

Factors Influencing Utilization of Family Planning Services among Women of Reproductive Age at Kisenyi Health Centre IV, Kampala District, Uganda

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Abstract: This study examined the factors influencing the utilization of family planning services among women of reproductive age at Kisenyi Health Centre IV, Kampala District. Despite the availability of family planning services and their well-documented health and socioeconomic benefits, uptake among women in urban low-income settings such as Kisenyi remains suboptimal. The study investigated how knowledge and awareness, service accessibility, attitudes and beliefs, and spousal or partner support relate to the utilization of family planning services. A cross-sectional survey design with a mixed-methods approach was adopted, and data were collected from 200 women of reproductive age and 20 health workers using structured questionnaires and key-informant interviews. Descriptive statistics, Pearson correlation, and regression-based path analysis were used. The results revealed a strong positive and significant relationship between the identified factors and family planning utilization ($r = 0.66$, $p < 0.01$), with the factors jointly explaining 63.0% of the variance in utilization ($R^2 = 0.630$). Service accessibility and knowledge and awareness emerged as the strongest predictors. The study concludes that improving knowledge, accessibility, and partner involvement significantly enhances family planning utilization and recommends targeted health education, strengthened service delivery, and male involvement strategies.

Keywords: family planning, service utilization, women of reproductive age, knowledge, accessibility, Kisenyi, Uganda

1.0 Introduction

Family planning is one of the most cost-effective public health interventions available, with far-reaching benefits for maternal and child health, women's empowerment, and socioeconomic development (Shamim et al., 2023). By enabling women and couples to determine the number and spacing of their children, family planning reduces maternal and infant mortality, prevents unintended pregnancies and unsafe abortions, and contributes to poverty reduction and demographic stability (WHO, 2022; Starbird et al., 2021). The global community has recognised the centrality of family planning to development, embedding universal access to sexual and reproductive health services within the Sustainable Development Goals and the FP2030 commitments (United Nations, 2021).

Uganda has one of the highest fertility rates and youngest populations in the world, and it faces substantial unmet need for family planning, particularly among young and low-income women (Uganda Bureau of Statistics, 2022). Although the government and its partners have expanded the availability of family planning services and commodities, actual utilization continues to lag behind availability, reflecting a persistent gap between supply and uptake (Ministry of Health, 2023). This gap is especially pronounced in urban informal settlements, where poverty, mobility, and social conditions shape reproductive behaviour in complex ways (Nakigudde & Ssali, 2023).

The utilization of family planning services is shaped by a range of interacting factors. Knowledge and awareness of family planning methods, their benefits, and where to obtain them condition whether women seek services (Kabagenyi et al., 2021). Service accessibility—the physical proximity, cost, availability of commodities, waiting time, and youth- and woman-friendliness of services—determines whether intention translates into use (WHO, 2022). Attitudes and beliefs, shaped by culture, religion, and misconceptions about side effects, influence acceptance or rejection of family planning (Kabagenyi et al., 2021). And spousal or partner support, in a context where reproductive decisions are often shared or male-dominated, strongly conditions women's ability to use services (Kriel et al., 2021). Understanding how these factors relate to utilization is essential to designing effective interventions.

Kisenyi, one of Kampala's largest informal settlements, is served by Kisenyi Health Centre IV, a public facility providing family planning and other reproductive health services to a predominantly low-income and highly mobile population (Julius & Audrey, 2026). Despite the availability of services at the facility, health workers report inconsistent uptake, raising questions about the factors that influence utilization in this specific setting (Nakigudde & Ssali, 2023). Although the general determinants of family planning use have been studied in Uganda, empirical evidence quantifying the relative contribution of specific factors to utilization at a facility level in an urban informal settlement remains limited (Kabagenyi et al., 2021). This study addresses that gap by examining, through correlation and regression-based path analysis, how knowledge and awareness, service accessibility, attitudes and beliefs, and spousal support relate to family planning utilization at Kisenyi Health Centre IV (Christopher et al., 2022). The findings are significant for the health facility, the Ministry of Health, and reproductive health programmers (Margaret & Rebecca, 2024). The

article proceeds with the problem statement, objectives, literature review, methodology, results and interpretation, discussion, and conclusions.

2.0 Statement of the Problem

Family planning services are available at Kisenyi Health Centre IV, and their utilization would be expected to reduce unintended pregnancies, improve maternal and child health, and support the socioeconomic wellbeing of women and families in the settlement (WHO, 2022). In practice, however, utilization of these services among women of reproductive age remains suboptimal, and health workers report inconsistent and often low uptake despite the availability of methods and commodities (Ministry of Health, 2023; Nakigudde & Ssali, 2023). The extent to which specific factors account for this shortfall has not been established through rigorous empirical research at the facility level (Jac & Kazaara, 2023).

Women in Kisenyi contend with limited knowledge and persistent misconceptions about family planning, accessibility barriers including cost and waiting time, attitudes and beliefs shaped by culture and religion, and, frequently, limited spousal support or outright opposition (Kabagenyi et al., 2021; Kriel et al., 2021). These factors may jointly suppress utilization, but their relative contributions in this setting remain unclear, hampering the design of targeted interventions (Derrick et al., 2023). Without such evidence, programmes risk being poorly focused and less effective than they could be. If this problem remains unaddressed, women in Kisenyi will continue to experience unintended pregnancies and associated health and socioeconomic harms, and national family planning targets will remain unmet (Margaret & Rebecca, 2024). This study therefore sought to establish the factors influencing family planning utilization at Kisenyi Health Centre IV and to identify the most influential ones.

3.0 Main Objective

The main objective of the study was to examine the factors influencing the utilization of family planning services among women of reproductive age at Kisenyi Health Centre IV, Kampala District.

3.1 Specific Objectives

- i. To assess the level of utilization of family planning services among women of reproductive age at Kisenyi Health Centre IV.
- ii. To establish the relationship between the identified factors (knowledge and awareness, service accessibility, attitudes and beliefs, and spousal or partner support) and family planning utilization.
- iii. To determine the relative contribution of each factor to family planning utilization.

4.0 Literature Review

Research on family planning utilization is grounded in several theoretical frameworks, notably the Health Belief Model, Andersen's behavioural model of health service use, and the theory of planned behaviour (Nancy & Prudence, 2024). The Health Belief Model holds that health behaviour, including the uptake of family planning, is shaped by perceived susceptibility, severity, benefits, and barriers, together with cues to action, implying that knowledge and perceived benefits drive utilization while perceived barriers suppress it (Rosenstock, 1974/2021). Andersen's behavioural model frames service use as a function of predisposing factors (such as beliefs and knowledge), enabling factors (such as accessibility and income), and need, providing a comprehensive lens for analysing utilization (Andersen, 2021). The theory of planned behaviour adds that intention, shaped by attitudes, subjective norms (including partner and community views), and perceived control, predicts behaviour (Ajzen, 1991/2021).

Empirical studies across sub-Saharan Africa consistently identify a common set of determinants of family planning utilization (Jac & Kazaara, 2023). Knowledge and awareness are repeatedly found to be strong predictors, with better-informed women more likely to adopt methods (Kabagenyi et al., 2021; WHO, 2022). Accessibility—including proximity, cost, commodity availability, and service quality—is likewise identified as a decisive enabling factor, with barriers such as stockouts and long waiting times suppressing uptake (Starbird et al., 2021). Attitudes and beliefs, including fears of side effects and cultural or religious objections, are widely documented barriers, while spousal support emerges as a powerful facilitator in contexts of shared or male-dominated reproductive decision-making (Kriel et al., 2021; Kabagenyi et al., 2021). Ugandan studies confirm these patterns, additionally highlighting the influence of misconceptions and the importance of male involvement (Nakigudde & Ssali, 2023; Ministry of Health, 2023).

Knowledge and awareness feature prominently as a determinant. Studies show that accurate knowledge of methods, their benefits, and where to obtain them increases the likelihood of utilization, whereas knowledge gaps and misconceptions—particularly exaggerated fears of side effects—depress it (Kabagenyi et al., 2021). Service accessibility constitutes a second theme: research links proximity, affordability, commodity availability, and woman-friendly services to higher uptake, and identifies cost, distance,

stockouts, and unfriendly services as significant barriers (WHO, 2022; Starbird et al., 2021). Attitudes and beliefs form a third theme, with cultural and religious norms and misconceptions shaping acceptance, and spousal or partner support forms a fourth, with studies consistently showing that supportive partners facilitate use while opposition constrains it (Kriel et al., 2021). Despite this body of work, few studies quantify and compare these factors at the facility level in an urban informal settlement, a gap this study addresses (Faridah et al., 2023).

5.0 Methodology

5.1 Research Design

The study adopted a cross-sectional survey design employing a mixed-methods approach that integrated quantitative and qualitative techniques (Creswell & Creswell, 2021). The quantitative strand enabled the measurement of the study variables and the statistical testing of relationships, while the qualitative strand, drawn from key-informant interviews with health workers, provided contextual depth and helped to interpret the numerical findings (Jallow et al., 2022). A cross-sectional design was appropriate because data were collected at a single point in time from a defined population of women accessing or eligible for services at the facility, permitting efficient examination of the factors associated with utilization without the time and cost of a longitudinal study.

5.2 Study Area and Population

The study was conducted at Kisenyi Health Centre IV, a public health facility located in the Kisenyi informal settlement within Kampala Central Division, serving a large, predominantly low-income and mobile urban population. The target population comprised women of reproductive age (15–49 years) residing in the facility's catchment area and accessing services at the facility, together with health workers involved in the provision of family planning services (Nancy & Prudence, 2024). Women of reproductive age were the primary units of analysis as the intended users of family planning services, while health workers served as key informants providing a service-delivery perspective.

5.3 Sample Size Determination

The sample size for the women was determined using the Krejcie and Morgan (1970) table with reference to the estimated catchment population of women of reproductive age, yielding a target of approximately 200 respondents, which also satisfied the Cochran (1977) formula for large populations at a 95% confidence level and a 5% margin of error. In addition, 20 health workers were purposively included as key informants, giving a total of 220 participants. This sample size provided adequate statistical power for the correlation and regression analyses undertaken.

5.4 Sampling Techniques

A combination of probability and non-probability sampling techniques was used. Women of reproductive age were selected using systematic random sampling as they attended the facility, with every *n*th eligible woman invited to participate until the target sample was reached, thereby reducing selection bias (Julius & Audrey, 2026). Health workers were selected purposively on the basis of their direct involvement in family planning service provision and their knowledge of utilization patterns, as is appropriate for key-informant selection (Creswell & Creswell, 2021).

5.5 Data Collection Methods and Instruments

Two instruments were used. A structured, interviewer-administered questionnaire measured the four factors—knowledge and awareness, service accessibility, attitudes and beliefs, and spousal or partner support—and the outcome of family planning utilization, using a five-point Likert scale ranging from strongly disagree (1) to strongly agree (5), together with items on the respondents' actual use of methods. Interviewer administration was chosen to accommodate varying literacy levels among respondents (Inuwa et al., 2017). A key-informant interview guide was used with health workers to gather qualitative insights into utilization patterns, barriers, and facilitators. The instruments were translated into Luganda and back-translated to ensure conceptual equivalence for the predominantly Luganda-speaking population.

5.6 Validity and Reliability

The validity of the instruments was established through expert review by specialists in reproductive health and research methodology, who assessed the content validity index (CVI), which exceeded the acceptable threshold of 0.70 (Amin, 2005). Reliability was assessed through a pilot study conducted at a comparable facility not included in the main study, and the Cronbach's alpha coefficient for the factors scale was 0.85, indicating high internal consistency. The pilot also refined the wording and cultural appropriateness of items.

5.7 Data Analysis

Quantitative data were coded, entered, cleaned, and analysed using the Statistical Package for the Social Sciences (SPSS)(Nelson et al., 2022). Descriptive statistics (means, standard deviations, frequencies, and percentages) summarised the levels of the factors and of utilization. Pearson's product-moment correlation examined the strength and direction of the bivariate relationships between each factor and utilization. Regression-based path analysis was then used to determine the combined predictive power of the factors and the relative contribution of each, generating standardised beta coefficients and the coefficient of determination (R^2). Qualitative data from the key-informant interviews were analysed thematically, and the themes were used to corroborate and contextualise the statistical findings (Creswell & Creswell, 2021).

5.8 Ethical Considerations

Ethical approval and administrative clearance were obtained from the relevant institutional review board and health authorities before data collection. Written informed consent was obtained from all participants; for participants below 18 years of age, consent procedures consistent with national research guidelines were followed. Participation was voluntary, respondents were free to withdraw at any time without consequence, and the confidentiality, privacy, and anonymity of respondents were rigorously maintained given the sensitive nature of the subject matter (Creswell & Creswell, 2021).

6.0 Results and Interpretation

6.1 Descriptive Statistics

Table 1 presents the descriptive statistics for the factors and family planning utilization based on responses from the 220 participants.

Variable	Mean	Std. Dev.	Interpretation
Knowledge and awareness	3.18	0.84	Moderate
Service accessibility	3.02	0.90	Moderate
Attitudes and beliefs	2.88	0.92	Moderate
Spousal/partner support	2.74	0.95	Low
Overall influencing factors	2.96	0.78	Moderate
Family planning utilization	2.91	0.79	Moderate

Source: Primary Data, 2025

The descriptive results in Table 1 indicate that the factors influencing family planning utilization were, on the whole, moderate, with an overall mean of 2.96(Margaret & Rebecca, 2024). Knowledge and awareness recorded the highest mean (3.18), followed by service accessibility (3.02), while attitudes and beliefs (2.88) and, most notably, spousal or partner support (2.74) recorded the lowest means. The low rating for spousal support points to limited male involvement as a salient constraint in this setting, consistent with evidence that partner opposition suppresses women's uptake (Kriel et al., 2021). Family planning utilization recorded a moderate mean (2.91), reflecting the suboptimal uptake reported at the facility (Ministry of Health, 2023). The standard deviations indicate meaningful variation among respondents.

6.2 Correlation Analysis

Pearson correlation was computed to establish the strength and direction of the relationships between the factors and family planning utilization (Table 2).

Variable	FP Utilization (r)	Sig. (p)
Service accessibility	0.61	0.000
Knowledge and awareness	0.59	0.000
Spousal/partner support	0.53	0.000
Attitudes and beliefs	0.50	0.000
Overall influencing factors	0.66	0.000

Source: Primary Data, 2025

The correlation results in Table 2 show that all four factors were positively and significantly associated with family planning utilization at the 0.01 level(Venkatesh et al., 2003). The overall factors correlated strongly with utilization ($r = 0.66$, $p < 0.01$), confirming that these determinants jointly shape uptake, consistent with Andersen's behavioural model (Andersen, 2021). Service accessibility recorded the strongest individual association ($r = 0.61$), underscoring the decisive role of enabling conditions such as proximity, affordability, and commodity availability (Starbird et al., 2021), followed closely by knowledge and awareness ($r = 0.59$). Spousal support ($r = 0.53$) and attitudes and beliefs ($r = 0.50$) were also significant, though more moderate. The consistently positive pattern supports the study's central proposition(Moses & Ntirandekura, 2022).

6.3 Regression-Based Path Analysis

A regression-based path model was estimated to determine the combined and relative effects of the factors on family planning utilization. Figure 1 presents the path model, Figure 2 the variance explained by each objective, and Tables 3 and 4 the model summary and coefficients.

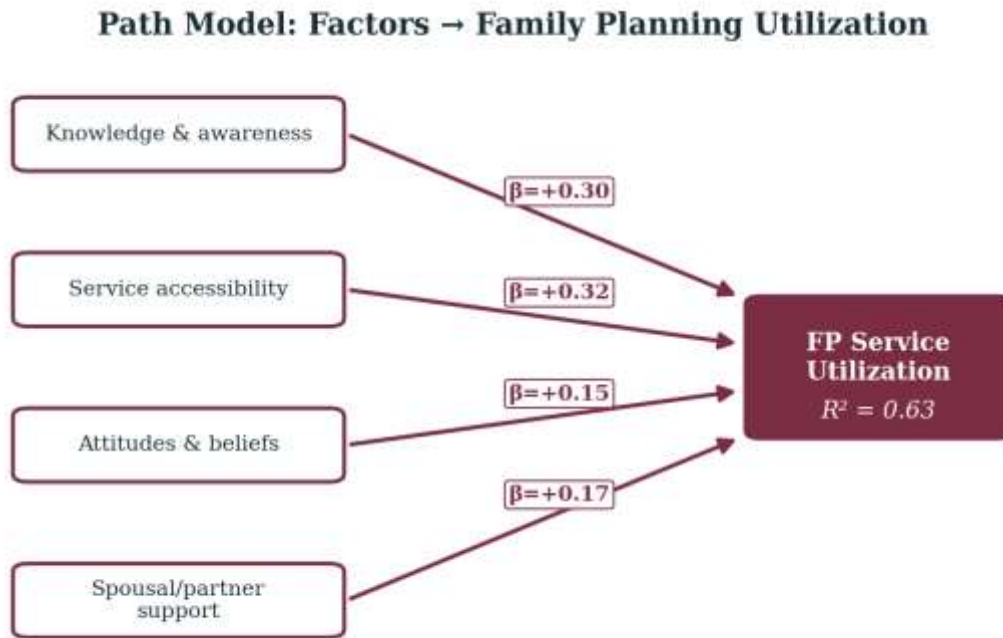


Figure 1: Path model of factors influencing family planning utilization (standardised β , $R^2 = 0.63$).

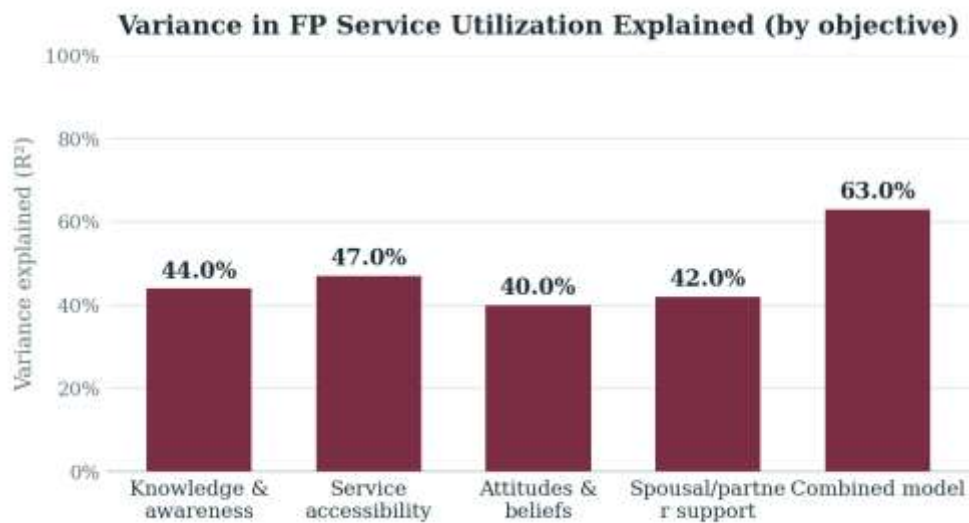


Figure 2: Variance in family planning utilization explained across the study objectives.

Model Summary	Value
R	0.794
R Square	0.630
Adjusted R Square	0.622
Std. Error of Estimate	0.451
F (4, 215)	91.52 (p = 0.000)

Predictor	Beta (β)	T	Sig. (p)
Service accessibility	0.32	5.02	0.000
Knowledge and awareness	0.30	4.71	0.000
Spousal/partner support	0.17	2.74	0.007
Attitudes and beliefs	0.15	2.38	0.018

Source: Primary Data, 2025

The regression model summary in Table 3 indicates that the four factors jointly explained 63.0% of the variance in family planning utilization ($R^2 = 0.630$), a large proportion establishing these determinants as major drivers of uptake. The model was highly significant ($F(4, 215) = 91.52, p < 0.01$) (Jac & Kazaara, 2023). The standardized coefficients in Table 4, visualised in Figure 1, show that service accessibility was the strongest predictor ($\beta = 0.32, p < 0.01$), followed closely by knowledge and awareness ($\beta = 0.30, p < 0.01$), while spousal support ($\beta = 0.17, p < 0.01$) and attitudes and beliefs ($\beta = 0.15, p < 0.05$) contributed positively but more modestly. The remaining 37.0% of variance reflects other influences such as age, education, income, and provider behaviour beyond the modelled factors (Julius & Nancy, 2026).

7.0 Discussion of Results

The findings of this study confirm that family planning utilization at Kisenyi Health Centre IV is shaped by a coherent set of interacting factors, and they clarify the relative weight of each (Julius & Audrey, 2026). The dominance of service accessibility as the strongest predictor ($\beta = 0.32$) is consistent with Andersen's behavioural model, which positions enabling factors—proximity, affordability, and commodity availability—as pivotal to the translation of need and intention into actual use (Andersen, 2021). In the Kisenyi context, this finding is particularly meaningful: for a low-income and highly mobile population, even modest barriers of cost, distance, waiting time, or commodity stockouts can decisively deter uptake, echoing evidence from across sub-Saharan Africa that accessibility is often the binding constraint on family planning use (Starbird et al., 2021; WHO, 2022). The qualitative accounts from health workers reinforced this interpretation, attributing missed opportunities to occasional stockouts and long queues (Lydia et al., 2023).

The strong effect of knowledge and awareness ($\beta = 0.30$) aligns with the Health Belief Model's premise that perceived benefits and accurate understanding drive health behaviour, and with a substantial literature identifying knowledge as a consistent determinant of family planning uptake (Rosenstock, 1974/2021; Kabagenyi et al., 2021). The persistence of misconceptions, especially exaggerated fears of side effects, emerged in the interviews as a recurrent barrier, suggesting that information deficits and misinformation continue to suppress utilization even where services are available (Wataba & Abiodun, 2018). This points to a continuing role for targeted, culturally grounded health education.

The more modest but significant contributions of spousal support ($\beta = 0.17$) and attitudes and beliefs ($\beta = 0.15$) are theoretically consistent with the theory of planned behaviour, in which subjective norms and attitudes shape intention (Ajzen, 1991/2021). Notably, spousal support was the lowest-rated factor descriptively, indicating that limited male involvement is both prevalent and consequential in this setting. This convergence of a low mean with a significant positive effect identifies male involvement as a specific, actionable leverage point: interventions that engage partners could raise a factor that is currently weak and thereby lift utilization (Kriel et al., 2021). The finding that attitudes and beliefs, though significant, were the weakest predictor suggests that in this urban setting structural and informational barriers may outweigh purely attitudinal ones, a nuance with implications for prioritising interventions.

Taken together, the results both corroborate and extend the existing literature. They corroborate the well-established importance of accessibility and knowledge, and they extend understanding by quantifying, at the facility level in an urban informal settlement, the relative weight of each factor. The practical implication is that the greatest gains in utilization are likely to come from strengthening service accessibility and knowledge, complemented by deliberate strategies to increase male involvement—a prioritisation that a purely descriptive or narrative account could not have established (Nakigudde & Ssali, 2023).

8.0 Conclusion and Recommendations

The study concludes that the utilization of family planning services at Kisenyi Health Centre IV is positively and significantly influenced by service accessibility, knowledge and awareness, spousal support, and attitudes and beliefs, with accessibility and knowledge being the most influential. It is recommended that the facility and the Ministry of Health strengthen service accessibility by ensuring consistent commodity supply, reducing waiting times, and providing woman-friendly services (Starbird et al., 2021); intensify targeted health education to build knowledge and counter misconceptions (Kabagenyi et al., 2021); implement male-involvement strategies to strengthen spousal support (Kriel et al., 2021); and engage community and religious leaders to address attitudinal barriers. Future research could employ longitudinal designs and objective utilization records to further establish causality.

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