Perceptions of contraceptives as factors in birth outcomes and menstruation patterns in a rural community in Siaya county, Western Kenya

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Unmet need for contraception persists in Kenya despite an increase in awareness and availability of family planning services. There is a dearth of information on experiences and perceptions of contraception, specifically related to birth outcomes and menstruation patterns, in western Kenya. The aim of this study was to explore knowledge and perceptions on contraception, menstruation, and birth outcomes. In-depth interviews were conducted with 45 respondents: adolescent girls with children, mothers over age 20, and fathers. Six Focus Group Discussions were held with 60 participants drawn from Skilled Birth Attendants, Traditional Birth Attendants, and Community Leaders. A thematic content analysis approach was used. We found that most participants knew about contraceptives and accessed the services in their local health facilities. A majority of the women associated problems with the inability to track menstruation with contraceptive side effects. Beliefs linking contraceptives to the occurrence of preterm and birth defects were also reported among the respondents. Overall, most women approved of contraceptives, however, perceptions remained largely negative among men. While contraception remains an important health service for improvement of maternal-child health, the belief that it affects menstruation and contributes to preterm births hinders its uptake in the community. There should be programmatic intervention targeting families to change the negative perceptions linked to contraceptive use.

Contraceptive use is important in helping people achieve desired fertility, avoid unintended pregnancies, and prevent sexually transmitted infections, therefore directly influencing maternal and child health.1 At least 214 million women in developing countries are facing the unmet need for contraceptives despite many global initiatives including Family Planning 2020 and the Sustainable Development Goals (2016–2030).2 Additionally, due to the high unmet need for contraceptives, Sub Saharan Africa (SSA) has the highest burden of unintended pregnancies, unsafe abortions, and maternal mortality.3 Several factors have been linked to the low contraceptive uptake among women in developing countries. Knowledge, beliefs, perceived side effects, spousal support, cultural practices, and poor health infrastructure in rural communities are some of the documented hindrances to access and utilization of contraceptive services.4

Global and national policies have emphasized strategies for improving contraceptive access to an additional 120 million women by 2020.5 Recent research in Uganda has shown that comprehensive knowledge and understanding of contraceptives is associated with increased uptake and effective use.6 According to the Kenya Demographic Health Survey (2015), the unmet need for contraception among women declined from 26% in 2010 to the current 18% but varies significantly according to regions, levels of education, and economic status.6 Increased uptake of contraceptives has been associated with better living standards, gender equity and greater benefits to the individual, family, and nation.5 Family planning programs have been prioritized in many countries as some of the most cost-effective development investments due to their direct impact on improving lives through national security and enhanced economic benefits to communities.7 Therefore, there are several compelling reasons for developing countries to prioritize contraceptives as a strategy for attaining sustainable socio-economic growth. Despite remarkable levels of awareness on the benefits associated with contraceptives use, it is unclear why the uptake remains low in most of the SSA.

While a lot of global effort and focus have been directed at addressing the unmet need for contraception especially in the developing world, the phenomenon persists especially in poor rural settings.8 SSA continues to have the lowest contraceptive prevalence at 24% and the highest unmet need for contraceptives at 25%.9 A study in Nigeria established that levels of awareness on contraceptives were nearly 100% in most places including rural areas, yet unintended pregnancies and sexually transmitted infections were still prevalent.1 Similarly, contraceptive awareness in Kenya is relatively high, yet significant unmet need for contracep-
tives persists in most rural areas. It is therefore important to explore the knowledge and experiences of women to understand the underlying and confounding factors behind this phenomenon. There is a dearth of information on experiences and perceptions of contraception, specifically related to birth outcomes and menstruation patterns, in western Kenya.

Studies have established varied preferences among men and women concerning the use of contraceptives in regulating fertility. Perceived or actual partner’s fertility preferences and attitudes significantly influence the choices of women on contraceptive use. Though some studies have emphasized the involvement of men in the programs that address the unmet need for contraceptives, culturally motivated spousal hindrance to the uptake has been documented in many areas. It is noteworthy that cultural norms in rural communities vary significantly from peri-urban and urban areas where the gender roles have changed. According to research conducted in several developing countries, a significant proportion of married women do not access and use contraceptives due to spousal opposition. Additionally, contraceptives have been linked to adverse health effects such as infertility, irregular menstruation, stillbirths, and preterm births. The purpose of this study was therefore to explore knowledge and perceptions of men, women, and health workers on contraception, menstruation, and birth outcomes (including preterm birth).

METHODS

This qualitative study was carried out between August and November 2017 in a rural community living along the shores of Lake Victoria in Siaya County, Western Kenya. The study population was selected from households surrounding three health facilities namely; Uyawi, Usigu, and Got Agulu health centers in Bondo Sub County. The study participants were recruited from the community through the leaders, community health volunteers, and the health workers attached to the health facilities. The interviews were scheduled by the research assistants and conducted in the health facilities at appointed times that were convenient to the participants. The interviews were conducted in the local language (Dholuo), audio-recorded, and transcribed. The transcripts were then translated into English. Each of the In-Depth Interviews (IDIs) took about one and a half hours while the Focus Group Discussions (FGDs) took about three hours each. Before the data collection, the interviewees were fully informed on the nature and purpose of the study. They were also informed of any possible risks, their voluntary participation, and assured of the confidentiality of the information collected. They then signed the forms for consent before each of the interviews commenced. The study met all the ethical review approval requirements from the Ethical Review Board at Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) before commencement. The data used in this article were part of a larger study project that focused on preterm birth sponsored by Melinda and Gates Foundation in East Africa. Data collection was preceded by a piloting phase under which the instruments of data collection were tested for participant understanding. The piloting was conducted in a neighboring Gobei Health Centre, also in Bondo Sub-county after which the data collection tools were reviewed.

The target group selected included adolescent girls, men, and women in childbearing age who had experience with preterm births. In-depth interviews were conducted with 45 participants evenly drawn from adolescent mothers, adult mothers, and fathers, all who had children under 5 years. Additionally, 6 FGDs were held with a total of 60 participants with skilled birth attendants (SBA), traditional birth attendants (TBAs) and Community Leaders, in groups of about 10. The IDIs and FGDs were conducted by research assistants under the guidance of the investigators. The data was collected through note-taking, audio-recording, and photography. The use of both the IDIs and FGDs provided a process in which the data collected was verified and triangulated through varied sources. The data collected were transcribed and translated into English before being read and cleaned. Content and thematic analysis was conducted and a codebook was developed. The data were analyzed using Atlas-ti Version 7.5.7 Software.

RESULTS

DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Table 1 summarizes the socio-demographic characteristics of the study participants. Adult women were on average about 24 years, men about 35 years, and adolescent women about 18 years old. Most women had primary education (60%), whereas men were more highly educated. All respondents were Christian. Adult women had on average about 2 children, adolescent women 1 child and men 3 children. While fishing was the economic mainstay of the community, a majority of women in the study were involved in small scale businesses and subsistence farming for livelihood. A minority of the residents were in gainful formal employment while levels of poverty in the area were relatively high. Most of the residents in the area belonged to the Luo ethnic community with a mix of others from different ethnicities.

KNOWLEDGE ON CONTRACEPTIVES: DIFFERENCES BY AGE

All the participants in the study had knowledge of at least one contraceptive method and had either used a method in the past or were currently using a method. Most of the participants in the study indicated that they were using methods such as implants, injections or Intra-Uterine Devices (IUD) but a few were on rhythm method, condoms, and traditional methods. Married men and women knew more about contraceptives than those who were yet to get married. An interview with a young newly married father revealed a lack of sufficient information on contraceptives and unmet needs, leading to unintended pregnancy.

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**Respondent:** What we didn’t do that we were supposed to do by that time, we were supposed to go the hospital for advice or we could have been advised on how to prevent unexpected pregnancy.

**Interviewer:** That your baby is the first baby?

**Respondent:** Yes.

**Interviewer:** Then why do you say it was unexpected?

**Respondent:** Were you both married at that time?
Table 1. Participants’ demographic summary

| Parameter                      | Adult Mothers (n=15) | Adolescent Mothers (n=15) | Men (n=15) |
|--------------------------------|----------------------|--------------------------|------------|
| **Age (mean, SD)**             | 24.8, ±3.2           | 17.9, ±1.0               | 35.2, ±9.4 |
| **Education**                  |                      |                          |            |
| Primary                        | 60% (n=9)            | 60% (n=9)                | 46.7% (n=7) |
| Secondary                      | 26.7% (n=4)          | 40% (n=6)                | 46.7% (n=7) |
| Tertiary                       | 13.3% (n=2)          | 0                        | 6.7% (n=1)  |
| **Number of children (mean, SD)** | 2.1, ±0.6           | 1.3, ±0.6                | 3.3, ±1.8  |

**Respondent:** By that time we were a girlfriend, boyfriend, we were just friends.

**Interviewer:** You were not yet married?

**Respondent:** No we had not yet been married (25 year old father of one).

While most of the younger respondents approved of contraceptives, the older generation was less supportive of contraceptive use. According to a TBA in an FGD, contraceptives were negatively viewed by the older generation in the community.

On the issue of family planning, in the past a person could have as many children as she could. Nowadays we have been taught about spacing. Some do not accept to be told about family planning. For some if you tried to tell them you may be offended because some people do not accept this issue of family planning, especially the elderly. I could say some old men and women do not want this issue of family planning. If they hear the daughter-in-law has gone for family planning she can be sent away (woman, 62 years, TBA)

In contrast to the views of the elderly on contraceptives, the younger generation was more supportive of the use of contraceptives, especially for spacing of births. According one father interviewed, family planning was important in enabling families to space children appropriately and avoid undue economic burden;

Sometimes it depends on when a child is still very young, has not completed even two years and may be you planned that the child should be at least three years when he/she is even in pre-unit before you get another baby. So when you follow a child very closely, you may realize that even school fees may be a problem for them (35 year old father of three).

**PERCEPTIONS OF IMPACT OF CONTRACEPTIVES ON MENSTRUATION**

A majority of the women associated the contraceptives they were using or contraceptives in general with irregular menstruation. Some felt that contraceptives affected the patterns of their menstruation, making it difficult to track their monthly periods and leading to their inability to plan pregnancies or to avoid unintended pregnancies;

**Respondent:** I used to track before I started using family planning but since I started it keeps on changing.

**Interviewer:** So you think that family planning is the main factor?

**Respondent:** Yes, it is, some people even stay for 3 or 5 months without getting the menses, some even years.

**Interviewer:** Which family plan do you use?

**Respondent:** I used to use the injection that lasts 3 months, currently am using the one for 3 years (23 year old, married, mother of three).

Further, some of the respondents believed that using contraceptives either stopped their menses all together or contributed to abnormally heavy flow.

**Respondent:** My menstrual cycle has always been irregular, I do not have a specific date of the month when they come, and they always get me off guard. This month they can come on 30th, the next month on 1st, the following month on 27th so I don’t have a specific date when I can say that I will get my menses.

**Interviewer:** Since you started using family planning, do you have your menstrual cycle?

**Respondent:** No I don’t see my periods at all

**Interviewer:** At all at all

**Respondent:** At all (21 year old, married, mother of two).

An interview with a male respondent demonstrated the common perception on the impact of some family planning methods on menstrual flow among some women.

**Respondent:** One would say that his wife has taken two months before experiencing menstrual periods. So he would ask that: why is that happening? There are also some family planning methods which when are used some people don’t experience menses, some also experience over bleeding, so that can also happen.

**Interviewer:** What reason are they giving for one who is using family planning and is either not experiencing menses or is experiencing excessive bleeding?

**Respondent:** Some don’t experience their menses at all (31 years, married, father of two).

In an FGD interview, one of the discussants (a TBA) narrated her encounter with a girl who she believed had a heavy flow because of the use of contraceptives.

**Respondent:** There is a certain girl who goes to school, she is in form 2. Her mother told me that she had been on family planning and whenever she was on her period she bled so heavily that she could not even go to school. So her mother stopped her from family planning. So I advised her to take care of herself because she was not able to use the medicine. She should take care of...
In them in the area. Many women concurred that their part-
ners had negative attitude towards contraceptives as they
associated them with infertility, ailments, deformities, and
preterm births.

PERCEPTIONS ON THE EFFECTIVENESS OF
CONTRACEPTION

Although most women in the study confirmed that they
were on some family planning method, some of them
doubted the efficiency of the contraceptives. They perceived
them to have some level of unreliability that allowed in-
stances of unintended pregnancies. Below, two respondents
explained how contraceptive failure led to accidental preg-
nancies:

Respondent: Baby (names withheld) happened unex-
expectedly, I was on the injectable family planning. I
came for the injection in the 9th month and I was due
again in the 12 month for another injection, but the
date was not due I became sick when I came to the hos-
pital I was tested and found to be pregnant. (28 years,
mother of two).

Another participant narrates a similar experience of be-
ing on a contraceptive and expectant at the same time.

Respondent: Why am saying that I did not plan for it is
because when I had my baby who is now 8 years, I used
to go for the family planning injection for 3 months.
During the time I was on injection, I could still get my
menses and so I knew that even a week after my menses
I could not conceive. Actually, I was on injection and
expectant at the same time, that is what happened (25
years, married, mother of two).

Health workers interviewed perceived that the unintend-
ed pregnancies were among women using contraception
and ART drugs. They felt that the use of ARTs interfered
with the efficiency of some of the contraceptives occasion-
ally resulting in unintended pregnancies.

PERCEPTIONS ON THE IMPACT OF CONTRACEPTION ON
BIRTH OUTCOMES

It also emerged that some of the community members be-
lieved preterm births were related to the use of some con-
traceptives, especially long-term methods, as explained by
one woman below:

Interviewer: What do you think causes a woman to have
a preterm baby?
Respondent: Maybe if she used family planning meth-
ods for many years
Interviewer: What type of family planning method?
Respondent: The five-year type.
Interviewer: [interruption] You were telling me that if a
person uses the long term family planning methods she
would get a preterm baby.
Respondent: Yes, if she uses them for many years (19
years, married, mother of two)

Another respondent described her fears of family plan-
ning leading to birth defects:

Respondent: I never knew I would conceive again,
Interviewer: Why do you say that you never knew you

HUSBAND OPPOSITION AS A BARRIER

While most women viewed contraceptives positively despite
the perceived effects on menstruation patterns, a majority
of men were averse to their use. Therefore, some of the
women secretly used contraceptives without involving their
spouses. However, the reliance on covert use did create bar-
riers for women, as one female respondent explained how
she got pregnant after failing to get financial support from
the spouse to access family planning services in time.

Respondent: I could say it was unintended because by
then I was on the 3-month family planning method. I
was supposed to go for the next dose and I do not even
know what happened. I did not go back because I had
sneaked there the first time I went.

Interviewer: Sneaked?
Respondent: My husband was against the idea of family
planning. When it was time to go back and I needed to
ask him for money I could not. Our home is far from
Nango [location of health facility] I told myself I would
wait until I get money on my own and then I would go
for family planning. Two weeks later I began feeling ill
for about two months. I came to hospital and discov-
ered I was pregnant (20yrs, married, mother of two).

Another woman respondent narrated how her spouse
was opposed to contraceptives and therefore did not want
to listen to anything related to them:

Respondent: To me it was a surprise because I wasn’t
planning to get pregnant, I had planned to take care of
the other 2 before I would think of getting another one.
I came to the hospital and when I was tested they found
that I was expecting when I went back home I told him
though I was so shocked.

Interviewer: You told me that you cannot talk to him
about family planning and tracking of menses, how did
you tell him about this pregnancy?
Respondent: I told him that I want to go the antenatal
clinic because I was expectant, for him he wants many
children and he was happy about it. (25 years a married,
mother of three).

Some couples experienced conflicts due to differences in
preferences on contraceptive use. According to an experi-
ence shared by one of the study participants, some men
had strongly opposed the use of contraceptives, sometimes
causing family conflicts;

Respondent: It did not happen unexpectedly; I had
gone for family planning injection then later on there
were wrangles (conflicts) with my partner then I gave
in and removed it, so it did not come unexpectedly (22
years, a married, mother of two).

Although there were programs that sought to include
men in family planning practices, few men had participated
in them in the area. Many women concurred that their part-
ners had negative attitude towards contraceptives as they
associated them with infertility, ailments, deformities, and
preterm births.
can get pregnant again?
Respondent: After giving birth to my first daughter, I used the family planning method that takes 5 years, and people could give some horrifying experiences that the method makes some babies be born with deformities and that made me worried. I never knew I could get another baby because I was using family planning (21 years, married, mother).

DISCUSSION

The United Nations has prioritized family planning and contraceptive use in the Sustainable Development Goals (SDGs) as a key strategy of improving maternal-child health and ensuring sexual and reproductive health rights.2 Still, at least 14 million unintended pregnancies occur in sub-Saharan Africa most of which are linked to poor access and low uptake of contraceptives.8 Varied factors are associated with the unmet need for family planning and contraceptive services among both married and unmarried women in the developing world. Like in most of the other developing countries, the unmet need for contraception persists in Kenya despite an increase in awareness and availability of the services. Studies indicate that 53% of married and 61% of unmarried women use contraceptives in Kenya.6 Socio-economic, demographic, and geographic disparities in contraceptive access and use remain wide with significant implications on the attainment of sexual and reproductive health rights.11 More women in urban areas access and use contraceptives compared to their counterparts in rural areas.

In this study, while the levels of knowledge about contraceptives were relatively high, the access and use of contraceptives remained low among some categories of people in the community. Overall, women continue to surpass their desired number of children despite a significant contraceptive awareness, accessibility and availability. For instance, adolescents had lower levels of knowledge as well as greater unmet need for contraceptives compared to other categories of sexually active people. Studies have documented similar findings in several SSA countries confirming lower contraceptives awareness and the highest prevalence of unintended and unwanted pregnancies among adolescents.12 This finding contradicts Kenya demographic health survey (2015) that established higher access to contraceptives among unmarried sexually active women compared to the married ones.6 However, it should be noted that our sample only consisted of women who already had children, even the adolescents, therefore, were limited to those who were most likely less knowledgeable than the average adolescent who was able to avoid a birth at that age. Studies confirm that most of the adolescents faced morbidity and mortality from unsafe abortion due to their low contraceptive knowledge and uptake.13

Many of the respondents identified side effects of using contraceptives, especially related to menstruation. It was found that the most common side effects among the participants included irregular patterns of menstruation, excessive bleeding, and sometimes discontinuation of the menses. This finding resonates with studies in other countries which acknowledged that contraceptives impact on menstruation pattern and intensity, besides other effects such as low libido, vaginal wetness, and decreased sexual pleasure among others.9 Although some of the side effects have been documented by other studies as myths and misconceptions, their impact on contraceptives uptake cannot be overemphasized.8 Some of the perceived and experienced side effects of contraceptives often led to a negative attitude and unwillingness to use contraception, or to discontinuation of these methods. Other studies have linked the perceptions of side effects to inadequate information on contraceptives, cultural constructs on reproductive behavior, and gender power dynamics.9 Respondents in the study also associated contraceptives with negative birth outcomes including deformities and preterm births. On the contrary, other studies have established contraceptive use as an important means of preventing adverse birth outcomes including preterm births.14 It is important to note that respondents in the study had a preterm birth so they might have been more likely to think about this specific outcome or be looking for an explanation for their experiences. This finding is in concurrence with a similar study in Uganda that established fear of adverse effects such as infertility and poor birth outcomes as some of the deterrents to the use of contraceptives.5 Women's education in the community was found to be instrumental in addressing some of the unfounded fears and misconceptions related to contraceptives.15 The developers of the hormonal injections and implants should also consider further research on how to address some of the widespread concerns such as effects on menstruation. This could significantly reduce the unmet need for contraceptives in rural communities in developing countries.

Although contraceptives generally received approval from most of the community members in the study, their efficiency was a concern. Some of the participants confirmed that the methods they were using had failed them and occasionally resulted in unintended pregnancies. A study conducted across Africa confirms that the efficacy of contraceptives in preventing unintended conceptions was not fully established as cases of failures have occasionally been documented.12 As revealed by further inquiry on the contraceptive failures in our study, several factors could be responsible for the failures, for instance, health status of the person using the contraceptive, drugs taken for other illnesses while on contraceptives, knowledge on fertility and contraceptives used among other factors.

While most people appreciated the use of contraceptives, different categories of people in the community had varied perspectives on the same. More men were averse to contraceptive use in their families sometimes, leading to conflicts with their partners who supported the use. These conflicts sometimes led to women discontinuing their methods or getting pregnant when they did not desire another pregnancy. This finding echoes others that have identified opposition from partners as a significant factor in low contraceptive uptake among married women.5 The impact of obstructive partners have been documented in studies in South Africa where male partners’ demands for more children and also the gender power dynamics that sometimes contribute to discontinuation of contraceptive use in many families.9 Active involvement of men in family planning programs has
been emphasized by policy-makers as a way of addressing spousal conflicts affecting uptake of contraceptives. The younger people were more aware of modern methods and largely supportive of contraceptives use while the elderly still preferred the traditional methods. Some studies have documented challenges of access to contraceptives among the younger generation as the main obstacle to meeting their contraceptive needs while for the older generation, the obstacle is in their beliefs and perspectives of contraceptives. Other literature cites cultural and social norms that emphasize traditional role of the woman as childbearing, prohibits contraceptive use, limits communication on reproductive health in the family and values large families. There is a need to create more awareness and education especially to men and other categories of people who view contraceptives negatively to improve uptake of these methods.

Even though contraceptives are mainly used for fertility control, some are important in preventing sexually transmitted infections. For instance, condoms are used both to prevent unwanted pregnancies and STIs. It was however noted that in the study, little attention was paid to STI prevention function of contraceptives as most of the respondents focused on the efficiency and side effects of contraceptives on fertility and health.

Like any other research, the study had some limitations. Since it focused on adolescent mothers and adult mothers and fathers, we missed the voices of male adolescents and women and men who had not given birth. Thus, these findings may not adequately represent the knowledge levels and perceptions of the community on contraceptives, menstruation, and preterm birth more broadly. The voices of adolescent boys may be especially important for future research, since they are sexually active and decision-makers about contraceptives. Additionally, the study was conducted in a rural set up in western Kenya, therefore it may not depict the general situation on contraceptive knowledge and perception across the country or anywhere else. Nonetheless, the study gives useful insight into contraceptive knowledge and experience of a rural setting in a developing country.

CONCLUSIONS

The study found that although most people had information on contraception, negative perceptions remained, potentially limiting use. Although a majority of women in the study believed that some contraceptives negatively affect ed menstruation patterns, the role of contraceptives in the spacing of births and maternal health were largely appreciated. Therefore, it is necessary to strengthen their knowledge of contraceptives to maintain use and increase acceptance among those who are averse to the methods. Socio-cultural factors influencing perceptions of contraceptives play a significant role in access and by extensions infant and maternal health outcomes in the community. Strengthening the link between the rural communities and the health facilities would play a major role in improving contraceptive knowledge, access, and use. Additionally, community education that target men and young people would significantly help in mitigating poor attitude and the low uptake of contraceptives, especially in rural areas.

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