Open Access Journal of Contraception

Dovepress
Taylor & Francis Group

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COMMENTARY

Reframing Contraception as Healthy Birth Spacing in Somalia: Tackling Myths, Partner Dynamics, and Service Trust

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Abstract: In Somalia, women's desire to space births contrasts sharply with limited access to safe and trusted contraception. Modern contraceptive use remains extremely low, unmet need is substantial, and birth intervals are often shorter than recommended for maternal and child health. In a predominantly Islamic and post-conflict context, community narratives about future infertility, concerns about side effects, male partner refusal, and fear of marital instability interact with low health literacy, fragile service delivery, and limited trust in health systems. This commentary synthesizes Somalia-specific evidence and relevant comparative literature to argue that progress depends on reframing contraception as voluntary healthy birth spacing, strengthening respectful counseling and side-effect support, engaging men and trusted religious and community leaders, and improving reliable access to a broader method mix through maternal and child health contacts and community outreach. This study contributes a contraception focused implementation perspective that links sociocultural acceptability, continuation, and service trust in a fragile setting.

Keywords: contraception, birth spacing, unmet need, Somalia, reproductive autonomy, counseling, service trust

Background

Somalia's reproductive health context is shaped by prolonged insecurity, displacement, constrained primary health-care capacity, and persistent gaps in education and health literacy. These conditions allow rumor, lived experience, and community narratives to shape contraceptive decision-making as strongly as formal clinical advice. The 2025 Track20 and FP2030 estimates suggest that only 68,000 women in Somalia use modern contraception, with an estimated mCPR of 1.5% among all women, an unmet need for modern contraception of 27.5%, and demand satisfied by modern methods of only 5.4%.[1]

The SHDS 2020 provides a national baseline for this challenge. Among currently married women aged 15 to 49 years, 6% were using any contraceptive method and only 1% were using a modern method. The same survey reported that 37% of currently married women had an unmet need for birth spacing services, including 29% for spacing births and 8% for limiting childbearing. It also reported a median birth interval of 21 months, with 27% of births occurring after an interval of less than 18 months.[2] A recent secondary analysis of SHDS data similarly reported an unmet contraception need of 37.2% among married women, reinforcing the scale of the gap between reproductive intentions and contraceptive use.[3]

These figures show that the central issue is not simply lack of demand. Many Somali women and couples may accept the idea of spacing births, but the language of family planning, the perceived safety of modern methods, and the trustworthiness of services remain contested. This distinction is central in a high fertility Islamic context, where fertility is socially valued and where contraception may be judged through moral, marital, and community lenses rather than only through biomedical information.

https://doi.org/10.2147/OAJC.S597200
Received: 19 January 2026
Accepted: 3 June 2026
Published: 5 June 2026

Existing Evidence and the Contribution of This Commentary

Prior Somali research has already shown that child spacing can be more acceptable than the term family planning, especially when family planning is interpreted as limiting children. In focus group discussions among young people with tertiary education in Mogadishu, participants were more comfortable with child spacing than with limiting births, and many questioned the reliability of modern contraceptive medicines available in the country.[4] Qualitative work with Somali religious leaders has also shown that birth spacing can be supported when framed as protecting maternal and child health, although views differ by method and by concerns about moral misuse.[5] Reviews from Islamic countries similarly suggest that religion does not produce a single uniform response to contraception and that acceptability depends on how temporary contraception, health protection, and religious legitimacy are communicated.[6]

This commentary does not claim to be the first Somali paper to discuss child spacing or contraception myths. Its contribution is more specific: it connects the most recent national indicators, Somali qualitative evidence, and service delivery constraints into a contraception. The aim is to clarify how myths, partner dynamics, side effects, and fragile services may interact to shape initiation, continuation, discontinuation, or refusal of modern methods, and to propose practical counseling and service pathways that remain appropriate for this article.

Why Modern Contraceptive Methods are Commonly Avoided

Fear of permanent infertility remains one of the most powerful deterrents to contraceptive use. Many women believe that modern methods, particularly hormonal contraception, may cause long-term reproductive harm or prevent future conception. Menstrual changes, amenorrhea, or delayed return to fertility may be interpreted as irreversible damage when counseling is limited or when follow up is not available. Qualitative work from Somaliland similarly documents widespread misconceptions, limited exposure to accurate counseling, and the sensitivity of discussing birth spacing in communities where women may rarely receive structured information in health facilities or through outreach.[7]

Male partner refusal is another decisive barrier. In many households, husbands influence whether contraception is considered acceptable, and opposition may reflect a desire for more children, concern about future fertility, suspicion that contraception may enable infidelity, or fear that modern methods may harm the wife. These concerns are intensified by economic vulnerability and limited social protection, because childbearing can be closely tied to marital security and social acceptance. Some women may also fear that delaying pregnancy could trigger abandonment or a husband taking another wife, especially early in marriage or when fertility is viewed as evidence of marital commitment.[7]

Concerns about side effects further reduce initiation and continuation. Bleeding changes, weight change, reduced libido, mood symptoms, and other perceived effects can become socially risky when they affect daily functioning, intimacy, or perceived wellbeing. A cross-sectional study from Mogadishu reported a substantial burden of depressive symptoms among women using hormonal contraceptives, which reinforces the need for individualized counseling, careful listening, and nonjudgmental switching pathways when side effects occur.[8] This evidence should not be used to stigmatize hormonal contraception; rather, it supports a safer counseling model that takes women's reported symptoms seriously and helps them choose, continue, or switch methods according to their needs.

Finally, many couples prefer approaches they view as natural, reversible, and less threatening, including condoms, withdrawal, breastfeeding-related spacing, or fertility timing practices. These preferences may reflect low trust in modern methods and health facilities rather than rejection of birth spacing itself. They also highlight the importance of counseling that explains relative effectiveness, correct use, return to fertility, and method choice without dismissing community fears.

Service Delivery Realities in a Fragile Health System

Service delivery constraints can amplify social barriers. When commodities are inconsistent, counseling is rushed, privacy is not protected, or providers have limited training in side effect management, negative experiences can spread quickly and become community evidence that contraception is harmful. The FP2030 Somalia opportunity brief points to large missed opportunities for increasing modern contraceptive use, including postpartum family planning, adolescent

and youth outreach, and method choice.[9] However, these opportunities must be adapted to the realities of Somalia's health system rather than presented as simple facility-based solutions.

The recommendation to integrate contraception into postpartum and child health contacts is sensible but has important limitations in Somalia. According to the SHDS 2020, only 32% of births in the five years preceding the survey were attended by a skilled health professional, and 60.2% of children aged 12 to 23 months had received no vaccinations. Only 10.7% had received all basic vaccinations.[2] Therefore, postpartum, delivery, and immunization platforms should be strengthened, but they cannot be the only route to contraceptive counseling. Facility-based integration should be combined with outreach, community health workers, mobile services, and trusted community dialogue so that women outside routine service contact are not excluded.

This post-conflict context also affects trust. Repeated displacement, political instability, workforce shortages, weak supply chains, and donor-dependent programming may lead communities to view contraceptive services as temporary, externally driven, or unreliable. Adolescents and unmarried women may be especially difficult to reach and measure because of stigma, social risk, and limited confidential services. These groups should be considered in policy and counseling design, while maintaining culturally sensitive and legally appropriate safeguards.

A Path Toward Addressing Contraception Challenges

A Somalia-specific strategy should begin by shifting the public and clinical frame from limiting births to voluntary healthy birth spacing. This framing emphasizes maternal recovery, child nutrition and development, household wellbeing, and protection from closely spaced pregnancies, which is consistent with WHO guidance on birth spacing.[10] It also aligns with Somali religious leaders' perspectives when contraception is discussed as a temporary spacing for health rather than permanent limitation of children.[5]

Counseling should directly address infertility myths in plain Somali language. Providers should explain which methods are temporary, what side effects may occur, when fertility usually returns after stopping a method, and when a woman should seek care. Counseling should also include shared decision-making, respect for refusal, and support for switching methods. WHO guidance on contraception emphasizes informed choice, access to a range of methods, and counseling that supports voluntary decision-making.[11] In Somalia, these principles need to be translated into short, practical scripts and visual tools that can be used by midwives, nurses, doctors, and community health workers.

Male engagement should be routine but should not become a gatekeeping requirement. Couple-centered counseling can help when a woman wants her husband involved, especially where partner fears drive refusal or discontinuation. At the same time, requiring male permission or mandatory partner presence can restrict women's autonomy and confidentiality. Studies among Somali populations, including Somali immigrant women, show that partner communication, tailored information, and trust in providers are important for contraceptive use and acceptance.[12]

Religious and community engagement should also move beyond occasional awareness sessions. Trusted religious leaders, women's groups, community health workers, and elders can help correct misconceptions when messages are accurate, respectful, and focused on preventing harm. Such engagement should avoid coercive language and should make clear that contraception is a voluntary health service, not a population control agenda.

Finally, service reliability must match the message. Reliable commodities, privacy in service points, method choice, provider training, and follow up for side effects are quality indicators that directly influence trust, continuation, and discontinuation. Expanding method choice within primary care, establishing referral pathways for long acting reversible methods, and combining facility integration with outreach can help make birth spacing both acceptable and practically accessible in Somalia.

Conclusion

Somalia's low modern contraceptive use is best understood as the outcome of intertwined fertility norms, misinformation about infertility, partner and marital dynamics, side effect concerns, and fragile service trust rather than religion alone. The evidence base shows that many women and couples may support spacing births but remain reluctant to use modern methods when counseling is weak, side effects are poorly managed, or services appear unreliable. Progress is most likely when programs use faith compatible birth spacing language, provide respectful and confidential counseling, engage men

and community leaders without limiting women's autonomy, and ensure dependable access to a broader method mix through both health facilities and community outreach. This approach preserves the Commentary's central message while aligning more directly with contraception initiation, continuation, discontinuation, and reproductive autonomy in a low resource and post-conflict setting.

Data Sharing Statement

No datasets were generated or analyzed for this commentary. All sources discussed are publicly available and are cited in the reference list.

Ethics and Consent

This article is a commentary based on published literature and publicly available information and did not involve human participants, identifiable data, or new data collection. Therefore, ethics committee approval and informed consent were not required.

Acknowledgments

This research was supported by SIMAD University, Mogadishu, Somalia.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agreed to be accountable for all aspects of the work.

Funding

The study was Supported by SIMAD University, Mogadishu, Somalia.

Disclosure

The authors report no conflicts of interest in this work.

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