Understanding Childbearing for Households in Emerging Slum Communities in Lagos State, Nigeria

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Abstract: **This study examined child bearing practices with critical focus on the fertility behaviour for men and women in emerging slum communities. The author analysed respondents' responses on fertility behavior and knowledge. A descriptive cross-sectional survey method was applied with the use of semi-structured questionnaire among 364 households. The study revealed that average age at first actual marriage in emerging slum communities is 27 ± 23 years with minimum ages at 19 ±16, while the minimum age at first birth for women is 15years. Nevertheless majority had their first birth between the ages of 25-49. Also, more than half of the population has giving birth to not lesser than 4 children in their life time and a few still have desire for more children. Knowledge of other modern methods of contraceptives aside condoms and pill was very low.**

Keywords: **Fertility, Emerging Slum, Contraceptive, Nigeria**

I. INTRODUCTION

Fertility is one of the most important components in demographic studies affecting almost all aspects of human life. Fertility is the only biological replication method for human being to ensure continued existence on earth. If the human society is to prevail, fertility is key and that is why, of the three main aspects of demography; fertility, mortality and migration, fertility occupies a central position in population study irrespective of the geographical settings; rural, urban or in slums. Human fertility is a complex process responsible for the maintenance of human society. In African societies, families measured their riches by the number of healthy children they had, however in an unpredictable circumstances, fertility preference seem unstable (Machiyama, Mumah, Mutua, et al, 2019). In Sub-Saharan Africa, there is the record of the lowest rate of contraceptive use in the world, especially in poor countries and on the other hand having the highest unmet need for contraceptives (Population Reference Bureau, 2019). This is a result from a number of factors; difficulties in getting contraceptives supplies, lack of adequate family planning clinics, low social economic levels and high value many cultures place on large family size.

The fertility of rate of any population is influenced by various factors, directly or indirectly. The degree of influence of these factors; Age at menarche, age at menopause, age at marriage, age at first conception, per capital annual income, education and occupation on fertility differ from society to society (Chan et'al, 2020; Sharma, 2019). Studies have shown that fertility behaviour of urban dwellers is tailored in the line of low fertility unlike the rural populace. However, within the urban centres there are differential behaviours per spatial locations of individuals which explain the little increase in fertility often experienced in urban areas. This is a factor of the urban and urban slum areas or the urban rich and urban poor. The urban slums have quite distinctive response to fertility however due to population dynamics there is the possibility that emerging slum areas may (not) have same behavioural pattern.

Particularly to slum dwellers, studies have revealed quite succinctly on fertility behavior both in developed and developing countries. In Africa, in the study of unintended pregnancies among young women living in urban slums in Kenya found that Forty-two percent of women who wanted to have a child within two years and 37% of those wanting in two to four years became pregnant within two years while 21% of women wanting to wait for at least five years and 16% of those wanting no more children conceived during the same period (Machiyama, Mumah, Mutua, et al, 2019). In a different study among rural Africans, the desire to limit childbearing among married women could lead prediction of childbearing to over two to three years period (Machiyama, 2015).

Ram Chandra (2010) found in a study on the effects of demographic factors affecting fertility behaviours in the slums in Western Terai of Nepal that education played a key role in the determination of fertility and amongst couples of different religion, the Muslim couples have the highest fertility and the Hindus have the lowest. The role of socioeconomic factors influencing fertility has been clearly pointed out by Kieru, Ngige and Ondigi (2015). In a study on factors associated with reproductive behavior of low income mothers in Kiandutu Slum in Thika Municipality in Kenya, using the family resource management model, the study found that level of education, occupation, income levels, religious affiliation and attitude towards contraception had significant relationship with mothers' reproductive behavior.

In a bid to combine health and fertility, Wekesa and Coast (2014) in a study of fertility desires among men and women living with HIV/AIDS in the slums of Nairobi pointed that fertility desires require new understanding in a context of expanding access to antiretroviral therapy for people living with HIV/AIDS in Sub-Saharan Africa. The study reaveals that fertility desires reflects a system of complex tensions between social pressures to have children and pressure to prevent HIV infection.

The use of contraceptive is a major component in understanding individual fertility behavior (WHO, 2020; Bawah, Asuming, Achana, et al, 2019). Fertility and contraceptive use in poor urban areas of developing countries found that fertility among urban poor varies between and within cities and is affected by many factors (Beson et al, 2018; viisah, 2018; Debebe, 2017; Masuman et'al 1993). Those with fertility enhancing effects include decreases in breastfeeding and sexual abstinence taboos. Reasons behind these changes from the study include ideas of modernity, increases in women employment, the need for further child labour and the breakdown of the extended family. These studies further pointed that fertility-reducing effects include the proportions marrying, age at first marriage, age at first marriage, increased spousal separation and increased use of contraception. It was understood these in turn are driven by increased access to contraception, smaller norms for family size, increases in female education and employment, improved child survival and changes in family structure and earning power.

In a Nigeria study by Adedimeji et'al, (2009) on contraceptive use and behaviour among young urban slums inhabitants in Southwest Nigeria reveled that there was a widespread knowledge and low levels of condom use particularly among young people aged 15-29 living in the slums despite the high level of sexual risky behaviour. According to Emmanuel, Andrea, et al (2010), the prevalence rate of modern contraceptive in Nigeria is low (11%-13%) despite the high rate of sexual activity. In a different study by Odor (2011) on the use of condom amongst the elderly in high risk urban slum communities in Nigeria found that 25% of the respondents already had extra-marital sex since they attained elderly age. However, among this subgroup 6.8% used a condom. It was also found in the study that more males 5.3% than females 1.5% used condom during their last extramarital sex. It was reported that low level of condom use was attributed to condom not worthwhile and the opinion that condom not meant for the elderly.

Furthermore, Joshua, Akanni and Adesegun (2014) on women's perception in family planning adoption in selected urban slum areas in Nigeria found that women in the selected communities expressed desire or family planning adoption. Three main reason accounted for these; perceived need to space childbirth; family's financial condition and potential adverse effect of high fertility on the woman's health. Findings also revealed that male partners' support for the use of family planning by women was low which was due to misconceptions about family planning and traditional pro-natalistic beliefs and tendencies. However studies on the go, this paper further strengthens the discuss of child bearing practices by extension focusing on the child bearing processes for men and women in emerging slum communities.

II. METHODS AND MATERIALS

A combination of cluster and simple random sampling was used to select 364 households across the major selected areas. A semi-structured questionnaire was administered to respondents to elicit information on socio-demographic characteristics of household members and household characteristics. Quantitative data was analyzed using descriptive statistics. Using the cluster sampling, the study area was divided into 10 major households' from the major areas in Ayobo; Ayobo central, Bada community, Odo-Adamo, Isefun, Alaja, Camp Davies, Ayetoro Road, Amule, Orisunbare, Onikanga. In each sub-area there are up to 8 streets which led to the first stage of random selection. Each street in each sub-area was given a number and using the ballot process 4 streets were selected for inclusion. Lastly, since every house on each street have a street number, the table of random number was systematically employed in selecting 40 numbers vertically. Any house with the number selected was picked for inclusion in the study.

III. RESULTS

The fertility behavior is measured in this study by seven indices namely: age at first marriage, age at first birth, number of children ever born-total fertility rate, number of surviving births, child spacing, desire for more births, number of intending births and the knowledge and use of contraceptives. The study utilized data gotten using the questionnaire from each household respondent self-reporting. Ages were regrouped in the interval of 5 to show the relevance of each age group. The percentages of male and female in this section signifies fathers and mothers from each household.

Table 1 below shows the frequency distribution of age at first marriage for both male and female from each household in Ayobo. Majority of the males got married at the age of 30-34 (36.3%) while majority of the females (38.2%) got married at 25-29years, although 3.0% males and 6.9% females got married within the ages of 15-19 years. The average age at marriage is 27, 23 for male and female respectively while the minimum age is 19 and 16 respectively.

Table 1 - Respondents Age at First Marriage

Age At Marriage	Male		Female	
	Frequency	Percentage (%)	Frequency	Percentage (%)
15-19	11	3.0	25	6.9
20-24	121	33.2	139	38.2
25-29	132	36.3	98	26.9
30-34	10	2.7	100	27.5
35-39	68	18.7	2	.5
40-44	22	6.0	0	.0
Male - Minimum=19 Maximum= 43 Average Age at Marriage=27.22 Female - Minimum=16 Maximum= 38 Average Age at Marriage=23.71				

Source: Author's Field Survey

Table 2 below further shows that more than 2/3rd of the women 124(34.1%) had their first birth within the ages of 20-24years. However, 13 (3.6%) of the women had their first birth at a early age of 15-19 years while none (0.0%) had their first child above 39 years of age.

Table 2- Respondents Age at Fist Birth

Age At First Birth	Female	
	Frequency	Percentage (%)
15-19	13	3.6
20-24	124	34.1
25-29	119	32.7
30-34	101	27.7
35-39	13	3.6
40-44	0	.0
Female - Minimum=15 Maximum= 39 First Conception=23.91 WGB at Age 18-24 (28.0%)		Average Age at

Source: Author's Field Survey

From the distribution of children ever born and fertility rate in Ayobo, it was found that the average number of CEB in the study is 4.43. The total fertility rate (TFR- 2.8) shows the population is growing. Women with CEB above 6 children are 19.8% while more than half (51.9%) of the respondents have given birth to not less than 3 children in their life time as shown in table 3 below.

Table 3- Distribution of the respondents' number of children ever born

Number of children ever born (CEB)	Women	Percentage (%)
1-2	103	28.3
3-4	189	51.9
5 and above	72	19.8
Minimum=1 Maximum=8 Average Number of CEB=4.43		

Women	Number of children								Total
Age in Cat (15-49)	1	2	3	4	5	6	7	8	
20-24	24	10	10	11	2	3	0	0	60
25-29	12	25	20	8	1	4	0	0	70
30-34	14	25	13	28	13	3	3	0	99
35-39	7	38	9	25	19	8	3	1	110
40-44	1	10	20	21	12	3	0	2	69
45-49	1	14	14	29	12	19	1	0	90
50-59	0	3	22	11	14	12	1	1	64
N(CEB)=562, Total Fertility Rate TFR=2.8									

Source: Author's Field Survey

One other area of finding is the desire for more children in the area. Although this analysis did not show the various factors leading the decision but it was found that 68 (18.7%) of the

respondent have desired to have more children while 8.5% were not sure either to have more children or not. The unstructured section of the research instrument was used to gather and group the reasons given for desire of more children. From the 18.7% of the respondents with the desire for more children, the following reasons given by the respondents were; having children is socially normal, there is still the desire for more children and lastly, having the financial ability to cater for more children. More significantly, 72.8% of the respondents do not want more children. This figure does not statistically infer the percentage of those that have crossed menarche or menopause but rather a decision borne out of both partners agreement. However, majority of the respondent with the desire to end births were giving reasons tending towards an economic determinant. The frequency distribution is shown in table 3a below.

Table 4- Respondents desire for more children

Decision	Frequency	Percentage (%)
Yes	68	18.7
No	265	72.8
Don't know	31	8.5

Source: Author's Field Survey

Figure 1 below further expatiates on the reports in table 3 by showing the number of intending births. From the 18.7% of respondent with the desire for more children as shown above, 4.7% desire additional one child, 6.9% desire additional 2 children, 4.4% desire additional 3 children while less than ¼ of the respondent (1.9%) desire additional 4 children.

Figure 1- distribution showing the desired number of intending births
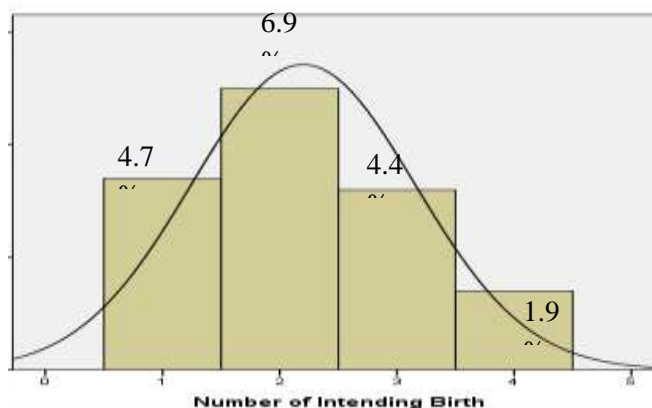
Source: Author's Field Survey

Generally there was an observed wide spread of knowledge of both traditional and modern methods but 28.3% of the respondent do not understand the conceptual meaning of contraceptive but have a good understanding when it is been explained in the light of family planning and also the methods involved. However, 261 (71%) of the respondent have a good knowledge of contraceptive. In addition, figure 4.2.3b below shows that 100% of the respondents had the knowledge of any

method of contraceptives and also any modern method of contraceptive. Albeit, 279(76.6%) have heard of other modern methods of contraceptives aside condoms and pills while only 131(35.9%) were found to have heard of all modern methods of contraceptive as highlighted in the table 5 below.

Figure 2- Knowledge of both modern and traditional methods of contraceptive
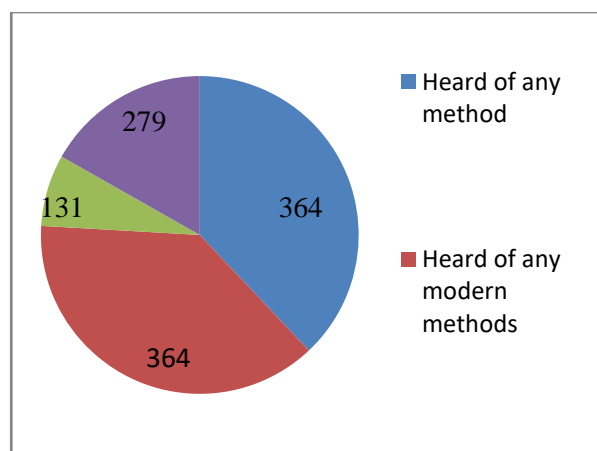
Source: Author's Field Survey

From a broader description, it was found that modern and traditional methods of contraceptive were used interchangeably. The use of modern methods of contraceptive was found to be higher than the use of traditional methods from the study. More than half of the population 71.2% has used condoms while amongst the 49.5% currently using contraceptives 13.7% currently use condom. Also, 30.8% respondent has used one type of pill or the other (Duofem Confidence, Microgynon, Lofemenal, Neogynon, Postinor) at one point in time or the other. It was also found that 1.6% of the respondents used the sterilization methods however that was after last birth. 54.7% and 58.5% of the respondents have used rhythm and withdrawal traditional methods respectively although only 18.4% are currently using the withdrawal methods. Table 5 below shows the distribution.

Table 5- Distribution of contraceptive methods and respondent pattern of usage

Contraceptive Methods	Used	Never Used	Used After Last Birth	Currently Using	Contraceptive Use (NDHS, 2013) Lagos (%)
Sterilization	6 (1.6%)	252 (69.2%)	6 (1.6%)	.**	0.1
Pill (Duofem Confidence, Microgynon, Lofemenal, Neogynon, Postinor)	112 (30.8%)	204 (56.3%)	70 (19.2%)	32 (8.8%)	6.5
IUD (the intrauterine device)	129(35.4%)	235 (64.6%)	20 (5.5%)	24 (6.6%)	2.4
Injectables (Noristerat, Norigynon, Depo Provera)	118(32.4%)	246 (67.6%)	6 (1.6%)	3 (0.8%)	4.6
Implants	139(38.2%)	225 (61.8%)	.**	.**	0.3
Condom	259(71.2%)	105 (28.8%)	85 (23.4%)	50 (13.7%)	10.3
Diaphragm,	130(35.7%)	234 (64.3%)	7 (1.9%)	.**	-
Foam/jelly,	59 (16.2%)	305 (83.8%)	.**	.**	-
LactationalAmenorrhoeamethod (LAM),	81 (22.3%)	283 (77.7%)	5 (1.4%)	1 (0.3%)	0.9
Emergency contraception	122(33.5%)	242 (66.5%)	.**	3 (0.8%)	-
Rhythm (periodic abstinence)	199 (54.7%)	165 (45.3%)	16 (4.4%)	.**	10.2
Withdrawal methods	213 (58.5%)	151 (41.5%)	21 (5.8%)	67 (18.4%)	9.0
None	.**	.**	128 (35.2%)	184 (50.5%)	

Source: Author's Field Survey

Table 6 below further displays the cross tabulation of the number of surviving children and type of contraceptive use. It is found that respondents with less than four children tend to use less of contraceptive than those with four surviving children and more. The table further shows that there is more use of condoms (50) and withdrawal (51) contraceptive methods.

Table 6- Number of surviving births and current contraceptive use

Number of Children	Contraceptive							
	Pills	IUD	Injectable	Condom	Lactational Amenorrhoea Method (LAM)	Emergency Contraception	Withdrawal Methods	Total
1	**	**	**	7	**	**	**	7
2	**	1	**	**	**	**	9	10
3	3	9	**	**	1	**	8	21
4	26	14	**	16	**	3	14	73
5	3	**	**	15	**	**	20	38
6	**	**	**	9	**	16	**	25
7	**	**	3	3	**	**	**	6
Total	32	24	3	50	1	19	51	180

Source: Author's Field Survey (**- empty cells) (N=180)

In the cross tabulation of religion and contraceptive use, the study found that there is more use of contraceptives by the Protestant/Anglican than any other religion type. However, there are little differences in the low use of contraceptives between the Catholics and the Muslims which is a total of 31 and 33 respectively. Amongst the 31 Catholics currently using contraceptive, majority (17) use the withdrawal method of contraceptive as could be seen in table 7 below.

Table 7- Religion of respondents and contraceptive use

Religion	Contraceptives							
	Pills	IUD	Injectable	Condom	LAM	Emergency Contraception	Withdrawal Methods	Total
Muslim	3	11	0	10	0	0	9	33
Protestant/Anglican	29	12	3	28	1	0	41	114
Catholic	0	1	0	10	0	3	17	31
African traditional	0	0	0	2	0	0	0	2
Total	32	24	3	50	1	3	67	180

Source: Author's Field Survey

The duration of child spacing after first birth for women in households with 2 or more children was another indicator used in this study to measure the fertility behavior of the people in area. A question was asked on the period of first surviving birth within the union and the time of the preceding birth to determine the child spacing or period of waiting after first birth. The study found that 43 (8.54%) of the households with 2 children waited for less than 12 months before having a second child also 14 (2.78%) of the women with 7 children had less than 12 months interval between first and second birth. It was also found that more than half (77.13%) of the women had birth space of 0-2 years between the first and second birth as shown in table 8 below.

Table 8- Child spacing after first surviving birth

Number of Children	< 12 months	1-2years	3-5 years	≥ 6years
2	43 (8.54%)	29 (5.76%)	17 (3.37%)	2 (0.39%)
3	56 (11.13%)	19 (3.77%)	25 (4.97%)	2 (0.39%)
4	26 (5.1%)	24 (4.77%)	11 (2.18%)	4 (0.79%)
5	22 (4.37%)	62 (12.32%)	19 (3.78%)	10 (1.98%)
6	23 (5.57%)	38 (7.55%)	6 (1.19%)	9 (1.79%)
7 and more	14 (2.78%)	32 (6.36%)	7 (1.39%)	3 (0.59%)

Source: Author's Field Survey

IV. DISCUSSION

In understanding the fertility beahviour of the household respondents, the study used a number indices leading to explaining fertility behaviour. Firstly, the study found that the average age at first marriage in Ayobo was 27 years and 23 years for male and female respectively. The study also showed that the minimum age at first birth was19 and 16 years for male and female respectively. However, the minimum age at first birth for women was 15years while women that had their first birth at age 18-24 years was 28%. In a different perspective, considering the pattern of Nigeria education system an individual within these aforementioned ages at first birth should either be in secondary school or at the entry level in the university irrespective of the location. Considering the age at first birth as found in the study and the perceived commitment involved before and after birth, there is the likely possibility that either many of the females if not all would have dropped out of school or suspended their education at one point or the other just as Beguy, Mumah and Gottschalk (2014) found amongst women living in the slums in Kenya.

More so, comparing these statistics found with what has been documented on Lagos, PMA Survey report (2016) showed that the median age at first marriage for females in Lagos is

24.5 years also only 2.3% women had their first birth within the ages of 18-24 years. It was also found in this study that a total of 64.0% of women had their first birth between the ages of 25-49, albeit the NDHS, 2013 revealed a lower percentage of 23.8% for women within the age category in Lagos. Furthermore, studies (Chidubem et'al 2015; Odor, 2011) have shown that there are slums in Nigeria with significant population of the elderly, nonetheless in supporting findings from this study, Akinwale et al, 2014 and Daniel et' al (2013) have shown that age at first marriage in major slums in Lagos (Amukoko, Ijora-Oloye, Ajegunle) ranged from 17-19 years for both male and female which supports findings from this study. Outside of Lagos and Nigeria, Beguy, Mumah and Gottschalk (2014) found in their study if young women in urban slums in Nairobi that 41% of the pregnant women were adolescent within the ages of 15-22 years.

The average number of CEB in the study was 4.4 while the total fertility rate in Ayobo is 2.8 with 51.9% of women giving birth to not less than 4 children in their life time. However, according to the PMA Survey report (2016) and the NDHS (2013), TFR for Lagos was 3.4 and 4.1 respectively. It was also found in the study that 18.7 % of the respondents desired to have additional children out of which 1.9% of the respondent desired additional 4 children and 4.4% desired additional 3 children with what they already have. In many cases studies (Abbasi and McDonald, 2005; Ali 2005; Maitra 2004) have shown that fertility desire in urban areas is generally low and this is as a result of so many factors. Similarly, the PMA report (2016) also showed that only 15.7% have the desire for additional birth in Lagos. Although a lower figure (3.6%) was reported in NDHS (2013). Albeit, Masuma et.al (1993) pointed earlier that the desire to have children by slum dwellers is usually unplanned.

Furthermore, with the regards to contraceptive use, the study showed that 71.7% have a good knowledge of modern and traditional methods of contraceptive while 28.3% do not understand the conceptual meaning of contraceptive but understood only when explained in the line of family planning. This means everyone have knowledge of contraceptive which is strengthens the report of the NDHS (2013) which showed that 99.9% have knowledge of both modern and traditional methods of contraceptive in Lagos.

More so, it was found that 76.6% have heard of other modern methods of contraceptives aside condoms and pills while only 35.9% were found to have heard of all modern methods of contraceptive used in Nigeria. Significantly, the study found the use of condom, withdrawal methods and rhythm to be higher in Ayobo. However the use of condom has been found to be low in Maroko in Lagos given to reasons of it being too sophisticated and denies pleasure while in other slums (Ijeshatado and Itire) the traditional methods was found to mostly used than the modern contraceptives (Osun Defender, 2016). It was generally observed that the use of condom was perceived to be an effective birth control mechanism in the area, but Adedimeji, Omololu and Odutolu (2007) found that the use of condom amongst young slum dwellers in Ibadan was perceived more as a protective mechanism against sexually transmitted diseases like HIV/AIDS.

Succinctly, the fertility behavior as found in Ayobo is slightly different from what has been found in existing slum areas. Obviously, things are changing and human behaviours are no exception. However, adolescent sexuality remains a major issue cause in Ayobo majority of the women had their first birth at an early age and this is one area, emerging slum communities might likely follow the precedence of existing slums, thereby compounding issues. The increasing awareness which includes knowledge of contraceptive is very positive to family planning but on the other hand, makes it possible for youths to engage more in sexual activities and where this leads to pregnancy it becomes a dual burden for the urban poor parents and the baby (Joshua et.al, 2014). More so, just as could be found in the rural areas, contraceptive knowledge does not necessarily transcend to decrease in birth rate, because despite the level of knowledge observed in emerging and existing slum areas, families keep producing more children for the society (Adedimeji et.al, 2009).

All of these lead us back to the focus of the Nigeria Population Policy. The urban poor and rural areas stand at vulnerable positions and by so doing should relatively drive the direction of population policy in Nigeria. The economic state of the urban poor directly influences their decision to increase or decrease birth regardless of the position of the policy. From a wider scope, this means the population increase in urban centers is hitherto fuelled by the reproductive activities of the urban poor and if urban renewal initiatives are less effective, population policies might scarcely achieve it targets in urban areas. Nevertheless, population increase is not a problem if available resources are properly harnessed with the active use of the youth bulge in driving development rather than having segments in cities where lives are wasted in idleness and crime.

V. CONCLUSION

It is clear that Lagos has become the epicenter for birth and rebirth of slums in Nigeria. This is so accorded on the bases of fast proliferation of slum communities with unpleasant living conditions. While migration is an indicator, fertility and fertility behaviour on the other hand contributes to increase in the number of persons living in cities which invariably lead to the emergence of slums where coping strategies are no longer sustainable. Emerging slum communities have almost no difference with actual grown slums, where birth rate is high, family size is large, fertility knowledge is low. While there is need to stop the further increasing of slums through the government paying grasp attention to slum upgrade, there is but more urgency in cubing emerging slums in all aspects. There is need for an improved awareness with regards to fertility planning however without neglecting root curses such as socioeconomic status, education which affects age at marriage and general living conditions.

More critically, there is an all-important need to generate political will to change or update the indicators of maternal health in the Nigeria population policy and other population-health strategic planning documents with regards to contraceptive use especially for low income households. A number of programs and policies have been formulated by the government but just like the case of Kenya, Nigeria can through the Ministry of Health introduce a concentration line for contraceptives in addition to a paradigm shift on access to health services and ensure periodic measurement on the impact especially among slum and low income households in general.

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DECLARATION