

Family planning with sexual orientations and Contraceptive use among Christians in Lagos State, Nigeria: A Cross-Sectional Study

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Abstract

Despite high awareness of contraceptives in Nigeria, modern contraceptive prevalence remains low (12–16%), with significant religious and regional variations. Christians in Southern Nigeria, particularly Lagos State, demonstrate higher contraceptive uptake (31.3%) compared with national averages, yet the role of family planning with sexual orientations in shaping contraceptive decisions among Christian couples remains underexplored. This study examined the association between family planning with sexual orientations and contraceptive use among Christians in Lagos State, Nigeria. A cross-sectional quantitative design was employed with 250 married Christian couples (500 individuals) recruited from 15 churches across three senatorial districts in Lagos State using multistage sampling. Family planning with sexual orientations was measured with an 8-item researcher-developed family planning with sexual orientations Scale, while contraceptive use was assessed via self-reported current use of modern methods (pills, injectables, implants, intrauterine devices, condoms, male/female sterilisation) and traditional methods (withdrawal, fertility awareness, abstinence). Data were analysed using chi-square tests, Pearson correlation, and multiple logistic regression, controlling for age, gender, education, wealth index, number of living children, and church attendance frequency. Overall, 34.2% of participants reported current use of modern contraceptives, with condoms (18.6%), pills (9.4%), and injectables (4.2%) being the most common methods. Family planning with sexual orientations was significantly higher among modern contraceptive users ($M = 6.1$, $SD = 1.4$) than non-users ($M = 5.2$, $SD = 1.7$; $t = 7.82$, $p < 0.001$). Logistic regression showed that family planning with sexual orientations significantly predicted modern contraceptive use (adjusted OR = 1.42, 95% CI: 1.28–1.58, $p < 0.001$), such that each one-unit increase in family planning with sexual orientations was associated with 42% higher odds of modern contraceptive use, controlling for covariates. Other significant predictors included tertiary education (aOR = 2.15, $p < 0.01$), wealth index (richest vs. poorest: aOR = 2.67, $p < 0.001$), and number of living children (≥ 4 vs. 0–2: aOR = 3.12, $p < 0.001$). Church attendance frequency was not significantly associated with contraceptive use ($p = 0.34$). Family planning with sexual orientations is a significant, independent predictor of modern contraceptive use among Christians in Lagos State, beyond the effects of education, wealth, and fertility preferences. Findings support integrating evidence-based sexual and reproductive health education into church-based premarital and marital counselling programmes to enhance informed contraceptive decision-making among Christian couples.

Keywords: Family Planning with Sexual Orientations; Contraceptive Use; Modern Contraception; Reproductive Health; Cross-Sectional Study.

I. INTRODUCTION

Family planning remains a critical public health priority in Nigeria, where high fertility rates (5.3 children per woman), maternal mortality (512 deaths per 100,000 live births), and unmet need for contraception (22%) continue to challenge national development goals. Despite decades of policy interventions and programme investments, modern contraceptive prevalence remains stubbornly low at 12–16%, with significant regional and religious disparities. Christians in Southern Nigeria, particularly Lagos State, demonstrate higher contraceptive uptake (31.3%) compared with national averages and Northern regions, yet substantial unmet need persists even within this relatively high-use population.

Lagos State, Nigeria's commercial capital and most populous city, exemplifies the complex interplay between urbanisation, religious influence, and reproductive health behaviour. With over 20 million residents, high literacy rates, and extensive health infrastructure, Lagos presents a paradox: despite favourable socio-economic indicators and strong Christian presence (approximately 70% of the population), many couples still do not use modern contraceptives or rely on less effective traditional methods. This gap suggests that factors beyond access and availability—such as knowledge, attitudes, and religious beliefs—may shape contraceptive decisions.

Family planning with sexual orientations —the factual understanding of human anatomy, physiology, reproduction, contraception, and sexually transmitted infections—has emerged globally as a critical predictor of contraceptive use and reproductive health outcomes. Research indicates that individuals with higher Family planning with sexual orientations are more likely to use modern contraceptives, communicate effectively with partners about family planning, and seek timely reproductive health services. However, evidence from Nigerian Christian contexts remains fragmented, with most studies treating Family Planning as a sub-theme within broader investigations of contraceptive awareness, religious influence, or spousal communication.

This study addresses this gap by examining the association between Family Planning and contraceptive use among Christians in Lagos State, Nigeria. Specifically, the research tests whether greater Family Planning predicts higher modern contraceptive uptake after controlling for socio-demographic factors (age, education, wealth, parity) and religious commitment (church attendance). Findings contribute to scholarly understanding of reproductive health behaviour in urban African Christian contexts and offer actionable recommendations for church-based family planning programmes.

Statement of the Problem

Despite high awareness of contraceptives in Lagos State (reported at 85–95% among women of reproductive age), actual modern contraceptive use remains suboptimal at approximately 31%, with many couples relying on less effective traditional methods or experiencing unmet need. This awareness–use gap suggests that knowledge of contraceptive existence does not automatically translate into informed, consistent use of effective methods.

Qualitative studies in Lagos reveal that many Christian couples enter marriage with inadequate understanding of reproductive physiology, contraceptive mechanisms, side effects, and correct usage, leading to misconceptions, fear, and method discontinuation. Common myths include beliefs that contraceptives cause permanent infertility, promote promiscuity, or violate divine will—misconceptions that persist despite high general awareness. Consequently, couples may avoid modern methods altogether or use them inconsistently, increasing risks of unintended pregnancy and unsafe abortion.

While premarital counselling (PMC) is widely practised in Nigerian churches, its content and quality vary considerably. Many programmes emphasise spiritual and moral dimensions (e.g. fidelity, submission, prayer) but neglect evidence-based sexual and reproductive health education, leaving couples ill-equipped to make informed contraceptive decisions. Some clergy actively discourage modern contraception, citing biblical interpretations or denominational doctrines, while others remain silent on the topic, creating ambiguity for congregants.

Empirical research on Family Planning and contraceptive use in Nigeria is scarce, with existing studies focusing primarily on awareness, attitudes, or religious influence without isolating Family Planning as a distinct predictor. Most national surveys (e.g. Nigeria Demographic and Health Survey) measure contraceptive awareness but not detailed Family Planning, limiting understanding of how specific knowledge domains (e.g. ovulation, method mechanisms, side effects) influence behaviour. Furthermore, no known study has examined this association specifically among Christians in Lagos State, despite the city's unique urban dynamics, religious diversity, and relatively high contraceptive prevalence.

Addressing these gaps is urgent, given the social, economic, and health costs of unintended pregnancy, unsafe abortion, and high fertility in Nigeria. This study responds by providing robust empirical evidence on the association between family planning with sexual orientations and contraceptive use among Christians in Lagos State, offering actionable recommendations for churches, health providers, and policymakers.

Research Questions

This study was guided by the following research questions:

1. What is the level of family planning with sexual orientations among married Christian couples in Lagos State, Nigeria?
2. What is the prevalence and pattern of contraceptive use (modern vs. traditional methods) among married Christian couples in Lagos State, Nigeria?
3. Is there a significant relationship between family planning with sexual orientations and contraceptive use among married Christian couples in Lagos State, Nigeria?
4. Does family planning with sexual orientations significantly predict modern contraceptive use after controlling for socio-demographic variables (age, gender, education, wealth index, number of living children) and religious commitment (church attendance frequency) among married Christian couples in Lagos State, Nigeria?
5. How can the findings inform the integration of sexual and reproductive health education into church-based premarital and marital counselling programmes in Lagos State, Nigeria?

Aim and Objectives**Aim**

The primary aim of this study was to examine the association between family planning with sexual orientations and contraceptive use among Christians in Lagos State, Nigeria.

Specific Objectives

1. To assess the level of family planning with sexual orientations among married Christian couples in Lagos State, Nigeria.
2. To determine the prevalence and patterns of contraceptive use (modern vs. traditional methods) among married Christian couples in Lagos State, Nigeria.
3. To examine the bivariate relationship between family planning with sexual orientations and contraceptive use among married Christian couples in Lagos State, Nigeria.
4. To determine whether family planning with sexual orientations significantly predicts modern contraceptive use after controlling for socio-demographic variables (age, gender, education, wealth index, number of living children) and religious commitment (church attendance frequency) among married Christian couples in Lagos State, Nigeria.
5. To offer evidence-based recommendations for integrating sexual and reproductive health education into church-based premarital and marital counselling programmes in Lagos State, Nigeria.

II. LITERATURE REVIEW

Conceptualising Family planning with sexual orientations and Sexual Health Literacy Family planning with sexual orientations refers to individuals' factual understanding of human sexuality, including anatomy, physiology, reproduction, contraception, sexually transmitted infections, and normative sexual behaviours within marriage. In recent scholarship, this construct has been extended into sexual health literacy (SHL), defined as the knowledge, attitudes, beliefs, motivations, and abilities that enable individuals to access, understand, evaluate, and apply sexual and reproductive health information in everyday life. SHL encompasses not only factual knowledge but also the capacity to communicate about sex, make informed decisions, and navigate sexual concerns within relationships.

Empirical studies demonstrate that higher SHL is associated with better contraceptive use, greater sexual satisfaction, and improved reproductive health outcomes across diverse cultural contexts. For instance, research among Nigerian women found that those with comprehensive knowledge of ovulation and contraceptive mechanisms were significantly more likely to use modern methods consistently compared with those with limited knowledge. Similarly, studies in Kenya and Ghana showed that sexual health literacy predicted contraceptive self-efficacy, partner communication, and method continuation, independent of education and wealth.

Evidence from Asia reinforces these findings. A systematic review of 47 studies across 15 Asian countries found that comprehensive sexuality education significantly improved contraceptive knowledge, self-efficacy, and uptake among adolescents and young adults. In India, a longitudinal study of 2,400 married women demonstrated that those with higher family planning with sexual orientations were 2.1 times more likely to use modern contraceptives consistently over a 24-month period, even after controlling for education, wealth, and spousal approval. Similarly, research in Bangladesh showed that women who participated in community-based sexual health literacy programmes had 1.8 times higher odds of modern contraceptive use compared with controls.

Latin American evidence further supports the knowledge–contraception link. A multi-country study across six Latin American nations (Brazil, Colombia, Mexico, Peru, Argentina, and Chile) found that family planning with sexual orientations was a stronger predictor of contraceptive use than education or income, particularly among young women aged 18–29. In Brazil, a randomised controlled trial of a sexual health literacy intervention among 1,200 low-income women demonstrated a 35% increase in modern contraceptive uptake at 12-month follow-up, mediated by improved knowledge and self-efficacy.

European and North American studies, while conducted in high-prevalence contexts, similarly highlight the importance of knowledge. A systematic review of 62 studies from Europe and North America concluded that comprehensive sexuality education programmes consistently improved contraceptive knowledge, reduced unintended pregnancies, and increased modern method use, particularly among marginalised populations. In the United States, research among Latina Catholics found that religious affiliation did not negatively affect contraceptive practice when women had accurate knowledge of Church teaching (which permits natural family planning) and modern methods, challenging assumptions about religion as a barrier.

Although these studies are not Lagos-specific, they provide a robust theoretical foundation for hypothesising that family planning with sexual orientations and SHL shape contraceptive behaviour among Christian couples in Lagos, regardless of cultural or religious context.

Contraceptive Use among Christians in Nigeria and Lagos State Religion plays a significant role in shaping contraceptive behaviour in Nigeria, with Christians generally demonstrating higher uptake than Muslims or adherents of traditional religions. National data from the 2018 Nigeria Demographic and Health Survey (NDHS) show that modern contraceptive prevalence among Christian women (16%) is nearly double that of Muslim women (8%), with even higher rates in Southern regions (e.g. 31.3% in Lagos). This disparity is attributed to differing religious doctrines, with some Muslim and Catholic denominations discouraging or prohibiting modern contraception, while many Protestant and Pentecostal churches adopt more permissive stances.

In Lagos State, studies report modern contraceptive prevalence rates ranging from 28% to 35% among women of reproductive age, with condoms, pills, and injectables being the most common methods. However, significant unmet need persists (approximately 18%), and many users rely on short-term methods rather than long-acting reversible contraceptives (LARCs) such as implants or intrauterine devices. Qualitative research reveals that Christian couples in Lagos often cite religious beliefs, spousal opposition, fear of side effects, and misinformation as barriers to use, despite high awareness and access.

Comparative evidence from sub-Saharan Africa shows similar patterns. In Tanzania, Christians demonstrated higher contraceptive prevalence than Muslims in some regions, while the opposite pattern emerged in other contexts, suggesting that local religious milieus and historical factors moderate the religion–contraception relationship. In Kenya, qualitative studies found that both Christian and Muslim youth perceived their religions as unsupportive of contraceptive use, yet actual behaviour varied significantly based on access, education, and peer norms.

Family planning with sexual orientations and Contraceptive use: Empirical Evidence A growing body of international evidence links family planning with sexual orientations to contraceptive use, with knowledgeable individuals more likely to adopt modern methods, use them correctly, and continue use over time. For example, a study in Ethiopia found that women with comprehensive knowledge of fertility and contraception had 2.3 times higher odds of modern contraceptive use compared with those with limited knowledge. Similarly, research in India showed that family planning with sexual orientations predicted contraceptive self-efficacy and partner communication, which in turn mediated contraceptive use.

In Nigeria, evidence is more limited but suggestive. A study in Southwest Nigeria found that women who could correctly identify the ovulation cycle were significantly more likely to use modern contraceptives than those who could not. Another study in Lagos reported that contraceptive awareness was high (92%) but detailed knowledge of method mechanisms, side effects, and correct use was poor, correlating with inconsistent use and high discontinuation rates. These findings imply that family planning with sexual orientations —particularly domain-specific knowledge about fertility and contraception—may be a critical but overlooked determinant of contraceptive behaviour among Nigerian Christians.

Evidence from Asia provides compelling support. In Pakistan, a cluster randomised trial of 3,600 married women demonstrated that a community-based family planning with sexual orientations intervention increased modern contraceptive prevalence from 24% to 41% over 18 months, with effects mediated by improved knowledge, reduced fear of side effects, and enhanced spousal communication. In Indonesia, research among 1,800 Muslim couples found that family planning with sexual orientations was a stronger predictor of contraceptive use than religious observance, suggesting that cognitive factors may outweigh doctrinal influences in some contexts.

Latin American evidence further reinforces these findings. A prospective cohort study of 2,200 young women across five Latin American countries found that baseline family planning with sexual orientations predicted contraceptive initiation and continuation over 24 months, independent of education, wealth, and partner support. In Mexico, a quasi-experimental study of a church-based sexual health programme (adapted for Catholic contexts) showed that knowledgeable participants were more likely to use contraceptives consistently, challenging assumptions about Catholic doctrine as an absolute barrier.

European and North American studies, while conducted in high-prevalence contexts, similarly highlight the importance of knowledge. In the United Kingdom, research among British Pakistani and British Caribbean communities found that family planning with sexual orientations interventions significantly improved contraceptive uptake, particularly among women who initially held misconceptions about side effects or fertility. In the United States, a national survey of 5,000 women found that family planning with sexual orientations was the strongest predictor of contraceptive consistency, surpassing education, income, and insurance status.

Religious Influence on Contraceptive Use: Global Perspectives Religious leaders and institutions significantly influence contraceptive behaviour globally, with effects varying by denomination, cultural context, and level of religious involvement. The Nigerian Urban Reproductive Health Initiative (NURHI) found that women who heard supportive family planning messages from

religious leaders were 1.6 times more likely to use modern contraceptives compared with those who did not. However, religious influence is complex: while some clergy actively promote family planning as responsible parenthood, others discourage it based on doctrinal interpretations or concerns about promiscuity.

Among Christians in Lagos, denominational differences matter. Catholic churches officially prohibit artificial contraception (permitting only natural methods), while many Protestant and Pentecostal denominations adopt neutral or supportive stances. This doctrinal diversity creates varying normative environments for contraceptive decision-making, suggesting that the association between family planning with sexual orientations and contraceptive use may be moderated by denominational affiliation and clergy messaging.

Global comparative evidence reveals nuanced patterns. A multi-country study across 20 sub-Saharan African nations found that frequent church attendance was positively associated with modern contraceptive use among Christians, net of denominational affiliation, suggesting that religious involvement may facilitate rather than hinder family planning in some contexts. In Latin America, research among Catholic women found that those with accurate knowledge of Church teaching (which permits natural family planning and does not condemn all modern methods) were more likely to use contraceptives consistently than those with misconceptions, highlighting the importance of knowledge within religious frameworks.

In North America and Europe, studies consistently find that religion is no longer a primary determinant of contraceptive use among Christians. Research among US Catholics found that 98% had used contraception at some point, despite official Church prohibition, suggesting that personal knowledge, health considerations, and quality of life often outweigh doctrinal constraints. Similarly, studies in Canada, the United Kingdom, and Australia found minimal differences in contraceptive prevalence across Christian denominations, with secular factors (education, access, partner support) playing larger roles.

These global patterns suggest that while religion matters, its influence is mediated by knowledge, context, and individual agency—supporting the hypothesis that family planning with sexual orientations may moderate or even outweigh religious factors in shaping contraceptive behaviour among Lagos Christians.

Gaps in the Literature

Despite growing recognition of the importance of family planning with sexual orientations for reproductive health outcomes, several gaps remain in the Nigerian Christian context and globally:

- Limited focus on family planning with sexual orientations as a distinct predictor: Most studies treat family planning with sexual orientations as part of broader constructs such as awareness, attitudes, or health literacy, rather than examining its direct association with contraceptive use. This is true across African, Asian, and Latin American contexts.
- Geographical and denominational specificity: Few studies focus specifically on Lagos State or compare outcomes across Christian denominations, despite the city's unique urban dynamics and religious diversity. Similarly, global studies often aggregate Christians into a single category, obscuring denominational differences.
- Integration of faith and evidence-based sexual education: While church-based programmes increasingly include family planning
- Mediating mechanisms: Few studies examine the pathways through which family planning with sexual orientations influences contraceptive use (e.g. self-efficacy, communication, attitudes), particularly in African Christian contexts. Global evidence suggests these mechanisms are critical but underexplored.

The present study addresses these gaps by examining the association between family planning with sexual orientations and contraceptive use among Christians in Lagos State, Nigeria, while drawing on global evidence to inform interpretation and recommendations.

Theoretical Framework

This study was guided by two complementary theoretical frameworks: Social Cognitive Theory (SCT) and the Theory of Planned Behaviour (TPB).

Social Cognitive Theory

Social Cognitive Theory, developed by Albert Bandura, posits that behaviour is determined by the reciprocal interaction between personal factors (knowledge, attitudes, self-efficacy), behavioural patterns, and environmental influences. In the context of contraceptive use, SCT suggests that family planning with sexual orientations provides the cognitive foundation for developing accurate reproductive scripts, fostering self-efficacy, and reducing misconceptions about contraception.

Key SCT constructs relevant to this study include:

- Knowledge: Factual understanding of reproductive physiology, contraceptive mechanisms, and side effects, which shapes expectations and reduces anxiety.
- Self-efficacy: Belief in one's capacity to obtain and use contraceptives effectively, which is enhanced by accurate knowledge.
- Outcome expectations: Anticipated consequences of contraceptive use (e.g. pregnancy prevention, side effects, spousal approval), influenced by knowledge and prior experiences.
- Observational learning: Acquisition of reproductive scripts through media, peers, or religious teaching, which may be accurate or distorted.

SCT predicts that higher family planning with sexual orientations enhances contraceptive self-efficacy, promotes constructive partner communication, and reduces dysfunctional beliefs (e.g. fear of infertility), thereby increasing modern contraceptive uptake.

Theory of Planned Behaviour

The Theory of Planned Behaviour, developed by Icek Ajzen, explains how attitudes, subjective norms, and perceived behavioural control shape behavioural intentions and actual behaviour. In the context of contraceptive use, TPB suggests that family planning with sexual orientations influences attitudes towards contraception (e.g. perceived benefits vs. risks), subjective norms (e.g. perceived spousal or religious approval), and perceived behavioural control (e.g. access, affordability, ability to use correctly).

Key TPB constructs relevant to this study include:

- Attitudes: Positive or negative evaluations of contraceptive use, shaped by knowledge of benefits (pregnancy prevention, health spacing) and risks (side effects, moral concerns).
- Subjective norms: Perceived social pressure from spouses, religious leaders, or peers to use or avoid contraception.
- Perceived behavioural control: Perceived ease or difficulty of obtaining and using contraceptives, influenced by knowledge of methods, sources, and correct usage.

TPB predicts that knowledgeable individuals will hold more positive attitudes towards contraception, perceive greater social support, and feel more capable of using methods effectively, thereby increasing intention and actual use.

Integration of SCT and TPB

The convergence of SCT and TPB in explaining the present findings suggests a complementary framework: family planning with sexual orientations (SCT) provides the cognitive tools necessary for individuals to form positive attitudes, perceive supportive norms, and feel capable of using contraception (TPB). Knowledgeable couples are not only better informed about reproductive physiology and contraceptive options but also more confident in their ability to navigate health systems, negotiate with partners, and manage side effects, thereby increasing modern contraceptive uptake.

This integrated perspective is particularly relevant in the Nigerian Christian context, where religious teachings, spousal dynamics, and health system barriers intersect to shape contraceptive decisions.

III. METHODOLOGY

Research Design

A cross-sectional quantitative design was employed to examine the association between family planning with sexual orientations and contraceptive use among Christians in Lagos State, Nigeria. This design was deemed appropriate for assessing prevalence, describing patterns, and testing associations between variables at a single point in time.

Setting

The study was conducted in Lagos State, Southwest Nigeria, Africa's most populous city and a major economic and cultural hub. Lagos comprises 20 local government areas (LGAs) across three senatorial districts (Lagos West, Lagos East, and Lagos Central) and is characterised by ethnic diversity (predominantly Yoruba, with significant Igbo, Hausa, and other groups), high urbanisation, and a strong Christian presence (approximately 70% of the population).

Participants and Sampling

The target population comprised married Christian couples residing in Lagos State. A multistage sampling technique was employed:

1. Stage 1: Three LGAs were randomly selected from each senatorial district (nine LGAs total) to ensure geographical representation.
2. Stage 2: Five churches were randomly selected from each LGA (45 churches total), stratified by denomination (Catholic, Protestant, Pentecostal/Charismatic, and Aladura/African Independent Churches) to capture theological diversity.
3. Stage 3: From each church, 5–6 married couples were purposively selected based on inclusion criteria: (a) both spouses identified as Christian, (b) married for at least one year, (c) aged 18–65 years, (d) at least one living child, and (e) residing in Lagos State.

The final sample consisted of 250 married couples (500 individuals). This sample size exceeded the minimum requirement for logistic regression analysis with 6–8 predictors (approximately 10 events per predictor variable) and provided adequate power (>0.80) to detect medium effect sizes (odds ratio = 1.5) at $\alpha = 0.05$, assuming a modern contraceptive prevalence of 30–35%.

Instruments

Family planning with sexual orientations Scale (SKS)

Family planning with sexual orientations was measured using an 8-item researcher-developed Family planning with sexual orientations Scale, adapted from validated instruments in sexual health literacy research. Items assessed factual knowledge of human anatomy, physiology, reproduction, contraception, and sexually transmitted infections (e.g. 'A woman can become pregnant during her menstrual period' – True/False; 'Using condoms reduces the risk of HIV transmission' – True/False; 'Ovulation typically occurs midway through the menstrual cycle' – True/False). Each correct response was scored 1, and incorrect or 'don't know' responses were scored 0, yielding a total score ranging from 0 to 8 (higher = greater knowledge). The scale demonstrated acceptable internal consistency in this sample (Cronbach's $\alpha = 0.72$).

Contraceptive use

Contraceptive use was assessed via self-reported current use of any method, categorised as:

- Modern methods: Pills, injectables, implants, intrauterine devices (IUDs), male/female condoms, male/female sterilisation, emergency contraception.
- Traditional methods: Withdrawal, fertility awareness-based methods (e.g. calendar method), lactational amenorrhoea method, abstinence.
- No method: Not using any contraceptive method.

Participants were asked: 'Are you or your spouse currently using any method to delay or prevent pregnancy?' If yes, they were asked to specify the method(s) used. Current use was defined as use at the time of the survey or within the past month.

Demographic and Control Variables

A researcher-designed demographic questionnaire collected data on age, gender, education, occupation, household assets (for wealth index construction), number of living children, denomination, and frequency of church attendance. Wealth index was constructed using principal component analysis of household assets (e.g. television, refrigerator, car, home ownership) and categorised into quintiles (poorest, poorer, middle, richer, richest). These variables were included as controls in regression models based on prior evidence of their association with contraceptive use.

Procedure

Ethical approval was obtained from the [Name of Institutional Review Board] (Approval No: XXX/2025). Permission was sought from church leaders, and informed consent was obtained from all participants prior to data collection. Trained research assistants administered questionnaires in private rooms within church premises or participants' homes, ensuring confidentiality and minimising social desirability bias. Both spouses completed instruments independently to prevent response contamination. Data collection occurred over eight weeks (January–March 2025), with an average completion time of 25–30 minutes per couple.

Data Analysis

Data were analysed using IBM SPSS Statistics version 28. Descriptive statistics (means, standard deviations, frequencies, percentages) were computed for all variables. Chi-square tests and independent t-tests were used to examine bivariate associations between family planning with sexual orientations, contraceptive use, and demographic variables. Multiple logistic regression was conducted to test the predictive power of family planning with sexual orientations on modern contraceptive use (vs. traditional/no method), controlling for age, gender, education, wealth index, number of living children, and church attendance frequency. Assumptions of linearity (for continuous predictors), absence of multicollinearity, and adequate sample size were verified prior to

analysis. Effect sizes were reported as adjusted odds ratios (aOR) with 95% confidence intervals (CI). Statistical significance was set at $p < 0.05$ (two-tailed).

Ethical Considerations

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

Findings

Descriptive Statistics

The sample comprised 500 individuals (250 married couples) with a mean age of 35.17 years ($SD = 7.57$), ranging from 22 to 56 years. Participants' family planning with sexual orientations scores ranged from 0 to 8, with a mean of 5.52 ($SD = 1.67$), indicating moderate levels of family planning with sexual orientations overall.

Table 1 presents the socio-demographic characteristics of participants.

Table 1: Socio-Demographic Characteristics of Participants (N = 500)

Characteristic	Category	Frequency	Percentage (%)
Age (years)	20–29	85	17.0
	30–39	245	49.0
	40–49	135	27.0
	50–65	35	7.0
Gender	Male	250	50.0
	Female	250	50.0
Education	Secondary or less	75	15.0
	OND/NCE	100	20.0
	Bachelor's degree	225	45.0
	Postgraduate	100	20.0
Wealth Index	Poorest/Poorer	120	24.0
	Middle	130	26.0
	Richer/Richest	250	50.0
Number of Living Children	0–2	145	29.0
	3–4	230	46.0
	≥ 5	125	25.0
Church Attendance	Weekly	275	55.0
	2–3×/month	125	25.0
	Monthly	60	12.0
	Rarely	40	8.0

Contraceptive Use Patterns

Overall, 34.2% ($n = 171$) of participants reported current use of modern contraceptives, 18.6% ($n = 93$) reported use of traditional methods, and 47.2% ($n = 236$) reported no current use. Among modern method users, the most common methods were male condoms (18.6%, $n = 93$), oral contraceptive pills (9.4%, $n = 47$), and injectables (4.2%, $n = 21$). Long-acting reversible contraceptives (LARCs) such as implants and IUDs were rarely used (combined 2.0%, $n = 10$).

Bivariate Associations

Family planning with sexual orientations was significantly higher among modern contraceptive users ($M = 6.1$, $SD = 1.4$) than traditional method users ($M = 5.4$, $SD = 1.5$) and non-users ($M = 5.2$, $SD = 1.7$; $F = 31.45$, $p < 0.001$). Independent t-tests showed that modern users had significantly higher family planning with sexual orientations than non-users ($t = 7.82$, $p < 0.001$).

Chi-square tests revealed significant associations between modern contraceptive use and education ($\chi^2 = 28.34$, $p < 0.001$), wealth index ($\chi^2 = 42.17$, $p < 0.001$), and number of living children ($\chi^2 = 35.62$, $p < 0.001$), but not church attendance frequency ($\chi^2 = 3.21$, $p = 0.34$).

Multiple Logistic Regression

A multiple logistic regression was conducted to test whether family planning with sexual orientations significantly predicted modern contraceptive use (vs. traditional/no method) after controlling for demographic variables. The model was statistically significant ($\chi^2 = 142.38$, $p < 0.001$) and correctly classified 68.4% of cases.

Table 2 presents the regression coefficients.

Table 2: Multiple Logistic Regression Predicting Modern Contraceptive Use (N = 500)

Predictor	Adjusted OR	95% CI	p-value
Family planning with sexual orientations (per unit increase)	1.42	1.28–1.58	<0.001
Age (per year increase)	1.01	0.98–1.04	0.52
Gender (Male vs. Female)	0.89	0.61–1.30	0.55
Education (ref: Secondary or less)			
OND/NCE	1.45	0.78–2.70	0.24
Bachelor's degree	2.08	1.18–3.67	0.01
Postgraduate	2.15	1.15–4.02	0.02
Wealth Index (ref: Poorest/Poorer)			
Middle	1.52	0.92–2.51	0.10
Richer/Richest	2.67	1.68–4.25	<0.001
Number of Living Children (ref: 0–2)			
3–4	2.34	1.48–3.70	<0.001
≥5	3.12	1.85–5.27	<0.001
Church Attendance (ref: Weekly)			
2–3×/month	0.92	0.58–1.46	0.72
Monthly	0.78	0.42–1.45	0.43
Rarely	0.85	0.41–1.76	0.66

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

Family planning with sexual orientations emerged as a significant positive predictor of modern contraceptive use (adjusted OR = 1.42, 95% CI: 1.28–1.58, $p < 0.001$), such that for each one-unit increase in family planning with sexual orientations, the odds of modern contraceptive use increased by 42%, holding other variables constant. Other significant predictors included tertiary education (Bachelor's: aOR = 2.08, $p = 0.01$; Postgraduate: aOR = 2.15, $p = 0.02$), wealth index (Richer/Richest vs. Poorest/Poorer: aOR = 2.67, $p < 0.001$), and number of living children (3–4 vs. 0–2: aOR = 2.34, $p < 0.001$; ≥5 vs. 0–2: aOR = 3.12, $p < 0.001$). Age, gender, and church attendance frequency were not significantly associated with modern contraceptive use (all $p > 0.05$).

Table 3: Sexual Family planning with sexual orientations and use of contraceptive (N = 500)

	Frequency	Percentage (%)
If ones Partner is in favour of the use of modern contraceptives in the family		
Yes	103	43.1
No	117	28.0
No response	119	28.9
Modern Birth Control/Contraception		
Yes	239	58.2
No	200	41.8
Which of the following methods are being used currently in planning for the family		
Pills	439	7.6
Injection	439	7.6
IUCD	439	7.6
Implants	439	7.6
Diaphragm	439	7.6
Foam/Jelly spermicide	439	7.6
Condom	439	7.6
Tubal ligation	439	7.6
Vasectomy	439	7.6

Exclusive breast feeding	439	7.6
Withdrawal	439	7.6
Periodic abstinence	439	7.6
Others	439	7.6
If no to the question above, what are the main reason for not using any method		
Not married	45	11.7
Not sexually active	37	8.4
Infrequent sex	74	23.8
Want more children	75	24.3
Not in favour of FP	28	4.6
Do not know any method	19	0.8
Fear of side effect	31	5.9
Religious reasons	28	4.6
Too costly	20	1.3
Not convenient to use	21	1.7
Spouse/partner opposed	35	7.5
Others	30	5.4

Source: Field Survey, 2025.

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

‘Our Leadership must begin to contribute their congregation on and use of contraceptive, we must begin to call it as it is, not minimising words in form of the old methodology, but with intentionality of calling it as it is truly call in the contemporary time for the sake of the planning of the family’

A 48 year old male respondent

‘For the growth and development of the Church of God I think the place of Family Planning must be looked into for us to grow a healthy and rupturable church today, there is a need to reorientate the coming generation and those to take after us before the second coming of Christ, there is a need to raise a healthy and stronger generation in our family’

A 53 year old Female respondent

IV. DISCUSSION

Interpretation of Findings

The present findings provide robust empirical evidence that family planning with sexual orientations is a significant, independent predictor of modern contraceptive use among Christians in Lagos State, Nigeria. The 42% increase in odds of modern contraceptive use per unit increase in family planning with sexual orientations (aOR = 1.42) underscores the critical role of cognitive factors in reproductive health decision-making, consistent with Social Cognitive Theory and the Theory of Planned Behaviour.

Family planning with sexual orientations as a Catalyst for Contraceptive Uptake

The strong positive association between family planning with sexual orientations and modern contraceptive use aligns with global evidence that knowledgeable individuals are more likely to adopt effective methods, use them correctly, and continue use over time. In this sample, modern users demonstrated significantly higher knowledge scores (M = 6.1) than non-users (M = 5.2),

suggesting that understanding reproductive physiology, contraceptive mechanisms, and side effects reduces fear, corrects myths, and enhances self-efficacy.

Specifically, knowledgeable couples may be better equipped to:

- **Navigate misinformation:** Accurate knowledge counters myths that contraceptives cause permanent infertility, promote promiscuity, or violate divine will—common concerns among Nigerian Christians.
- **Communicate effectively:** Knowledgeable individuals are more likely to discuss family planning with partners, negotiate method choice, and seek joint decisions, reducing spousal opposition.
- **Manage side effects:** Understanding potential side effects (e.g. irregular bleeding, weight gain) and their temporary nature reduces discontinuation rates, promoting consistent use.
- **Access services confidently:** Knowledge of method options, sources, and costs empowers couples to seek services proactively, reducing barriers related to stigma or uncertainty.

Socio-Demographic Predictors: Education, Wealth, and Parity

The significant associations between modern contraceptive use and tertiary education (aOR = 2.08–2.15), wealth (aOR = 2.67 for richest vs. poorest), and parity (aOR = 3.12 for ≥ 5 children vs. 0–2) reflect well-documented socio-economic gradients in reproductive health behaviour. Educated, wealthier, and higher-parity women typically have greater access to information, resources, and health services, enabling informed contraceptive choices.

Notably, the effect of family planning with sexual orientations persisted even after controlling for these socio-demographic factors, suggesting that knowledge operates through distinct cognitive and behavioural pathways (e.g. self-efficacy, attitudes, communication) beyond mere access or affordability. This finding supports targeted educational interventions even among already-advantaged populations.

Religious Commitment and Contraceptive use

The absence of a significant association between church attendance frequency and contraceptive use ($p = 0.34$) is noteworthy, particularly given prevailing assumptions that religious commitment discourages contraception. This finding suggests that among Lagos Christians, religious participation does not necessarily preclude modern contraceptive use, possibly due to:

- **Denominational diversity:** Many Protestant and Pentecostal churches in Lagos adopt neutral or supportive stances on family planning, unlike Catholic doctrine.
- **Private belief vs. public practice:** Individuals may attend church regularly while privately adopting contraceptive methods aligned with personal or spousal preferences.
- **Evolving norms:** Urban, educated Christians may reinterpret religious teachings to accommodate modern family planning as responsible parenthood.

This finding challenges simplistic narratives about religion as a barrier to contraception and highlights the need for nuanced, denomination-specific engagement with faith leaders.

Theoretical Implications

The findings validate the application of Social Cognitive Theory and the Theory of Planned Behaviour to understanding contraceptive behaviour in African Christian contexts. Family planning with sexual orientations operates through multiple SCT pathways (knowledge $\rightarrow$ self-efficacy $\rightarrow$ behaviour) and TPB pathways (knowledge $\rightarrow$ attitudes $\rightarrow$ intention $\rightarrow$ behaviour), suggesting that educational interventions should target not only factual knowledge but also self-efficacy, attitudes, and perceived behavioural control.

Limitations

Several limitations warrant acknowledgment:

1. **Cross-sectional design:** Causal inferences cannot be drawn; longitudinal studies are needed to establish temporal precedence.
2. **Self-report bias:** Social desirability may have influenced contraceptive use reporting, particularly among highly religious participants.

3. Sampling bias: Participants were recruited from churches, potentially over-representing highly religious, married, urban Christians; findings may not generalise to non-church-attending Christians, Muslims, or rural populations.
4. Unmeasured confounders: Variables such as spousal communication, partner approval, health system factors, and media exposure were not assessed, potentially confounding observed associations.
5. Measurement limitations: Family planning with sexual orientations was measured with a brief 8-item scale; more comprehensive instruments may capture additional knowledge domains (e.g. STI prevention, method-specific knowledge).

V. CONCLUSION

This study provides compelling evidence that family planning with sexual orientations is a significant, independent predictor of modern contraceptive use among Christians in Lagos State, Nigeria. Key conclusions include:

1. Family planning with sexual orientations matters: Higher family planning with sexual orientations is associated with significantly higher odds of modern contraceptive use, even after controlling for education, wealth, and parity.
2. Socio-economic gradients persist: Education, wealth, and number of living children remain strong predictors of contraceptive use, highlighting persistent inequalities in reproductive health access and outcomes.
3. Religious commitment is not a barrier: Church attendance frequency was not significantly associated with contraceptive use, suggesting that religious participation does not necessarily preclude modern family planning among Lagos Christians.
4. Theoretical validation: The findings validate the application of Social Cognitive Theory and the Theory of Planned Behaviour to understanding contraceptive behaviour in African Christian contexts.

RECOMMENDATIONS

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

1. Integrate Evidence-Based Sexual and Reproductive Health Education into Premarital Counselling

Christian denominations in Lagos State should revise premarital counselling (PMC) curricula to include structured, evidence-based modules on sexual and reproductive health, covering:

- Human anatomy and physiology (male and female reproductive systems, ovulation, conception)
- Contraceptive methods (mechanisms, effectiveness, side effects, correct use)
- Family planning benefits (maternal health, child spacing, economic stability)
- Myth-busting and correction of common misconceptions about contraception

Training should be provided for clergy and lay counsellors to ensure accurate, biblically aligned, yet scientifically grounded content delivery.

2. Develop Church-Based Family Planning Programmes

Building on the concept of sexual health literacy (SHL), churches should offer ongoing family planning workshops for married couples, addressing:

- Enhancing contraceptive self-efficacy through skills-building exercises (communication, negotiation, problem-solving)
- Promoting shared decision-making between spouses
- Addressing specific concerns (side effects, moral dilemmas, denominational doctrines) through pastoral counselling and peer support

Programmes should be denominationally sensitive, incorporating biblical principles while avoiding shame-based or fear-driven messaging.

3. Strengthen Referral Pathways between Churches and Health Facilities

Churches should establish formal referral partnerships with nearby family planning clinics, pharmacies, and patent medicine vendors to facilitate access for congregants. Pastors and counsellors can provide information cards, hotline numbers, or accompaniment services to reduce barriers related to stigma, cost, or uncertainty.

4. Promote Research on Mediating Mechanisms

Future research should examine the mediating roles of contraceptive self-efficacy, partner communication, attitudes towards contraception, and perceived behavioural control in the relationship between family planning with sexual orientations and contraceptive use, as hypothesised by Social Cognitive Theory and the Theory of Planned Behaviour. Longitudinal and dyadic designs would clarify causal pathways and partner effects.

5. Policy Implications for Public Health and Family Welfare

The Lagos State Ministry of Health and the Federal Ministry of Health should consider:

- Collaborating with religious organisations to disseminate accurate sexual and reproductive health information, leveraging churches' extensive reach and trust within communities
- Supporting training programmes for clergy and counsellors on evidence-based family planning education and counselling
- Integrating family planning with sexual orientations assessment into national family life and HIV education (FLHE) curricula for adolescents and young adults, preparing them for informed reproductive health decisions

REFERENCES

- [1]. Abiodun, K., Ogunwuyi, B., Olaiya, S., & Araromi, C. (2022). Emotional intelligence and
- [2]. marital satisfaction of Christian couples in CAC, Nigeria. *Applied Journal of Economics, Management and Social Sciences*, 3(2), 1–15.
- [3]. Adebowale, T., & Ogunlade, S. (2023). Sexual communication and marital satisfaction among married couples in Lagos, Nigeria.
- [4]. *African Journal of Social and Behavioural Sciences*, 13(2), 45–58.
- [5]. Adegoke, A., & Oladipo, J. (2024). Religious commitment and marital fidelity among Christian couples in Southwest Nigeria. *Journal of Religion and Health*, 63(1), 112–128. <https://doi.org/10.1007/s10943-023-00987-2>
- [6]. Adeyemo, T., & Oluwale, O. (2019). Sexual intimacy and marital stability among Christian couples in Nigeria. *Journal of Family Studies*, 25(3), 245–260.
- [7]. Ajzen, I. (1991). The theory of planned behaviour. *Organizational Behaviour and Human Decision Processes*, 50 (2), 179–211. <https://doi.org/10.1016/0749-5978>(91)90020-T
- [8]. Alabi, O., et al. (2023). Sexual autonomy and the use of modern contraceptives in Nigeria. *Nigerian Medical Journal*, 64(3), 245–253.
- [9]. Amato, P. R. (2014). Marital stability and family well-being. *Journal of Marriage and Family*, 76(5), 923–938.
- [10]. Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall.
- [11]. Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology*, 52(1), 1–26.
- [12]. <https://doi.org/10.1146/annurev.psych.52.1.1>
- [13]. Birinci, G., & Rahime, K. (2022). Sexual health literacy and reproductive health. *Turkish Journal of Public Health*, 20(1), 45–58.
- [14]. Brown, O. (2019). Communication skills and conflict resolution in Nigerian marriages. *African Journal of Counselling Psychology*, 11(2), 78–92.
- [15]. David, A., & Stafford, L. (2015). Spiritual bonding and marital satisfaction. *Journal of Psychology and Theology*, 43(2), 112–125.
- [16]. Eze, C., & Nwachukwu, P. (2023). Premarital counselling and marital stability among
- [17]. Pentecostal Christians in Lagos, Nigeria. *Journal of African Christian Thought*, 26(1), 34–49.
- [18]. Gachutha, C. W., Alumada, A. K., & Kamau, E. W. (2026). Evidence-based premarital counselling: A clinical guide for practitioners. *International Journal of Research and Innovation in Social Science*, 10(3), 5849–5873. <https://doi.org/10.47772/IJRISS.2026.10035849>
- [19]. Ijadunola, K. T., et al. (2010). Knowledge and practice of contraception among women in a Nigerian urban community. *African Journal of Reproductive Health*, 14(2), 112–120.
- [20]. Mahoney, A. (2010). Religion and marital quality. *Journal of Family Theory*, 22(4), 567–585. <https://doi.org/10.1111/j.1741-3737.2010.00769.x>
- [21]. National Population Commission (NPC) & ICF. (2019). *Nigeria Demographic and Health Survey 2018*. NPC and ICF.

- [19]. Ogunleye, B., & Adebayo, S. (2024). Determinants of women's modern contraceptive use in Nigeria, context of family planning policy. UAPS 2024 Conference Proceedings, 1–18. Ojo, O., & Adebayo, R. (2025). Factors associated with modern contraceptives use in Nigerian youth: A comparative analysis of Northern and Southern Nigeria (2011–2021). *PLOS Global Public Health*, 5(6), e0004685. <https://doi.org/10.1371/journal.pgph.0004685>
- [20]. Oladipo, J., & Adegoke, A. (2025). Church-based premarital counselling programmes and marital outcomes in Lagos State, Nigeria. *African Journal of Counselling and Development*, 17*(1), 23–40. Speizer, I. S., et al. (2018). Role of religious leaders in promoting contraceptive use in Nigeria: Evidence from the Nigerian Urban Reproductive Health Initiative. *Global Health: Science and Practice*, 6(3), 500–513. <https://doi.org/10.9745/GHSP-D-18-00071>
- [21]. Yaya, S., & Okonofua, F. (2017). Determinants of contraceptive use among Nigerian
- [22]. couples. *BMC Public Health*, 17(1), 1–12. <https://doi.org/10.1186/s12889-017-4923-5>
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