

# Barriers that affect the use of birth control options among women of reproductive age in Bwaise slum. A cross-sectional study.

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## Abstract

### Background

Ugandan women, on average, give birth to nearly two more children than they want, one of the highest levels of excess fertility in Sub-Saharan Africa. More than half of pregnancies in Uganda are unintended, and almost a third of these end up in abortions. The purpose of the study was to assess the barriers that affect birth control use among women of reproductive age in the Bwaise slum.

### Methodology

A cross-sectional study design and systematic random sampling were used to reach 384 study participants. Data were collected using questionnaires through direct interviews. The Chi-square test was used to establish the hypothesis, the association between independent variables and the dependent variable was performed, and a p-value  $< 0.05$  was accepted as statistically significant at 95% CI.

### Results

Knowledge is universal (99.7 %). Each woman was aware of at least 2.7 birth control options on average, with 91.4% knowing at least one option and 86 % knowing at least one advantage of using birth control. About 66.4% of participants have ever used a birth control option, and at the moment of the survey, only 37.2% reported using a birth control option. Association between the use of birth control and knowledge about a facility with birth control services, distance to the facility, lack of money, previous experience of side effects, and religious discouragement were noted.

### Conclusion

Women of childbearing age in the Bwaise slums used contraceptives below the national target of 50% with a high dropout rate. Side effects, lack of money, lack of knowledge of a facility, distance to the facility, and religious discouragements impact the use of birth control in the Bwaise slum.

### Recommendation:

Active outreaches to relay comprehensive information about birth control options, involving women of childbearing age, and religious and cultural leaders in the Bwaise slum are needed.

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## 1. Background of the study

One of the major goals of the SDGs 2030 agenda is to provide everyone in need with access to quality, affordable, acceptable, and sustainable sexual and reproductive healthcare ser-

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vices. (Greene *et al.*, 2019) (Booklet, 2020). One of the main components of sustainable global development is the provision of modern birth control methods; poverty alleviation; environmental safety; increased life expectancy; women's empowerment; gender equality; and health promotion, which includes the reduction of maternal morbidity, mortality, and unsafe abortion practices; and the improvement of child survival and health through birth spacing. In 2019, 49% of all women in the reproductive age range (15-49 years) used some form of birth control, up from 42% in 1990. Only 34.1% of women of reproductive age in Sub-Saharan Africa used an option. (United Nations, 2020) despite a high total fertility rate of almost 5.4 (The, Global and Ahmed, 2020). Most Sub-Saharan African countries have limited access to and utilization of birth control methods due to a lack of knowledge about where to obtain birth control methods and a lack of information about what women consider to be trustworthy sources of birth control information and services. (Alege *et al.*, 2016a).

In most Eastern African countries, birth control use is low in comparison to an unmet need. According to most country reports, injectables and pills are the most popular methods, with condoms, implants, and intrauterine devices being underutilized (IUDs). Condom and IUD use is tainted by numerous myths and misconceptions, both among health professionals and the general public (Health, 2020).

Although birth control knowledge is universal in Uganda, at least one option is known by each woman in urban or rural areas (Alege *et al.*, 2016b) (District *et al.*, 2021), many women who want to avoid pregnancy are not using effective family planning methods (Planning, 2020). Ugandan women, on average, give birth to nearly two more children than they want (6.2 vs. 4.5), one of the highest levels of excess fertility in Sub-Saharan Africa (High *et al.*, 2017). More than half of pregnancies in Uganda are unintended, and almost a third of these end up in abortions. This is especially true for most women in rural areas and urban slums, who face various health constraints that increase susceptibility to unsafe abortions

and their complications. These account for 5% of maternal deaths in the country (Nteziyaremye and Nteziyaremye, 2020).

A qualitative study found that some Ugandan men believed that contraceptives could cause health problems, such as infertility and cancer, while others felt that contraceptive use might cause women to have extramarital affairs. Among sexually active married women, commonly cited reasons for not using contraceptives include personal or partner opposition to use, breastfeeding, or having recently given birth and concern about side effects or inconvenience. Male partners also may influence a woman's choice and use of birth control options. The lack of availability of a range of birth options, or of any at all, makes it difficult for a woman to use a method continuously and to obtain a method that is appropriate to her needs (High *et al.*, 2017). Another study conducted in Somali revealed health communication messages and birth control information provided by health providers, prevalent religious fallacies among women, and fear of permanent infertility upon modern using options also contribute to the low percentage of usage (Gele *et al.*, 2021).

Supportive social environment, insurance of privacy and confidentiality, availability, affordability, and accessibility of birth control options, as well as the desire to prevent unintended pregnancy and sexually transmitted infections (STI), were the motivating factors for birth control use among young women in sub-Saharan Africa. Despite these motivators, a numberless of factors such as personal, societal, and health systems-based barriers including myths and misconceptions, known side effects of birth control options, prohibitive social norms, and negative attitudes of health professionals were the major barriers to contraceptive use among young people (Engelbert *et al.*, 2021). In the USA, various factors have been cited as influencing a women's choice of contraception method, including her awareness and perceptions of the effectiveness and safety of the method. Moreover, LARCs in particular have been associated with many myths and misconceptions about their safety and side effects; such misinformation may contribute to lower use (Shartzter *et*

*al.*, 2016). In eastern Uganda, significant factors affecting uptake were noted, including age and marital status, the youngest child's age, the decision when to have the next child, history of the sexually transmitted disease, the partner's age, and support (Daisy *et al.*, 2021).

In sub-Saharan countries, higher levels of use are observed among unmarried sexually active than married females (Foundation, 2017). In Saudi Arabia, there was a significant increase in contraceptives used among working women, older, with a high level of education, and those having a large number of children (Elgharabawy and Ahmed, 2015). This was corroborated by the results of a study conducted in India which also showed that birth control users were more in the higher age group and among those having a higher number of living children (Lal, 2015).

A study conducted in Somalia revealed that birth control methods are considered an imported Western tradition, which is against their norms and traditions, thus the conception and use of these are affected (Gele *et al.*, 2021). In some selected Urban slums in Nigeria, family planning decision-making was shown to be governed by local culture and community norms, social economic status, family member influence, and individual characteristics (Aransiola, Akinyemi, and Fatusi, 2014). A qualitative study conducted in two rural districts in Uganda found that in some patrilineal traditions contraceptive use was additionally linked with high value for children and encourages large family sizes, having a lot of children was described as a sign of wealth and financial security (Kabagenyi *et al.*, 2014).

Despite the Ugandan Government's commitments to increase the modern contraceptive prevalence rate (mCPR) from 30.4% to 39.6% and reduce unmet needs from 17% to 15% by 2025, the projected high population growth rate for urban slums in the immediate future (Nolan, 2016), leads us to believe that birth control service conditions will get worse and the impact on availability and safety of options will be huge. It is critical to Improve Sexually and Reproductive Health (SRH), by raising awareness of and providing a variety of affordable, effective, and

safe birth control options (Renzaho *et al.*, 2017). Hence, it is relevant to address the gaps relating to birth control in slums for policy and program implementation for 2030 agenda effectiveness (Sustainable and Goals, 2020). The purpose of the study was to assess the barriers that affect birth control services utilization by women of reproductive age in the Bwaise slum.

## 2. Methodology

The methods describes here are similar to a study by (Muderhwa, 2022) that described the the Level of Knowledge of Birth Control among Women of Reproductive Age in Bwaise Slum.

### 2.1. Study design

A descriptive cross-sectional study survey was conducted employing quantitative approaches. This was to help in the collection of data from birth control among women of reproductive age.

### 2.2. Study area

The study was carried out in the Bwaise slum, in Kawempe Division, Kampala Central District, Uganda. It mixes commercial, industrial, and residential settlements. The data was collected between the second and third weeks of April 2022, from the 11th to the 23rd.

### 2.3. Study population

The study population was comprised of women of reproductive age (15–49 years) living in the Bwaise slum three months prior to the study and who were able to give consent to participate in the study.

### 2.4. Sample size determination

Sample of 384 married women was obtained using the Cochran formula  $n = Z^2pq/e^2$  (Naing, 2003 , where:

- The sample size is  $n_o$ .
- At a 95% confidence level, the standard normal deviation is set at 1.96 (Z).
- e, the margin of error, absolute size precision set to 5%. The level of significance is 0.05, i.e., 0.05

- $p$ , the estimated proportion of an attribute that is present in the population. The target population's characteristics are not known, so (50% or 0.5), which is the standard for unknown populations and

- $q = 1-p$
- $n_o = (1.96)^2 (0.5) (1-0.5) / (0.05)^2 = 384$

### 2.5. *Sampling procedure.*

Systematic random sampling was used for selection. Respondents in this targeted area were selected from a larger group using a random starting point, with a fixed interval of 10. This sampling method provided an equal probability for all women of reproductive age to be included in the study hence the selected sample was representative of the study population.

### 2.6. *Data collection method and tools*

A structured questionnaire was administered to collect data with closed-ended questions. A Google form, an instrument developed by the researchers, was used. The questionnaire in English was instantly translated into Luganda, the most widely spoken language in the study area, as per the respondent's choice.

### 2.7. *Quality control*

During data collection, the research supervisor was close to the researcher to ensure that the right data is collected. Continuous verification of data was done during data collection, entry, and cleaning to further ensure the integrity of the data. Identified errors during the process were immediately rectified at the different levels. The questionnaire was pretested in the parish of Bukesa. This was done to test the validity and reliability of the questionnaire's questions.

### 2.8. *Selection criteria*

#### **Inclusion criteria**

The study was carried out among married women of reproductive age (15–49) living in the Bwaise slum three months prior to the survey, and only those who gave consent were included in the study.

#### **Exclusion criteria**

Women who are not residents of the Bwaise slum and those who have stayed in the Bwaise slum for less than 3 months prior to the survey were not included. Women who refuse to give their consent and those not in the capacity to give consent were excluded.

### 2.9. *Data collection procedure*

An introductory letter from the head of department Cavendish University Uganda Faculty of Science and Technology was given to the researcher and this helped to introduce researchers to authorities, community leaders, and participants for a better collaboration after understanding the purpose of their presence in the area. The researcher administered the questionnaire to participants who consented through a face-to-face interview.

### 2.10. *Data management*

The data that were collected from each individual were kept on a secured computer under lock and key, with only the researcher and the assistant having access to them.

### 2.11. *Variables*

In this study, the independent variables were Socio-demographic characteristics and barriers to the use of birth control options, whereas the dependent variables were the use of birth control options.

### 2.12. *Data process*

All the 384 filled questionnaires were entered into one Excel sheet then edited, coded, and entered into IBM SPSS version 21 for analysis. Descriptive statistics were presented in frequency and percentage. The chi-square test was used to establish the hypothesis, and the association between the independent variable (social demographic variables) and the dependent variable (use of birth control options), and Fisher's exact test for variables with an expected count less than 5 in cells, was performed and a  $p$ -value  $< 0.05$  was accepted as statistically significant at 95% CI. ANOVA was also used to compare the means between the different barriers to BC use.

### 2.13. Ethical considerations

Respondents' safety, privacy, and anonymity were observed during recruitment and interviews, as recommended by the World Health Organization in the Standards and Operational Guidance for the Ethics Review of Health-Related Research with Human Participants. The interviews were voluntary after signing a written consent form, and participants could withdraw anytime they feel uncomfortable. Participants' confidentiality of collected information was insured by clients' not providing names or any other identifiers only a unique code, which was given to each participant. The study methodology was reviewed and approved by the Institutional Review Board (IRB) of Cavendish University Uganda.

### 2.14. Bias

The quality of data entered will depend on the credibility of respondents, Information bias may occur because of participants not responding truthfully, the confidentiality of the respondent must be ensured, and the question formulated in a way that minimizes the risk of inappropriate answers by emphasizing the purpose of the study. Limited resources like funds and time.

## 3. Results

### 3.1. Socio-demographic characteristics of the study participants

shows the socio-demographic characteristics of respondents in this study. A total of 384 women of reproductive age (15–49) took part, with a mean age of 26.39 and a distribution of ages as follows, under 18 being 66 (17.2%), 19-29 being 205 (53.4%), 30-39 being 78 (20.3%), and 40-49 being 66 (17.2%). About 198 (51.6%) of women reported living with their partners, either married or cohabiting. Approximately half of the participants, 178 (46.4 %), have completed some form of secondary education. In terms of religion, the majority of those polled (176, 45.8 %) were Protestants, followed by Muslims (117, 30.5 %), and Catholics (90, 23.4 %). Almost half of the participants (185, 48.2 %) have ever had an unplanned pregnancy and 73 (19.0%) have ever had

an abortion. At the time of the survey, 21 (5.5 %) respondents were pregnant. Our respondents had a variety of occupations, the majority 151 (39.3%) were small business owners, 78 (20.3 %) are housewives, 74 (19.3 %) are salaried, 57 (14.8 %) are students and 24 (6.3 %) no structured activity. 218 (56.8 %) have an income but only 37 (9.6 %) of these find it sufficient for themselves and for their families. 48.2% have ever had an unplanned pregnancy and 19.0% have ever had an abortion.

Table 1. Socio-demographic characteristics of the study participants

Variable	Frequency (n)	Percent (%)
<b>Age groups</b>		
19-29	205	53.4
30-39	78	20.3
≤18	66	17.2
40-49	35	9.1
<b>Marital status</b>		
Married/Cohabiting	198	51.6
Single, No partner	83	21.6
Single, Non-regular partner	66	17.2
Divorced/separated	29	7.6
Multiple partners	4	1.0
Widow	4	1.0
<b>Level of education</b>		
Secondary incomplete	178	46.4
Primary incomplete	84	21.9
Tertiary	55	14.3
Primary complete	31	8.1
Secondary complete	29	7.6
Non-formal education	7	1.8
<b>Religion</b>		
Protestant	176	45.8
Muslim	117	30.5
Catholic	90	23.4
None	1	.3
<b>Occupation</b>		
Housewife	78	20.3
Paid employment	74	19.3
School	57	14.8
Small business owner	151	39.3
Unemployed: no structured activity	24	6.3
<b>Income</b>		
Yes	218	56.8
No	166	43.2
<b>Sufficient income</b>		
Yes	37	9.6
No	347	90.4
<b>Unplanned pregnancy</b>		
Yes	185	48.2
No	199	51.8
<b>Abortion</b>		
Yes	73	19.0%
No	311	81.0%

### 3.2. Barriers to the birth control use

As shown in Table 2, about one quarter 91 (23.7%) of respondents who, either have never used any options or were not using any options during the survey, reported not being sexually active. While 33 (8.6%) reported fearing side effects, 27 (7.0%) do not want to use any options, 25 (6.5%) the partners were away, 20 (5.2%) still desire more children, 17 (4.4) were breastfeeding, 15 (3.9%) were pregnant. The least reasons were the opposition of the partner (.3%), the costs of the options (.3%), religious objections (.5%), health

issues (.5%), and lack of information (1.6%). Almost three-quarters of respondents 287 (74.7%), know the location of a facility that provides counseling for birth control. Among those who know the location of a facility, 216 (56.3%) reported that it needs transport to reach the facility, while 65 (16.9) said it needs transport but is affordable and 6 (1.6%) reported that it needs transport but not affordable. The majority of 299 (77.9%) participants reported that money was not an obstacle to birth control services utilization. About 202 (52.6%) of the respondents have ever experienced side effects of birth control options. Concerning religion, 201 (52%) of respondents said their religion does not discourage people from using birth control options and 79 (20.6%) said yes, their religion forbids birth control use while 104 (27.1%) do not know whether it is allowed or forbidden. Almost 231 (60.2%) reported having the intention of using a birth control option in the future and 54 (14.1%) did not know whether they will use one or not. Most of the participants 113 (29.4%) who intend to use a birth control option in the future do not know which option they will use. However, 71 (18.5%) intended to use injectables in the future followed by Norplant 51 (13.3%), oral pills 21 (5.5%), natural methods 14 (3.6%), and the least options intended to be used are emergency contraception 2 (.5%), IUD 4 (1.0%), female sterilization 4 (1.0%), condoms 4 (1.0%). Most participant 138 (35.9%) defend their choice by saying they do not know about other options, 99 (25.8%) said they heard of side effects of other options, 36 (9.4%) just do not want to use other options, and 8 (2.1%) feel comfortable using the chosen one. The least reasons for not choosing other options were the cost of the other options 1 (.3%), and religion 1 (.3%).

**Table 2.** Reason for not using any birth control option

Variables	Frequency (n)	Percent (%)
<b>Major reason for not using any birth control options</b>		
<i>Not sexually active</i>	91	23.7
<i>Fear side effects</i>	33	8.6
<i>Don't want</i>	27	7.0
<i>Partner away</i>	25	6.5
<i>Still desire more children</i>	20	5.2
<i>I am Breastfeeding</i>	17	4.4
<i>I am pregnant</i>	15	3.9
<i>Not well informed about birth control</i>	6	1.6
<i>Health issues</i>	2	.5
<i>Religious objections</i>	2	.5
<i>Expensive</i>	1	.3
<i>Not getting periods</i>	1	.3
<i>Partner not approve</i>	1	.3

**Table 3.** Other barriers to birth control use

Variables	Frequency (n)	Percent (%)
<b>Knowledge of facility for birth control counseling</b>		
<i>Yes</i>	287	74.7
<i>No</i>	97	25.3
<b>Distance to the facility</b>		
<i>Walking distance</i>	216	56.3
<i>Needs transport but affordable</i>	65	16.9
<i>Needs transport but not affordable</i>	6	1.6
<b>Money as obstacle to birth control use</b>		
<i>No</i>	299	77.9
<i>Yes</i>	85	22.1
<b>Ever experienced side effects</b>		

**Table 4.** Options intended to use in future

Variables	Frequency (n)	Percent (%)
<b>Option intended to use in future</b>		
<i>Don't know</i>	113	29.4
<i>Injectable</i>	71	18.5
<i>Norplant/Implant</i>	51	13.3
<i>Oral pills</i>	21	5.5
<i>Natural methods</i>	14	3.6
<i>Condoms</i>	4	1.0
<i>Female sterilization</i>	4	1.0
<i>IUD</i>	4	1.0
<i>Emergency contraception</i>	2	.5
<i>None</i>	1	.3

**Table 5.** Association between level of knowledge, previous training/teaching and knowledge about a facility with birth control services

		Level of knowledge of birth control options			
		Low	Moderate	High	P-value
Having been formally taught about birth control	Yes	15 (7.1)	177 (83.9)	19 (9.0)	<b>.000</b>
	No	63 (36.4)	102 (59.0)	8 (4.6)	
Know a facility which provides birth control services	Yes	34 (11.8)	228 (79.4)	25 (8.7)	<b>.000</b>
	No	44 (45.4)	51 (52.6)	2 (2.1)	

The number of unplanned pregnancies and abortions of respondents were also compared to the level of knowledge of birth control and revealed that abortion had a statistically significant difference with the level of knowledge ( $X^2=59.2$ ,  $df=6$ ,  $p<0.001$ ) while unplanned pregnancies had not.

**Table 7.** Unplanned pregnancy and level of knowledge

Sociodemographic factors	N (%)	Level of knowledge of birth control			
		Low	Moderate	High	P-value
<b>Unplanned pregnancies</b>					
0	199 (51.8)	49 (24.6)	139 (69.8)	11 (5.5)	.229
1-3	158 (41.1)	27 (17.1)	118 (74.7)	13 (8.2)	
4-6	24 (6.3)	2 (8.3)	19 (79.2)	3 (12.5)	
≥7	3 (8)	0 (0.0)	3 (100.0)	0 (0.0)	
<b>Abortions</b>					
0	311 (81.0)	75 (24.1)	219 (70.4)	17 (5.5)	<b>.001</b>
1-2	67 (17.4)	3 (4.5)	55 (82.1)	9 (13.4)	
≥3	6 (1.6)	0 (0.0)	5 (83.3)	1 (16.7)	

### 3.3. Association between barriers and use of birth control options

Using a Chi-square test, potential barriers to the use of birth control options were compared, and results showed that knowledge about a facility with birth control services ( $X^2=17.3$ ,  $df = 1$ ,  $p<0.001$ ), distance to the facility ( $X^2=19.5$ ,  $df = 3$ ,  $p<0.001$ ), lack of money ( $X^2=24.2$ ,  $df = 1$ ,  $p<0.001$ ), previous experience with side effects ( $X^2=118.1$ ,  $df = 2$ ,  $p<0.001$ ), religious discouragement ( $X^2=13.6$ ,  $df = 2$ ,  $p<0.05$ ), and level of satisfaction ( $X^2=11.08$ ,  $df = 4$ ,  $p<0.05$ ), all had a statistically significant difference with the use of birth control options.

A one-way ANOVA was run with currently using birth control as the dependent variable, and knowledge about a facility  $F(1, 382)=18.025$ ,  $p<.001$ , distance to the facility  $F(3,380)=6.803$ ,  $p<.001$ , lack of money  $F(1,382)=25.68$ ,  $p<.001$ , the experience of side effects  $F(2,381)=84.6$ ,  $p<.001$ , religion discouragements  $F(2,381)=7.007$ ,  $p=.001$ , intention to use a BCO in the future  $F(2,381)=26.86$ ,  $p<.000$  as independent variables. Results reveal a significant variation between the means of the above variables to the use of birth control.

Variable	N (%)	Use of birth control options			P-value
		Yes	No		
<b>Knowledge of facility with birth control services</b>					
Yes	287 (74.7)	124 (43.2)	163 (56.8)		<b>.000</b>
No	97 (25.3)	19 (19.6)	78 (80.4)		
<b>Distance to the known facility with birth control services</b>					
Walking distance	216 (56.3)	88 (40.7)	32 (49.2)		<b>.000</b>
Needs transport but affordable	65 (16.9)	3 (50.0)			
Needs transport but not affordable	6 (1.6)		207 (69.2)		<b>.000</b>
<b>Money as obstacle to birth control use</b>					
No	299 (77.9)	92 (30.8)	34 (40.0)		
Yes	51 (12.1)		18 (34.0)		<b>.000</b>
<b>Ever experienced side effects</b>					
Yes	85 (22.1)	108 (53.5)	129 (100.0)		
No	202 (52.6)	35 (66.0)			<b>.001</b>
<b>Religion discouragements</b>					
I've never used it	53 (13.8)		110 (54.7)		
No	129 (33.6)	91 (45.3)	79 (76.0)		
Don't know		25 (24.0)	52 (65.8)		
Yes		27 (34.2)			<b>.026</b>
<b>Level of satisfaction with one's reproductive health</b>					
Not at all	201 (52.3)	2 (40.0)	11 (44.0)		
Unsatisfied	104 (27.1)	14 (56.0)	12 (41.4)		
Somewhat satisfied	79 (20.6)	17 (58.6)	115 (65.7)		
Satisfied	79 (20.6)	60 (34.3)	100 (66.7)		
Very satisfied	5 (1.3)	50 (33.3)			
	25 (6.5)				
	29 (7.6)				
	175(45.6)				
	150(39.1)				

## 4. Discussion

Knowledge of family planning is regarded as the first step toward the adoption of a birth control option. In this study, participants had a high level of knowledge about birth control (99.7 %). Each woman was aware of at least 2.7 birth control options on average, with 91.4 knowing at least one option and 86 % knowing at least one advantage of using birth control. The most known options were injectable, oral pills, Norplant, and IUD. About 66.4% of participants have ever used a birth control option, and at the moment of the survey, only 37.2% reported using a birth control option.

### 4.1. Reasons for not currently using any option and barriers to the use

The decision to use birth control was taken in couples with 63% of respondents currently using a birth control option. About one quarter 91 (23.7%) of respondents who, either have never used any options or were not using any options during the survey, reported not being sexually active while 33 (8.6%) reported fearing side effects, 27 (7.0%), and the least reason was the opposition of the partner (.3%). A qualitative study conducted in Uganda revealed that commonly cited reasons for not using contraceptives include concern about side effects or inconvenience, followed by personal or partner opposition, breastfeeding or having recently given birth, and lack of availability of a range of birth options, or any at all in the area (High *et al.*, 2017). This study revealed that the distance was majorly a walking distance, however, 1.6% reported that it needs transport but is not affordable. About 52.6% of the respondents have ever experienced side effects of birth control options. Concerning religion, 20.6% said yes, their religion forbids birth control use. Almost 60.2% reported having the intention of using a birth control option in the future and 14.1% did not know whether they will use one or not. Almost 8% of respondents reported not being satisfied with their reproductive status. In the same way, In Tanzania, a study revealed fear of side effects, lack of knowledge, misconception, acces-

sibility of the methods, and limited health workers' skills to be the major barriers to the use of birth control options (Lee, 2021). The dropout observed in the study may be explained by the side effects experience as reported by most of the participants who were not using any option during the survey.

### 4.2. Association between barriers and use of birth control options

This study revealed an association between potential barriers to the use of birth control options were compared, and results showed that knowledge about a facility with birth control services, distance to the facility, lack of money, previous experience of side effects, religious discouragement, and level of satisfaction. Results reveal a significant variation of the means between the barriers to the use of birth control. The study found a statistically significant variation of the means responses between the above barriers to the use of birth control options. In Saudi Arabia, culture, demographic, medical, administrative, and barriers related to the method itself were the most reported. Psychosocial and physical were the least reported (Abdel-Salam *et al.*, 2020). The majority of respondents 33.3% reported that using a birth control option positively influenced their birth control, while a minority 2.9% reported that it positively influenced and stabilized the family economy, and the fewest 1.0% reported that it positively influenced their health. The majority of respondents in a study conducted in a slum in India also said contraceptive methods have benefits like avoiding unwanted pregnancy, maintaining birth spacing, and limiting the number of births. But less knowledge that contraceptive methods reduce the economic burden on the family (Verma and Bajpai, 2021). This study's findings on the impact of birth control confirm our findings.

There is a lack of adequate infrastructure in the slum. Total absence or inadequate conditions of available health facilities in an area such as a slum may impact the knowledge, accessibility, and utilization of health services.

## 5. Limitations of the study

The quality of data entered will depend on the credibility of respondents, Information bias may occur because of participants not responding truthfully, the confidentiality of the respondent must be ensured, and the question formulated in a way that minimizes the risk of inappropriate answers by emphasizing the purpose of the study. Limited resources like funds and time.

## 6. Conclusion

The study found that women of childbearing age in the Bwaise slums used contraceptives below the national target of 50% with a high dropout rate. Findings also show that fear and previous experience of side effects, lack of money, lack of knowledge of a facility with birth control services, distance to the facility, and religious discouragements impact the use of birth control options in Bwaise slum.

## 7. Recommendation

Research results indicated that fear of side effects, lack of knowledge about birth control facilities, distance to the facility, and religious discouragement are major barriers to the use of birth control. Therefore, we recommend, that the government health agency, to conducted active outreaches to relay comprehensive information about birth control options, involving women of childbearing age, and religious and cultural leaders in the Bwaise slum. This should include detailed knowledge of how the method works, benefits, expected side effects of using each of the options, and their costs. Government health agencies should also ensure that local health centers have a supply of contraceptives and that the medical staff at these health centers are adequately trained in reproductive health. We also recommend women of reproductive age in Bwaise attend at least one SRH counselling session annually in the nearest facility, to be updated with relevant information.

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## 9. List of Abbreviations.

BCO	Birth Control Option
CPR	Contraceptive Prevalence Rate
IUD	Intrauterine Device
IRB	Institutional Review Board
mCPR	Modern Contraceptive Prevalence Rate
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health

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## 11. Conflict of interest

We declare no conflict of interests.

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