

Concerns of Women Using Combined Oral Contraceptive Pills in Kwale County, Kenya

Rehema Rashid Juma, Facility Nurse Manager

Lungalunga SCH, Kwale County.

Prof. Samar K. Hafez, Professor

Obstetric and Gynecologic Nursing, Faculty of Nursing, Alexandria University

Dr. Abeer Hassan Shamekh, Lecturer

. Obstetric and Gynecologic Nursing, Faculty of Nursing, Alexandria University

Abstract:

Background: Despite family planning multiple benefits, women's experiences and concerns present a formidable barrier to the sustained use of contraceptives. Combined oral contraceptive pills use has remained low in Kwale County, owing to the various challenges that women of reproductive age face towards modern use of contraception. **Objective:** To explore concerns of women using combined oral contraceptive pills in Kwale County, Kenya. **Settings:** The study was carried out in the outpatient family planning clinics of 8 maternal and child health facilities in sub counties of Kwale county. **Subjects:** A convenient sample of 300 women attending selected settings was included in the study subjects. **Tools:** Four tools were used for data collection. **Tool I:** Socio-demographic and reproductive history structured interview schedule; **Tool II:** Concerns of women using combined oral contraceptive pills structured interview schedule; **Tool III:** Generalized anxiety disorder (GAD-7) screening tool and **Tool VI:** Women's knowledge of combined oral contraceptive use structured interview schedule. **Results:** Findings revealed that mean age of women using combined oral contraceptive pills was 28.71 ± 5.56 . Physical concerns were reported by less than two-thirds (60.7%) of study subjects. More than half (52.3%) had accessibility concerns, while, more than one-third (38.7%) had sexual concerns, and about one-fifth (19.7%) had socioeconomic concerns. **Conclusion:** Fears of side effects or health-related reasons were the dominant physical concern reported by women who were using combined oral contraceptive pills. **Recommendations:** Strengthen health education and to improve counseling practice for women and couples seeking FP services, especially on combined oral contraceptive pills.

Keywords: Concerns, Combined oral contraceptive pills

Introduction

Sexual and reproductive health (SRH) is an important and inevitable part of woman's life. Improving women's health through modern contraceptive methods is the key to prevent unwanted pregnancy and its complications. Also, it prevents pregnancies that may have a higher risk to women and children, reducing unsafe abortions and increases socioeconomic opportunities for women and their families. (Nations et al., 2020).

Globally, between 2015 and 2019, there was an annual average of 121 million unwanted pregnancies, which corresponds to 64 unplanned pregnancies per 1,000 women on an annual basis throughout the world among women of reproductive age. In 2020, 1.1 billion of the world's 1.9 billion reproductive-age women require family planning (FP), yet only modern contraception is used by 851 million people, whereas traditional contraception is used by 85 million people. Furthermore, despite their desire to avoid pregnancy, 172 million females do not use any method at all, indicating an unmet need for FP. (Bearak et al., 2020; and United Nations Department of Economic and Social Affairs, 2020).

The combined oral contraceptive pill is the world's most popular reversible contraception method. Between 1994 and 2019, the estimated number of women of reproductive age worldwide on pills increased from 97 million to 151 million, with 15% of married users and 26% of unmarried users. In Sub-Saharan Africa, however, the prevalence of oral contraceptive pills was at 3.7% and has remained largely consistent over the previous 25 years. In Kenya however, the reported prevalence of contraception use among women of reproductive age on oral contraceptive pill was at 3.5%. (Population Division, United Nations Department of Economic and Social Affairs, 2019).

Since 1962, the contraceptive pill has been utilized in Kenya's family planning program. The majority of women utilize combined oral contraceptives to prevent pregnancy, but just a small proportion use them for non-contraceptive reasons. In Kenya, oral contraceptive pill users, on the other hand, are more prone to switching to other methods, with 18% discontinuing within a year of using it. Side effects or health concerns accounted for 38% of the reasons for discontinuation, followed by a desire to become pregnant (24%), method failure (8%), and infrequent sex or partners being away (7% each). (Black et al., 2017; Kungu, 2021).

Identifying women's concerns related to family planning methods is significant in promoting contraception continuity and adherence.

Aim of the study

Explore the concerns of women using combined oral contraceptive pills in Kwale County, Kenya.

Research question

What are the concerns of women using combined oral contraceptive pills in Kwale County, Kenya?

Materials and Method

Materials:

Research design:

An exploratory, descriptive research design was utilized in this study.

Settings:

The study was conducted in outpatient family planning clinics of eight maternal and child health facilities in sub counties of Kwale county namely: Kinango, Mwabila, Lungalunga, Kikoneni, Tiwi, Kwale, Diani and Mvindi.

Subjects:

The sample size was estimated using Epi info 7 statistical program using the following parameters; total population (823

women using combined oral contraceptive pills for a period 6 months (Dhis2 Kenya, Kwale county database 2020), confidence level 95% and with 5% error margin. The minimum sample size was estimated to be 262 women

A convenient sample of 300 women attending previously mentioned settings, recently using COCPs for a maximum of 6 months, free from any medical or gynecological health problems and willing to participate in the study was included in the study subjects.

Tools: Four tools were used for collection of the data

Tool I: Socio-demographic and reproductive history structured interview schedule.

Part one: Socio-demographic data

This tool was used to obtain basic information about the subject's characteristics such as: age, education level, occupation, residence, religion, source of income, crowding index, type of family, partner's level of education, and age at first intercourse.

Part two: Menstrual and reproductive history

Menstrual history included: age of menarche, rhythm, duration of the menstrual flow, and amount of menstrual loss, information about menstrual cycles and the presence of dysmenorrhea on premenstrual symptoms.

Reproductive history entailed data related to gravidity, parity, number and sex of living children, number of still births, previous abortions, nature of last labor and age of the youngest child. History previous contraception, reasons for discontinuation, duration of currently used COCPs, associated side effects, and desired timing for next pregnancy were also included in that part.

Tool II: Concerns of women using combined oral contraceptive pills.

It included four essential parts developed by the researcher after an extensive review of recent and relevant literature. (Spitzer et al., 2006; Johnson et al., 2019).

Part one: Physical concerns included: side effects such as headache, nausea, menstrual disturbances, delayed fertility, risk of pregnancy, risk of thrombosis, high blood pressure, breast tenderness, breast enlargement, weight gain, and risk of cancer and drug interactions.

Part two: socioeconomic concerns such as cost of transportation, clinic inaccessibility, partner disapproval, smoking, and alcoholic or drug addiction.

Part three: Sexual concerns (reproduction and fertility preferences), such as libido fluctuations: increases or decreases in sexual desire, dyspareunia, inability to achieve orgasm, vaginal dryness, impaired sexual stimulation, fear of STDs, spouse (partners) preference, and pregnancy spacing.

Part four: Concerns related to accessibility of combined oral contraceptives pills included availability of the method, cost, waiting time, in addition to staff attitude, and stock outs.

Tool III: Generalized Anxiety Disorder (GAD-7) Screening Tool

This tool was adopted by the researcher used to assess psychological concerns which may be in the form of anxiety (Spitzer et al., 2006) & (Johnson et al., 2019).

Women's anxiety level was ranked as follows: Minimal anxiety (0–4), Mild anxiety (5–9), Moderately anxiety (10–14) and Severe anxiety (15–21).

Tool IV: Women's knowledge of Combined Oral Contraceptive Use

This tool was developed by the researcher based on a thorough review of the current relevant updated literature. (WHO, 2018). Women's knowledge was ranked as follows: Good overall score of 66-84, fair overall score of 47-65, and weak overall score of 28-46.

Method:

- A written approval to carry out the study was obtained from the Ethical Research Committee of the Faculty of Nursing, Alexandria University, and submitted to the responsible authority in Kwale County, informed about the study objectives.
- Permission was granted to conduct the study in Kwale County after an explanation of the aim of the study.
- The study tools I, II, and IV were developed by the researcher after a review of current related literature and tool III was adopted by the researcher. Tools were validated by five experts in the obstetrics and gynecology nursing field.
- Cronbach's Alpha Coefficient, was used to ascertain the reliability of tool II, III, and IV which both equaled $r=0.785$, $r=0.755$, and $r=0.9333$, respectively.
- A pilot study of 10% (30 women) using coops who were excluded from the study subjects was carried out to ascertain the clarity, practicability, and applicability of the study tools and to identify the obstacles that may be faced during data collection and necessary modification were done.

Statistical analysis:

Collected data was categorized, coded, computerized, tabulated, and analyzed using a statistical package for social science, IBM SPSS software package version 20.0 (Armonk, NY: IBM Corp). Qualitative data was described using

numbers and percentages. Significance of the obtained results was judged at the 5% level using the Chi-square test.

Ethical considerations:

Written informed consent to participate in the study was obtained from women after explaining the aim of the study, that participation is voluntary and they have the right to withdraw from the study at any time. Women's anonymity was maintained during the execution of the study. Privacy of the study participant was asserted and confidentiality of the collected data was entirely maintained.

Results

Table (1): shows the frequency distribution of the studied women according to their socio-demographic characteristics. Slightly more than half of the women (53%) aged from 20 to less than 30 years old. More than half (58.7%) of women were rural dwellers, and 59% were Muslims. Slightly less than one-third (32.3%) of women completed their secondary education Also, 59.3% of women were housewives, while 40.7% were employed. A large proportion (85.3%) of women were in nuclear families, while 14.7% had extended families. **Table (2):** Displays the frequency distribution of women according to their reproductive history. Slightly less than half (48.3%) of women were pregnant three to four while 9.7% of them were pregnant for more than 5 times.

Additionally, out of the total number of 85 studied women with experienced pregnancy complications, such as Hyperemesis gravidarum (45.9%), antepartum hemorrhage (25.9%) while, the least (7.1%) of them had gestational diabetes mellitus.

In relations to parity, about half (47.7%) of women delivered once to twice while the least (8%) of them delivered more than 5 times. The last delivery was normal vaginal among most of them (86.4%) while 13.2% had cesarean section. Also, the majority (86%) of women never had

abortion and the vast majority (95%) of them never had stillbirth.

Concerning the number of living children, slightly more than half (53.6%) of them had 1 to 2 children while the least (8%) of them had more than 5 children. Slightly more than half (53.6%) of women had both male and female. Also, it was observed that one quarter (25.2%) currently breastfeed their young children who aged less than 12 months (30%).

Figure (1): Presents the frequency distribution of women using COCPs according to their concerns. Physical concerns were reported by less than two-thirds (60.7%) of women using COCPs. More than half (52.3%) of them had accessibility concerns, while, more than one-third (38.7%) had sexual concerns, and about one-fifth (19.7%) had socioeconomic concerns.

Table (3): shows the frequency distribution of the women studied based on their total G.A.D. 7 anxiety scale score. Slightly more than half (51.3%) of women had minimal anxiety, 36.3% had mild anxiety, and the least (0.3%) of them had severe anxiety, with a mean of 4.51+ 4.05.

Figure (2): presents the frequency distribution of the studied women according to their overall knowledge of COCP use. Overall, three-quarters (75%) of women had poor knowledge of COCPs, while 24.7% had fair knowledge and 0.3% had good knowledge.

Discussion

Family planning (FP) is without a doubt an essential health intervention with enormous potential for saving lives, fostering development, and enhancing well-being. Because of considerable side effects, many women are hesitant to use combined oral contraceptive pills (COCPs), which has become a major public health concern. On the other hand, many women utilize them without a prescription or understanding how to use them correctly. Despite an increase in

contraceptive demand overall, women's worries play a substantial role in contraceptive use, non-use, and discontinuation. (Moreira et al., 2019).

The results of the present study revealed that slightly more than half of women currently on combined oral contraceptives were aged 20 to less than 30 years. On the other hand, a minority of women aged less than 20 years were unlikely to use COCPs. Chandra-Mouli & Akwara (2020) also demonstrated that young women's lack of self-assurance and independence may make them reluctant to seek contraceptives, reducing their choice of making decisions about contraception use.

On examining the demographic and socio-economic determinants of the studied women, the results revealed that more than half of the women were rural dwellers. It was expected because low-income women tend to have access to contraception in public healthcare facilities for family planning services. Also, most facilities under the study were located in the rural regions of Kwale county, where most women only access public health facilities for FP services. This is in agreement with KDHS (2014), which revealed that the higher uptake of modern contraception among rural dwellers is from public health facilities.

Regarding the educational background, the study revealed that COCP use was common in women with secondary education compared to women with university education, as well as those illiterate or who knew just how to read and write. Chola et al. (2020) similarly reported that adolescent girls with secondary education were more likely to use contraception compared to those with no education.

Concerning the occupation of the studied women, it was revealed that more than half were working. Some studies have also demonstrated an association between educational attainment and contraceptive

use. This result correlates positively with the finding by **Durowade et al. (2017)** that contraceptive utilization was higher among those self-employed and employed than those with no employment.

The findings of the present study showed that slightly less than half of the partner's educational level completed their secondary education. A few of them were illiterate and knew only how to read and write. In this regard, **Adjiwanou et al. (2018)** reported that women whose partners had an above-secondary level of education were more likely to use modern contraceptives compared to women whose partners had no education.

The results of the study revealed that the majority of the women were from nuclear families. More than two-thirds of them reported having adequate income per month, and less than half of their income came from their husbands. In addition, slightly more than two-thirds of them were living in overcrowded environments. **Roy et al. (2021)** reported a similar finding, indicating that less educated women were less likely to aspire to higher levels of employment, resulting in a lack of motivation to utilize family planning.

Although the age of first marriage is used as a predictor of first sexual intercourse, the two events may not always occur at the same time. The present study revealed that slightly more than two-thirds of women aged 15 to less than 20 years old had their first sexual intercourse at a median age of 18 years. **Ondenge et al. (2021)** reported that in Kenya, economic and gender inequalities, a lack of education, as well as cultural and societal variables such as family instability and early marriage expectations, are all linked to women's first sexual encounters at a young age.

The women using COCPs in the study cited side effects as their major health concern. More than two-thirds of them expressed physical concerns about COCP use, according to the findings of the current

study. The most common minor adverse effects of COCPs were headache, nausea, menstrual abnormalities, breast soreness and enlargement, and weight gain. Some women reported hypertension and thrombosis as two of the most common side effects. In addition, **Regidor (2018)** also reported a similar finding.

More than half of the studied women have concerns related to the accessibility of COCPs use. These findings could be attributed to forgetfulness, long waits at the health facilities, stock-outs, available methods at the clinic, cost, and staff attitude. Equally, **Caetano et al. (2019)** also revealed that women missed pills due to forgetfulness. The more preoccupied women are, the more likely they are to forget to take their pills.

About two-fifths of women in the study experienced sexual-related concerns. Decrease/increase or loss in sexual desires, fear of sexually transmitted diseases, decreased sexual pleasures, vaginal dryness/irritation, impaired sexual stimulation, inability to achieve orgasm and dyspareunia were the reported sexual-related concerns of women using COCPs. However, several studies have found that hormonal contraception can impact sexual function both positively or negatively, affecting numerous aspects of female sexuality such as desire, arousal, orgasm, lubrication, satisfaction, and pain. (**Elaut et al., 2016**).

In the current study, the cost of transport, partner acceptance, clinic inaccessibility, alcoholism/smoking were among the socio-economically related concerns reported by one-fifth of the women using COCPs, whereas more than three-quarters of women were concerned about the cost of transportation to get to FP services. In addition, in Kenya transportation expenses are a major barrier to women's access to FP especially for low-income women living in rural areas far from health care facilities. Because of high transportation expenses associated with

accessing FP services, many women may not perceive the need to travel to a distant healthcare facility because it would require them to forego other economically useful activities. This is especially true in rural areas. (Etokidem et al., 2017).

The psychological concerns were assessed using the general anxiety disorder-7 scale (G.A.D.-7). The scale score concluded that slightly more than half of the studied women on COCPs use had minimal anxiety. More than one-third of them reported having mild anxiety. In addition, about one-fifth had moderate anxiety and less than one-fifth had severe anxiety. Lewis et al. (2019) and Scheuringer et al. (2020) found no evidence that combined oral contraceptive use is linked to cognitive-emotional issues such as anxiety, impatience, and mood swings. However, they concluded that women with baseline trait anxiety and past psychological disorders during hormonal contraceptive use are more likely to have hormonal contraception-induced adverse mood symptoms.

According to the findings of this study, more than three-quarters of women had poor overall knowledge about COCPs use, whereas less than two-fifths had fair knowledge and less than a fifth had good knowledge. This study's findings about the contraceptive knowledge gap can be related to myths and misperceptions, a lack of contraceptive knowledge, and a lack of proper FP counseling services regarding COCP use. In a qualitative study on contraception knowledge, Mwaisaka et al. (2020) found similar results, concluding that the majority of women had a low level of contraceptive knowledge, particularly regarding contraceptive fears, which included both biological and social misperceptions about contraception use.

Regarding the **source of knowledge about COCPs use**, healthcare providers were the source of knowledge reported by the vast majority of women in this study. While less than half of them mentioned

family and relatives, neighbors, and friends as their sources of knowledge, other sources, such as socio-media and study books, provide less than a fifth of the information. The results from this finding can be enough to say that healthcare providers, especially nurses in Kenya, who are the main key players in family planning clinics in most of the public healthcare facilities, play a vital role in providing contraceptive information regarding the use of COCPs.

Conclusion

Based on the study findings, it can be concluded that the most studied women had concerns related to combined oral contraceptive pill use. Fears of side effects were the dominant concern reported by women. Accessibility, sexual, socio-economic, and psychological concerns were also witnessed in some of them.

Recommendations

Based on the results of the study, the following are recommended:

- Strengthening health education and improving counseling practice for women and couples seeking FP services, especially on combined oral contraceptive pills, is highly recommended.
- Improving the nurse-client relationship to increase positive attitude and reassurance by increasing women's satisfaction and contributing to improved contraceptive pill adherence.
- Enhancing family planning outreach programs in marginalized communities where access to SRH services remains difficult.
- Assessing women's and men's concerns for other types of contraceptive methods needs to be done.

Table (1): Distribution of women using COCPs according to their Socio-demographic data (n = 300)

| Socio-demographic data | No. | % |
|---|--------------|------|
| Age (Years): | | |
| <20 | 11 | 3.7 |
| 20 - <30 | 160 | 53.3 |
| 30 - <40 | 115 | 38.3 |
| ≥40 | 14 | 4.7 |
| Min. – Max. | 18.0 – 45.0 | |
| Mean ± SD. | 28.71 ± 5.56 | |
| Median | 28.50 | |
| Residence: | | |
| Urban | 124 | 41.3 |
| Rural | 176 | 58.7 |
| Religion: | | |
| Muslim | 177 | 59.0 |
| Christian | 123 | 41.0 |
| Educational level: | | |
| Illiterate/Read/write | 49 | 16.4 |
| Primary | 90 | 30.0 |
| Secondary | 97 | 32.3 |
| University | 64 | 21.3 |
| Working status: | | |
| Working | 178 | 59.3 |
| Not working | 122 | 40.7 |
| Marital status: | | |
| Married | 239 | 79.7 |
| Single | 48 | 16.0 |
| Divorced | 1 | 0.3 |
| Widow | 3 | 1.0 |
| Separated | 9 | 3.0 |
| Partners' level of education: | | |
| Illiterate/Read/write | 16 | 5.3 |
| Primary | 60 | 20.0 |
| Secondary | 138 | 46.0 |
| University | 86 | 28.7 |
| Type of family | | |
| Nuclear | 256 | 85.3 |
| Extended | 44 | 14.7 |
| Family income/month | | |
| More than enough | 40 | 13.3 |
| Just enough | 207 | 69.0 |
| Not enough | 53 | 17.7 |
| Source of income | | |
| Woman's work | 59 | 19.7 |
| Husband's work | 121 | 40.3 |
| Parent support | 7 | 2.3 |
| Woman's & Husband's work | 113 | 37.7 |
| Crowding index | | |
| Crowded >2 | 205 | 68.3 |
| Not Crowded <2 | 95 | 31.7 |
| Min. – Max. | 0.3 – 6.0 | |
| Mean ± SD. | 2.20 ± 0.96 | |
| Median | 2.0 | |
| Age at first intercourse (Years) | | |
| <15 | 14 | 4.7 |
| 15 - <20 | 206 | 68.7 |
| 20 - <25 | 68 | 22.7 |
| 25 - <30 | 11 | 3.7 |
| ≥30 | 1 | 0.3 |
| Min. – Max. | 12.0 – 30.0 | |
| Mean ± SD. | 18.12 ± 2.87 | |
| Median | 18.0 | |

Table (2): Distribution of women using COCPs according to their reproductive history (n = 300)

| Reproductive history | No. | % |
|---|------------------|------|
| Gravidity | | |
| Nulligravida | 24 | 8 |
| 1 – 2 | 102 | 34 |
| 3 – 4 | 145 | 48.3 |
| 5 or more | 29 | 9.7 |
| Min. – Max. | 0.0 – 8.0 | |
| Mean ± SD. | 2.54 ± 1.67 | |
| Median | 2.0 | |
| Previous pregnancy complications # | (n = 85) | |
| Hyperemesis gravidarum | 39 | 45.9 |
| Bleeding | 22 | 25.9 |
| Anemia | 21 | 24.7 |
| Pregnancy Induced Hypertension | 12 | 13.0 |
| Infection | 8 | 9.4 |
| Gestational Diabetes Mellitus | 6 | 7.1 |
| Parity | | |
| Nullipara | 35 | 11.7 |
| 1 – 2 | 143 | 47.7 |
| 3 – 4 | 98 | 32.6 |
| 5 or more | 24 | 8.0 |
| Min. – Max. | 0.0 – 7.0 | |
| Mean ± SD. | 2.25 ± 1.541 | |
| Median | 2.0 | |
| Mode of last delivery | (n = 265) | |
| Normal | 229 | 86.4 |
| CS | 35 | 13.2 |
| Instrumental | 1 | 0.4 |
| Number of abortions | | |
| None | 258 | 86.0 |
| 1 | 31 | 10.3 |
| 2 | 9 | 3.0 |
| 3 or more | 2 | 0.7 |
| Min. – Max. | 0.0 – 3.0 | |
| Mean ± SD. | 0.18 ± 0.50 | |
| Median | 0.0 | |
| Number of stillbirths | | |
| None | 285 | 95.0 |
| 1 | 15 | 5.0 |
| Min. – Max. | 0.0 – 1.0 | |
| Mean ± SD. | 0.05 ± 0.22 | |
| Median | 0.0 | |
| Number of living children | n= 250 | |
| 1 – 2 | 134 | 53.6 |
| 3 – 4 | 96 | 38.4 |
| 5 or more | 20 | 8.0 |
| Min. – Max. | 1.0 – 7.0 | |
| Mean ± SD. | 1.57 ± 0.75 | |
| Median | 1 | |
| Sex of living children | n = 250 | |
| Male & Female | 134 | 53.6 |
| Male | 56 | 22.4 |
| Female | 60 | 24 |
| Currently breastfeeding | | |
| Yes | 63 | 25.2 |
| No | 187 | 74.8 |
| Age of youngest child (months) | n= 250 | |
| < 24 | 75 | 30.0 |
| 24 | 175 | 70.0 |
| Min. – Max. | 2.0 – 120.0 | |
| Mean ± SD. | 32.30 ± 22.0 | |
| Median | 28.0 | |

#: More than one response

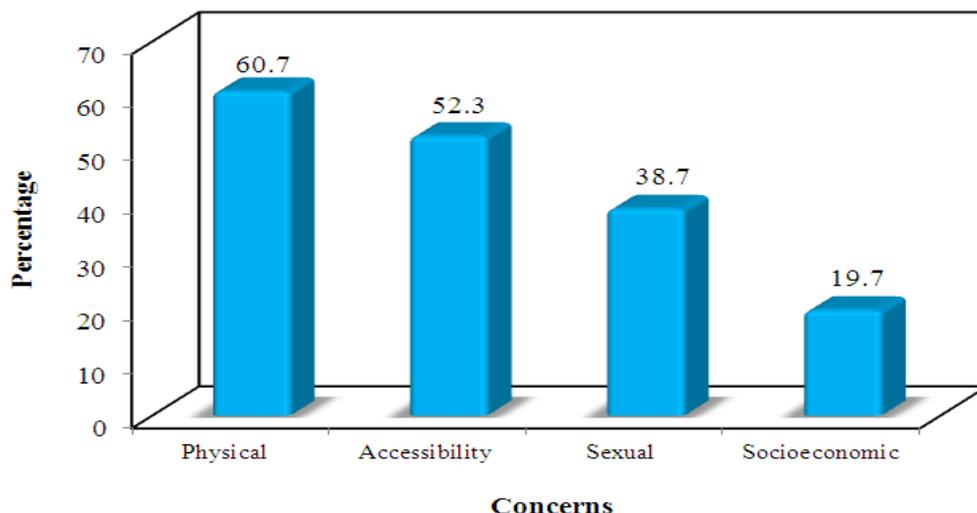


Figure (1): Frequency distribution of women using COCPs according to their concerns (n=300)

Table (3): Distribution of women using COCPs according to total score of (G.A.D 7 Anxiety scale) (n = 300)

| Psychological related concerns | No. | % |
|--------------------------------|---------------|------|
| Minimal anxiety (0 – 4) | 154 | 51.3 |
| Mild anxiety (5 – 9) | 109 | 36.3 |
| Moderate anxiety (10 – 14) | 36 | 12.0 |
| Severe anxiety (15 – 21) | 1 | 0.3 |
| Total score | (0–21) | |
| Min. – Max. | 0.0 – 18.0 | |
| Mean ± SD. | 4.51 ± 4.05 | |
| Median | 4.0 | |

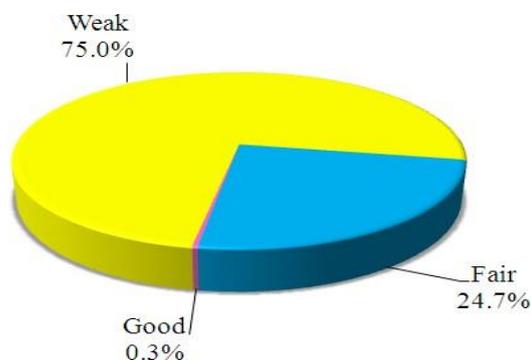


Figure (2): Overall knowledge about COCPs Use (n=300)

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