet. There are also indications that those who had between 1 to 5 children had higher chances of giving birth to more as the uptake of family planning is relatively poor in the area. This finding was in conformity with the assertion made by (Jerome, 2025) who opine that when people in patriarchal African societies are exposed to opportunities for education and employment, their long time desire of being highly valued with preference for large families automatically affects their household decisions on the number of children to bear. Therefore, Momsen (2020) observe that as people are faced with economic challenges of life, coupled with pressure from family to provide and satisfy their physical needs, they will be forced to make choices with respect to the number of children they should give birth to.

The age at first intercourse indicates that 51.2 % of the respondents started to have sex at adolescent age (15-20 years) while the age group of less than 15 years showed responses of about 41.5% having had sex before the age of 15 (see Table 3). The remaining 7.3% of the respondents engaged in sexual acts for the first time when they got above 20 years. The implication of this is a high rate of unwanted pregnancies in the coastal communities. This corroborates Santelli *et al.,* (2003) assertion that "unintended pregnancies are pregnancies that are reported to have been either unwanted (i.e., they occurred when no children, or no more children, were desired) or mistimed (i.e., they occurred earlier than desired)". Globally, about 16 million adolescent girls between 15 and 19 years give birth each year, which is approximately 1 in every 5. In the poorest regions of the world which includes the coastal communities, this figure rises to one in three girls (Nove *et al.,* 2014).

Table 3: Other family planning adoption parameters

Age at first intercourse	Frequency	Percentage
Less than 15 years	166	41.5
15 - 20 years	205	51.2
Above 20 years	29	7.3
Age at first birth (383 with children)		
Less than 15 years	189	49.35
15 - 20 years	162	42.29
Above 20 years	32	8.36
Interval of delivery (383 with children)		
A year	223	58.23
2 years	62	16.19
3 - 5 years	38	9.92
Above 5 years	60	15.66

Majority of the respondents which is 189 (49.35%) had their first births before the age of 15, 162 between the ages of 15 and 20 and 32 above 20 years. This brings the average age at first birth to 15 years. The study therefore indicate that most of the respondents get exposed to sex at their teenage years when they did not have any prior knowledge on prevention of pregnancy and so at the first sexual attempt, they got pregnant.

58.23% which accounts for over half of the respondents reported that they had their children at an interval of a year. Most of the women that fall in this category had already given birth to above five children and still counting. This invariably means that as soon as they were about three months delivered of a baby, another was in course. 16.19% of the respondents claimed they had their children at an interval of 2 years specifically attached this to their longer months of breastfeeding. They reported that breastfeeding their babies has helped them to plan their next pregnancy. However, they speculated that as soon as they stopped breastfeeding they were in for another child. This is quite interesting to note as it is sure that the respondents who fall into this category are actually familiar with their body systems and have successfully initiated a natural birth control which on the long run has saved them the stress of having more children. The remaining 9.92% and 15.66% of the respondents had their birth interval between 3- 5 years and over 5 years based on the use of preventive measures and natural delay in pregnancy respectively.

Reasons for non-utilization of family planning options

Findings from the study reveal that a number of factors account for the unwillingness of individuals in the coastal communities of Lagos State to engage in family planning practices (see Table 4). On the rationale behind non-usage of contraceptive among some family; a significant proportion of non-users sited religious belief (50%) as a major barrier to their adoption of family planning practices. This underscores the profound influence of religious beliefs on reproductive health behaviour in such community settings. For instance, Caldwell and Barkat-e-Khuda (2000) in a study of the influence of religious beliefs on the use of family planning observe that religious commitment is linked to less favourable adoption of family planning practices. Catholics, for example support natural family planning methods like withdrawal and prolonged breastfeeding but oppose artificial family planning practices. This invariably means that religious doctrines often shape perceptions of morality and eventually impede the use of family planning options. Thus, it can be purported that religion is a major barrier to the use of contraception in the study area.

Fear of side effects was reported by 30.5% of the respondents indicating a high potential for fear of the implications of family planning practices. This fear may stem from inadequate counselling, mis-information or previous experiences with family planning. This corroborates the findings of Adebayo et al., (2024) and Babalola and Olubiyi (2015) who observe that people are afraid of the side effects on use of contraceptives which may include irregular menstrual cycle, dizziness, and prolonged bleeding. Also, findings from the study reveal that 2.75% of the respondents are not interested in FP probably because they have experienced disappointment while using it and have chosen to discontinue its usage. It is also observed that only 7.5% claimed inaccessibility to contraception as the reason for its non-usage. This is likely because they are not just interested in adopting any family planning method.

Table 4: Reasons for Non Usage of Contraceptives

Reasons for Non Usage	Frequency	Percentage
Fear of side effects	122	30.5
Religion	200	50
Partner refusal	22	5.5
Not Interested /Ignorance	11	2.75
Inaccessibility	30	7.5
Not effective	15	3.75
Total	400	100

5.5% of the respondents believed that their spouse's refusal for them to use family planning options is the reason why they are yet to adopt a method. This indicates an influence of interpersonal and domestic dynamics on the reproductive health decisions of families. Several studies on family planning adoption in Nigeria found spousal disapproval as a major determinant of adoption of family planning practices. For instance, Fasanu et al., (2025) observe that the cultural norm that men have control over women's bodies, and they could decide whether they should use contraception or not is a serious threat to the lives and health of women and children. Similarly, Ngole and Joho (2025) found that poor male partner support on FP matters hinders women from adopting FP methods just as Akamike et al., (2020); Apanga et al., (2020) and Kassim & Ndumbaro (2022) found in their studies.

Influence of Respondents Socio-Demographic Status on their Level of Acceptance of Family Planning Options

In a bid to examine the factors that influence adoption of family planning in the selected coastal communities in Lagos State, multiple linear regression analysis was used (see Table 5). The dependent variables (Y) represents the decision of the people to adopt family planning while the selected independent variables are the socio-demographic characteristics of the people, which includes: age, sex and partner agreement, marital status, types of marriage, religion, education qualification, occupation group, income, years in marriage, age at first birth, number of dependents, interval between each delivery, methods of spacing pregnancies, average family size, intention to have more children and number of children intended.

The results of the Multiple linear Regression Analysis selected seven (7) of the sixteen (16) socio demographics characteristics as barriers to adopting family planning options in the study area. The selected variables includes; Methods in spacing pregnancies (x_{13}), sex (x_1), intention to have more children (x_{14}), number of dependents (x_{11}), interval between each child delivery (x_{12}), marital status (x_3) and education attained (x_6). All these seven (7) variables were able to explain 62.9% of the total determinants to adopt family planning. From the regression table 5, it is observed that the average age at first intercourse (X_{13}) is the main factor determining the adoption of modern family planning methods in the study area. The co-efficient (r) of this variable is 0.609 and co-efficient of variation (r^2) is 0.370. The co-efficient of determination indicates that about 37.0% of the variation in the number of the sexually actives usage of modern family planning options is associated with their age at first intercourse.

Gender which is sex differences (X_1) also appeared to be another important factor determining the usage of modern family planning services in the study area with a joint correlation co-efficient (r) of 0.687 and co-efficient of variation (r^2) of 0.472 and a co-efficient of determination of 47.2%. This means that about 47.2% of the variation in the adoption of modern family planning options in the study area is jointly explained by the respondent's age at first intercourse (X_{13}) and sex (X_1). Inconveniences added about 10.2% to the joint explanation. This further shows that there are side effects of the respondents' refusal to use modern family planning options. The extent of gender factor in determining the adoption of modern family planning services is not far fetched as most of the decision regarding family life is decided solely by the male with few exceptions which are made in agreement between the two genders. The dichotomy in the union which place the directive roles on the hands of the husband as indicated in this study, corroborates the assertion by Adugnaw et al., (2011) that the traditional role of the male as a decision-maker is evident in the area of family planning and Olaitan (2012) who identified the strong influence of men on fertility decisions.

The number of dependants (X_{11}) is also an important determinant of respondents' adoption of modern family planning options with a joint correlation (r) of 0.731 and co-efficient of determination 53.4. This indicates that only 6.2% variation of respondents' adoption of modern family planning options is explained by this variable. However, this suggests that about 53.4% of the joint variance in adoption of modern family planning options is explained by the two variables, X_1 and X_{11}. Invariably, the pressure to cater for the nuclear family and also to provide for the other members of the extended family and in cases where the bread winner of the family is not too buoyant; could lead to decision to adopt family planning options.

Table 5: Parameter Estimates of Respondents' Socio-Demographic Status on Adoption of Modern Family Planning

Variable	Parameter Estimates	Standard Error	R	R^2	% of Contribution	Cumulative %
Intercepts	1.616	0.229				
X_{13}	0.373	0.448	0.609	0.370		37.0
X_1	-0.006	0.427	0.687	0.472	10.20	47.2
X_{11}	-0.023	0.411	0.731	0.534	6.20	53.4
X_{14}	0.166	0.389	0.766	0.587	5.30	58.7
X_3	0.265	0.382	0.779	0.606	1.90	60.6
X_{12}	-0.437	0.365	0.787	0.619	1.30	61.9
X_6	-0.099	0.343	0.793	0.629	1.00	62.9

The intention to have more children (X_{14}) was high in its strength of contribution to the non-usage of modern family planning services in the study area. This variable jointly with the average age at first intercourse (X_{13}), gender of respondents (X_1) and number of dependants (X_{11}) have a co-efficient of correlation (r) 0.766, r^2 of 0.587 and a co-efficient of determination of 58.7%. This implies that about 58.7% variation in the failure to adopt modern family planning options in the study area is jointly explained by the average age at first intercourse (X_{13}), gender of respondents (X_1) and number of dependants (X_{11}). The intention to have more children however added about 5.3% to the total variance of the dependent variable. There is much evidence of the variable being a constraint to using modern family planning options as its estimated parameter is negative, this is because the need to have more children will not be met if contraceptives are used. This implies that perception and inclination of the people towards child bearing greatly determines their interest in family planning options. A family that is inclined to the disposition of "I will give birth as much as God gives" will likely be indifferent to the use of contraceptive.

In addition to the contributing factors for non-usage of modern family planning options in the study area is the marital status of the respondents (X_3). This has a joint correlation (r) of 0.779, r^2 of 0.606 and a co-efficient of determination of 60.6%. This reveals that about 60.6% variation in the non-usage of modern family planning options in the study area is jointly explained by variables X_{13}, X_1, X_{11}, X_{14} and X_3. However, results from the analysis shows that the marital status of the respondents (X_3) added about 1.9% to the total variance of the dependent variable. An inference from the sampled respondents out of which 289 (72.2%) are married while 111 (27.8%) were singles showed that among the people, 387 (96.75%) are sexually active whether married or single. It is therefore concluded that the singles are more into family planning than the married. This is because marriage is seen as a free ticket to intercourse without fear of bearing children.

Associated with the factors that influence the usage of modern family planning options in the study area is the Interval between each child delivery (X_{12}). Together with the aforementioned variables X_{13}, X_1, X_{11}, X_{14} and X_3; the correlating factors presented a joint correlation (r) of 0.787 and co-efficient determination (r^2) of 0.619. This clearly denotes that only 1.3% variation among the respondents' usage of modern family planning options is explained by this variable. However, it implies that about 61.9% of the joint variable in the usage of modern family planning options is jointly explained by six variables. Suffice to say here is that the shorter the interval between each delivery, the higher the likelihood to adopt modern family planning as a means to checkmate successive pregnancies.

Education is a powerful indirect determinant of fertility level because it is central to the attitude, behavior and subsequent adoption of modern innovations. Education is closely related to the level of enlightenment and awareness of individuals in the society. In addition to the already discussed variables is the level of education of the respondents (X_6) which related

well with the variation in the desire to use modern family planning services in the study area. The result corroborates with the assertion of Olusanya (2013) in his study on educational factors in human fertility. He observed that the level of educational attainment of an individual plays an important role in an ideal family size. In his observation, there is a tendency for education to affect the norms and values of one's culture and this will determine the extent of awareness and acceptance of family planning practices.

The results displayed a joint correlation (r) of 0.793, (r^2) of 0.629 and a co-efficient of determination of 62.9%. This means that about 62.9% of the variation in the non adoption of modern family planning options in the study area is jointly explained by the seven variables analyzed: average age at first intercourse (X_{13}), gender of respondents (X_1), number of dependants (X_{11}), intention to have more children (X_{14}), marital status (X_3), Interval between each child delivery (X_{12}) and level of educational attainment (X_6). This also suggests that the other variables (age of respondents, religion, number of years in marriage, involvement in formal jobs, income of respondents, partner involvement in family planning, access to family planning and age at first birth; though not rated significant in the analysis contribute 37.1% to the total socio-economic status that determines the adoption of modern family planning options in the study area. This further confirms a report that Nigerian women with higher education are more likely to plan their families, have fewer children, have better access to health services, and experience less maternal mortality (Federal Office of Statistics, 2003).

The explanatory regression equation for the effects of respondents' socio-economic status on their adoption of modern family planning options in the study area can be written as: equation 1

$Output = 1.616 + 0.373(X_{13}) - 0.006(X_1) - 00.023(X_{11}) - 0.166(X_{14}) + 0.265(X_3) - 0.437(X_{12}) - 0.099(X_6)$

RES = 62.9

As shown in equation 1 and Table 5, the intercepts X_{13}, X_1, X_{11}, X_{14}, X_3, X_{12} and X_6 representing the respondents' age at first intercourse, number of dependants, intention to have more children, marital status, interval between each delivery and their level of education respectively; depict that the respondents' age at first intercourse and their marital status have direct (Positive) relationship with their intention to adopt at least one of the available family planning methods in their community while sex, the intention to have more children, interval between each delivery and respondents' level of education are negatively related to their adoption of family planning methods. However, only the respondents' age at first intercourse and their marital status were found to be statistically significant in the regression model.

Barriers to family planning adoption

Table 6:

Reasons for Non Usage	Frequency	Percentage
Fear of side effects	122	30.5
Religion	200	50
Partner refusal	22	5.5
Not Interested /Ignorance	11	2.75
Inaccessibility	30	7.5
Not effective	15	3.75
Total	400	100

With the dependent variable (Y) representing the decision of the people to adopt family planning while the independent variables are the factors that hinder seeking and utilization of modern family planning. These independent variables includes: Exorbitant costs of utilizing family planning services (X_1), Inadequate modern family planning information dissemination (X_2), parents unwillingness to discuss reproduction issues with children (X_3), partner involvement (X_4), poor health facility (X_5), religious and cultural belief (X_6), ignorance of available methods (X_7), fear of side effects during usage (X_8).

Table 6 shows that the R value is positive for all the factors, invariably means the results of the multiple stepwise regression analysis selected five (5) cogent variables which are: fear of side effects, partner involvement, Inadequate family planning

information dissemination, ignorance and as having significant effect in predicting the decision of the people in adopting family planning. All the variables were able to explain 80.6%.

Table 7: Parameter Estimates of Constraints Respondents' have to face to access Modern Family Planning

Model	Estimated parameters	Std. error of estimates	R	R Square	% change	Cumulative%
Intercept	-1.327	0.296				
x_5	0.329	0.861	0.673	0.453		45.3
x_4	0.472	0.704	0.799	0.638	18.5	63.8
x_2	0.267	0.619	0.850	0.723	8.50	72.3
x_8	0.195	0.532	0.893	0.797	7.40	79.7
x_6	0.103	0.523	0.898	0.806	0.009	80.6

Poor health facility (x_5) is an important problem that hinders the usage of modern family planning in Lagos coastal environment. The correlation coefficient of this variable (r) is 0.673, r^2 of 0.453 and a coefficient determination of 45.3%. This indicates that about 45.3% of its variances are associated with decision on adopting modern family planning. The result is evidential as researcher's observation indicates that only four out of the 14 communities selected across the Local Governments had a place that could be referred to as a functioning health center.

Partner involvement (x_4) is another factor that constitutes a major constraint towards adopting family planning practices. The variable in association with poor health facilities has correlation coefficients of (r) which is 0.799, r^2 of 0.638 and a coefficient determination of 63.8%. The tendency for the residents to adopt modern family planning becomes unrealistic, and this can be linked with the researcher's observation since the men were not supportive.

Inadequate family planning information dissemination (x_2) is another important hindrance to utilization of modern family planning options in the study area. The variable has a joint correlation coefficient of 0.850, r^2 of 0.723 and coefficient determination of 72.3%. This implies that 72.3% of the reasons for non usage of modern family planning in the coastal areas of Lagos State can be explained by the variable together with the other two variables. An additional value of 8.5% is added by the inadequate knowledge of people as the most of them just base their judgment on the reports they hear from their friends and associates rather than going to seek for the right information from trained practitioners. Thus inaccessibility to such information accounts for non usage of family planning options.

Next is the fear of side effects (x8) which also rated very high in strength of its contribution to the non usage of modern family planning options in the study area. Being an impending constraint to the usage of modern family planning services in the study area, it added about 7.4% to the joint explanation. Together with Inadequate family planning information dissemination (x_2), the result shows a correlation co-efficient (r) of 0.893 and a coefficient of variation (r^2) of 0.797. The coefficient of determination indicates that about 79.7% of the variation in the percentage of those presently not using any form of modern family planning options in the study area is associated with the three factors: Poor health facility (x_5), partner involvement (x_4) and Inadequate family planning information dissemination (x_2). However, the fear of side effects added about 7.4% to the total variance of the dependent variable.

The last factor which is religious and cultural affiliations (x_6) has a joint correlation coefficient of 0.898, r^2 of 0.806 and coefficient determination of 80.6%**.** Though with meager contribution, this factor contributed 1% to the additional variation in the constraints to the usage of modern family planning as explained by the other four variables: Poor health facility (x_5) 45.3%, partner involvement (x_4) 18.5%, Inadequate family planning information dissemination (x_2) 8.5% and fear of side effects (x8) 7.4%.

The explanatory regression equation for the constraints to modern family planning in the study area can be written as:

Output = -1.327+ 0.329(x_5) + 0.472 (x_4) + 0.267(x_2) + 0.195(x_8) + (x_3) 0.103(x_3) ... equation 2

RES = 80.60%

As shown in equation 2 and Table 7, the intercepts X_5, X_4, X_2, X_8 and X_6 indicating fear of side effects, partner involvement, Inadequate family planning information dissemination, ignorance and religion/cultural belief as having significant effect in predicting the decision of the people in adopting family planning respectively depict that all the aforementioned factors have direct (Positive) relationship with the constraints responsible for the respondent's non-usage of family planning methods. They are therefore found to be statistically significant in the regression model.

5. DISCUSSION AND IMPLICATION OF FINDINGS

The acceptance and practice of family planning options play a crucial role in determining demographic patterns, health outcomes, and socioeconomic well-being, particularly within vulnerable settings such as the coastal communities of Lagos State. The multifaceted and far-reaching effects of having far above the number of children one can cater for significantly affects both population control efforts and the overall quality of life for people making them counterproductive thereby directly reducing their quality of life.

Additionally, there is the risk of maternal and child mortality which often leads to unintended pregnancies, unsafe abortions, and poorly spaced births, all of which contribute to elevated maternal and infant mortality rates. Many of these deaths are preventable and are directly linked to a lack of access to family planning tools and services. The overwhelming majority (275 out of 400) have more than 5 children indicates a high fertility rate. This undermines efforts at population control and puts pressure on health, education, and housing systems. Also, large family sizes may result in overstretched household resources, leading to inadequate access to quality education, healthcare, and proper nutrition for children. Additionally, families with many children often experience financial difficulties, which can trap them in cycles of poverty and reduce opportunities for upward mobility. This pressure manifests in the form of overcrowded housing, inadequate sanitation, poor waste management, and limited access to clean water—all of which degrade living conditions and expose residents to heightened health risks. Adelekan (2010) in his atusy underscores how coastal communities in Lagos are particularly vulnerable to environmental hazards, including flooding and erosion, due to unregulated urban expansion and poor infrastructure development.

Economically, large family sizes in contexts of poverty perpetuate cycles of deprivation and inequality. Families with limited resources find it increasingly difficult to invest in the education, healthcare, and nutritional needs of each child. The long-term effect is a reduced capacity for human capital development and sustained poverty across generations. A study by Njoku (2022) notes that the burden of caring for numerous dependents reduces household savings and limits opportunities for economic advancement, thereby weakening the broader economic fabric of the community.

This study recommends that to effectively address the low uptake of family planning practices and reduce the fertility level of the individuals so as to ensure better quality of life, there should be a channel by which awareness campaigns on the relevance of family planning practices is organized in the communities to address their misconceptions, male involvement initiatives should be enhanced through organizing couple-focused workshops and religious leaders be asked to be proactive in interpreting their faith in a way that aligns with health and wellbeing.

In conclusion, the implications of limited access to family planning services in the coastal communities of Lagos City extend well beyond fertility rates. They encompass critical concerns related to maternal and child health, environmental sustainability, climate resilience, economic development, gender equity, and the integrity of healthcare systems. Addressing these challenges requires a multifaceted approach, including policy reform, investment in reproductive health infrastructure, public education, and the active inclusion of community voices in the planning and delivery of health services.

REFERENCES

[1] Adebayo, S.B. (2014). Barriers to Contraceptive Use among Married Young Adults in Nigeria: A Qualitative Study. *International Journal of Tropical Disease and Health* 3(3): 267-282

[2] Adebayo, A. A., Awe, E. N., Akindola, R. B., Egbo, K. A., Abrifor, C.A. and Kolawole, T. O. (2024). The Socio-Cultural factors Affecting the Use of Family Planning in South West Nigeria: A Study of Oye-Ekiti, Nigeria. *African Journal of Development Studies*, 14 (1). https://hdl.handle.net/10520/ejc-aa_affrika1_v14_n1_a4

[3] Adelekan A, Omoregie P, Edoni E. Male involvement in family planning: challenges and way forward. International Journal of Population Research Volume 2014, http://dx.doi.org/10.1155/2014/416457

[4] Adugnaw B, Sibhatu B, Alemayehu A, Sudhakar M, Alemayehu B, Kebede D. (2011). Men's knowledge and spousal communication about modern family planning methods in Ethiopia. Afr J Reprod Health;15(4):24–32.

[5] Akamike, I. C., Okedo-Alex, I. N., Eze, I. I., Ezeanosike, O. B., & Uneke, C. J. (2020). Why does uptake of family planning services remain sub-optimal among Nigerian women? A systematic review of challenges and implications for policy. Contraception and Reproductive Medicine, 5(1), 1–11. https://doi.org/10.1186/s40834-020-00133-6

[6] Apanga, P. A., Kumbeni, M. T., Ayamga, E. A., Ulanja, M. B., & Akparibo, R. (2020). Prevalence and factors associated with modern contraceptive use among women of reproductive age in 20 African countries: A large population-—based study. https://doi.org/10.1136/bmjopen-2020-041103

[7] Babalola, B. T. and Olubiyi, O. A. (2015). Factors Affecting the Acceptability of Family Planning in Nigeria. *The International Journal of Science & Technoledge,* 3 (6), 38 - 46. https://www.researchgate.net/publication/343948523_ Factors_Affecting_the_Acceptability_of_Family_Planning_in_Nigeria

[8] Caldwell, B. and Barkat-e-Khuda (2000). The first generation to control family size: A micro-study of the cause of fertility decline in Rural Area of Bangladesh. *Studies in Family Planning,* 3, 239 - 251.

[9] Ekpenyong, N., Odejimi, O., & Ad, A. (2018). Factors influencing utilization of family planning services among female of reproductive age (15-45 years) in Bauchi local government area, Bauchi state. 3(2), 1–6. https://doi.org/ 10.15761/NPC.1000180

[10] Fasanu, A.., Fasanu, O. A., Adeyemo, S. C., Awodele, K., Olabode, E. D., Isawumi, A. I., Oyewole,A. and Olaitan, L. (2025). Perceived Barriers to Uptake of Family Planning Services Among Women of Reproductive Age in Osun State, Nigeria: Findings From a Qualitative Study. Cureus 17(4): e82823. https://doi:10.7759/cureus.82823

[11] Forty, J., Rakgoasi, S. D., & Keetile, M. (2021). Patterns and determinants of modern contraceptive use and intention to use contraceptives among Malawian women of reproductive ages (15–49years). Contraception and Reproductive Medicine, 6(1), 1–12. https://doi.org/10.1186/s40834-021-00163-8

[12] Hasan MR, Rabu KF, Muna MA, Hassan S, Rahman S. (2025). Investigating the Impact of Primary Education on Birth Control Practices in Bangladesh: A Primary Study. ASIDE Int Med., 1(2). https://doi:10.71079/ASIDE.IM. 02232529

[13] Sarnak, D. O., Wood, S. N., Zimmerman, L. A., Karp, C., Makumbi, F., Kibira, S. P. S., & Moreau, C. (2021). The role of partner influence in contraceptive adoption, discontinuation, and switching in a nationally representative cohort of Ugandan women. PLoS ONE, 16(1), 1–15. https://doi.org/10.1371/journal.pone.0238662

[14] Mushy, S. E., Tarimo, E. A. M., Fredrick Massae, A., & Horiuchi, S.(2020). Barriers to the uptake of modern family planning methods among female youth of Temeke District in DaresSalaam, Tanzania: A qualitative study. Sexual & Reproductive Healthcare, 24, 100499. https://doi.org/10.1016/j.srhc.2020.100499

[15] Najimudeen, M. (2020). Islamic Perspective on Family Planning. Scholars International Journal of Obstetrics and Gynecology, 3(3): 90-93. https://doi:10.36348/sijog.2020.v03i03.006/

[16] Nakirijja, D. S. (2018). Socio-economic determinants of access to and utilization of contraception among rural women in Uganda. 1–20. https://doi.org/10.21767/1791-809X.1000608

[17] Jerome, C. C. (2025). An Exploratory Study of Factors Affecting Uptake of Family Planning Among Women of Reproductive Age in Ungogo Local Government Area of Kano State, Nigeria. Texila International Journal of Medicine, https://doi:10.21522/TIJMD.2013.08.01.Art001

[18] Kassim, M., & Ndumbaro, F. (2022). Factors affecting family planning literacy among women of childbearing age in the rural Lake zone, Tanzania. BMC Public Health, 22(1), 1–11. https://doi.org/10.1186/s12889-022-13103-1

[19] Katalay, V.., Ndiga, B. & Gacheru, E. (2022). Religion a determinant of conventional family planning methods among women of childbearing age in Selembao: Case study of Sanru Project in Kinshasa, the Democratic Republic of the Congo. Journal of Research Innovation and Implications in Education, 6(3), 439 – 450

[20] Ngole, B. E. and Joho, A. A. (2025). Factors Influencing Modern Family Planning Utilization and Barriers in Women of Reproductive Age in the Iringa Region, Tanzania: A Mixed-Methods Study. SAGE Open Nursing. 2025;11. https://doi:10.1177/23779608251313897

[21] Okyere, Y. M., Aboagye, R.G., Boateng, E. N. K., Okyere, J., Osborne, A. and Ahinkorah, B. O. (2025). Spatial distribution and factors associated with unmet need for contraception in Ghana. *Reproductive Health*, 22 (31). https://doi.org/10.n1186/s12978-024-01935-6

[22] Olaitan, O (2012). Factors Influencing the Choice of Family Planning Among Couples in South West, Nigeria. *International Journal of Social Sciences.* 15(2), 25-32

[23] Olugbenga, A.I., Asekun, Olarinmoye, E.O., Adewole, A.O., Adeomi, A.A., Olarewaju, S.O. (2017). Perception, attitude and involvement of men in maternal health care in a Nigerian community. *Journal of Public Health.* 5(6), 262-270

[24] Oluwole, E.O., Kuyinu, Y.A., Goodman, O.O., Odugbemi, B.A. and Akinyinka, M.R.(2016). Factors Influencing the Uptake of Modern Family Planning Methods among Women of Reproductive Age in A Rural Community in Lagos State. *International Journal of Tropical Disease & Health* 11(3), 1-11

[25] Adedeji, I. (2023). Nigerian Urbanization and the Significance of Affordable Housing. Journal of Service Science and Management. 16, 251 - 368 https://doi.org/10.4236/jssm.2023.163020

[26] Adelekan, I. O. (2010). Vulnerability of Poor Urban Coastal Communities to Flooding in Lagos, Nigeria. Environment and Urbanization, 22, 433-450. http://dx.doi.org/10.1177/0956247810380141

[27] Adesola, R. O., Opuni, E., Idris, I., Okesanya, O. J., Igwe, O., Abdulazeez, M. D. and Lucero-Prisno, D. E. (2024). Navigating Nigeria's Health Landscape: Population Growth and its Health Implications. Health Services Insights, 17, 1 - 9 https://doi.org/10.1177/11786302241250211

[28] Aigbe, G.O. (2012). Fundamentals of Population Studies.Jehovah Shammah Publishers. Ibadan

[29] World Health Organization (2024). Family Planning/Contraception https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception

[30] Fotso, J. C., Ajayi, J. O.,Idoko, E., Speizer, I., Fasiku, D. A. and Mberu, B.and Mutua, M. (2011). Family Planning and Reproductive Health in Urban Nigeria: Levels, Trends and Differentials. Chapel Hill NC: Measurement, Learning & Evaluation (MLE) Project [UNC, USA] and National Population Commission (NPC) [Nigeria]. www.urbanreproductivehealth.org

[31] Micheal, T. O., Agbana, R. D., Ojo, T. F., Kukoyi, O. B., Ekpenyong, A. S. and Ukwandu D. (2021). COVID-19 pandemic and unmet need for family planning in Nigeria. Pan African Medical Journal, 40 (1), Article 186. https://www.panafrican-med-journal.com/content/article/40/186/full

[32] Nigeria Economic Summit Group, NESG, (2023). Maternal Mortality in Nigeria: What is Known and What needs to be done. https://nesgroup.org/download_resource_documents/NRFP%20Policy%20Brief-%20Prof%20Risikat%20Dauda%28MM%29_1701236063.pdf

[33] Okyere, Y. M., Aboagye, R.G., Boateng, E. N. K., Okyere, J., Osborne, A. and Ahinkorah, B. O. (2025). Spatial distribution and factors associated with unmet need for contraception in Ghana. *Reproductive Health*, 22 (31). https://doi.org/10.n1186/s12978-024-01935-6

[34] Olaitan, O (2012). Factors Influencing the Choice of Family Planning Among Couples in South West, Nigeria. *International Journal of Social Sciences.* 15(2), 25-32

[35] Olugbenga, A.I., Asekun, Olarinmoye, E.O., Adewole, A.O., Adeomi, A.A., Olarewaju, S.O. (2017). Perception, attitude and involvement of men in maternal health care in a Nigerian community. *Journal of Public Health.* 5(6), 262-270

[36] Oluwole, E.O., Kuyinu, Y.A., Goodman, O.O., Odugbemi, B.A. and Akinyinka, M.R.(2016). Factors Influencing the Uptake of Modern Family Planning Methods among Women of Reproductive Age in A Rural Community in Lagos State. *International Journal of Tropical Disease & Health* 11(3), 1-11

[37] Oyo-Ita, A., Dongo, S. T. and Ejembi, C. L. (2015).. Contracepttive prevalence in Nigeria: Trends and regional differences. https://pubmed.ncbi.nlm.nih.gov

[38] Teshale, A. B. (2022). factors associated with unmet need for family planning in sub-saharan Africa: a multilevel multinomial logistic regression analysis. PLoS ONE 17 (2):e0263885 https://doi:10.1371/journal.pone.0263885

[39] United Nations Department o Economic and Social Affairs (2016). World Population Prospects https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd_2016_nigeria_en_item4_0.pdf

[40] United Nations Population Fund (UNFPA, 2024). https://www.unfpa.org/family-planning

[41] World Bank (2023). Lagos Stae Urban Transport Project II - Project Appraisal Document. https://documents1.worldbank.org/curated/en/099062123034023646/pdf