



**Individual and socio-cultural factors influencing male involvement in family planning decision-making among men attending Ndejje Health Center IV, Wakiso District.
A cross-sectional study.**

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ABSTRACT

Background:

The study aimed to determine the individual and socio-cultural factors influencing male involvement in family planning decision-making among men attending Ndejje Health Center IV, Wakiso District.

Methodology:

This descriptive cross-sectional quantitative study was conducted at Ndejje Health Centre IV, Wakiso District, to assess male involvement in family planning decision-making. A sample of 50 men was calculated using the Kish and Leslie (1965) formula at a 95% confidence level with a 10% non-response rate. Participants were conveniently selected. Data were collected over five days using structured researcher-administered questionnaires covering demographic, individual, and sociocultural factors. Data were analyzed with Microsoft Excel and presented as frequencies and charts. Validity, reliability, ethical approval, informed consent, confidentiality, and voluntary participation were ensured.

Results:

The study included 50 men attending Ndejje Health Centre IV. Most respondents were aged 39-58 years (58%), while 16% were aged 59 years and above. A large proportion were cohabiting (40%), followed by singles (32%) and married men (16%). Nearly half were businessmen (46%), and 38% had attained secondary education, while 14% had no formal education. All respondents (100%) were aware of family planning methods. However, 78% reported unstable income, and 4% had no income. Although 82% personally supported family planning, 70% believed women are mainly responsible for FP decisions. More than half (54%) felt men have no role in FP, 76% sometimes avoided FP discussions due to stigma, 94% lacked social support, and 76% reported no religious encouragement for male involvement.

Conclusion:

Men's involvement in decision-making remained low due to unstable income and persistent socio-cultural barriers such as stigma, lack of social and religious support, and the belief that family planning is primarily a woman's responsibility.

Recommendation:

The Ministry of Health should prioritize the integration of male-focused reproductive health programs.

Keywords: *individual and socio-cultural factors, male involvement, family planning decision making.*

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BACKGROUND OF THE STUDY

Manly involvement in family planning (FP) decision-making refers to the active participation of men in choosing, supporting, and promoting contraceptive use within couples to insure participated responsibility in reproductive health

(Osuafor et al., 2023). Manly participation has been shown to ameliorate contraceptive uptake, reduce unintended gravidity, and enhance maternal and child health issues (McLean & Thulin, 2022). Despite these benefits, male involvement remains low in numerous settings due to



individual position and sociocultural barriers. Encyclopedically, fewer than 40 men are laboriously involved in FP decision-making, largely due to artistic beliefs, religious comprehensions, rigid gender roles, and misconceptions about contraception (D'Souza et al., 2022). In numerous societies, FP is traditionally perceived as a woman's responsibility, limiting men's engagement and adding women's unmet need for contraception (Solo & Festin, 2019). In Asia, male involvement ranges between 30 and 40, with sociocultural morals situating FP as a womanish duty and widespread fears about contraceptive side effects discouraging male support (Biswas et al., 2022). Also, in Sub-Saharan Africa, mainly involvement varies between 20 and 45, with traditional gender norms, low male mindfulness, and negative attitudes contributing to high fertility rates and adverse maternal and child health issues (Odira et al., 2025). In East Africa, male involvement ranges from 30 to 50, with gender conceptions and limited knowledge of ultramodern contraceptives contributing to low FP uptake and high teenage gestation rates. In Uganda, male involvement stands at roughly 27, with artistic beliefs, limited knowledge, and fiscal constraints impacting men's participation, performing in low contraceptive use and increased maternal health complications (Tekakwo et al., 2023).

In Wakiso District, male involvement is estimated at 35, where misconceptions, work-related commitments, and sociocultural prospects limit men's engagement in FP decision-making (Wambete et al., 2024). The study aimed to determine the individual and socio-cultural factors influencing male involvement in family planning decision-making among men attending Ndejje Health Center IV, Wakiso District.

METHODOLOGY

Study Design and Rationale

This research used a descriptive cross-sectional study design employing a quantitative research method to obtain data. The study was cross-sectional because it was carried out at one point in time without further follow-up. The design was chosen because it was cost-saving, easier to carry out, and carried out in a shorter time.

Study Setting and Rationale

The study was conducted at Ndejje Health Center IV, located in Ndejje Parish, Namasuba-Zzana, Makindye Ssabagabo Municipality, Wakiso District, in the Central

Region of Uganda. The health center is situated approximately 12 kilometers southwest of Kampala along Entebbe Road and serves as a major public health facility for residents of Ndejje, Namasuba, Zzana, Lubowa, Bunamwaya, and other surrounding areas. The approximate geographical coordinates of the health center are 0°41'24.0"N, 32°32'06.0" E (Latitude: 0.690000; Longitude: 32.535000). Ndejje Health Center IV is a government-managed facility under the Ministry of Health and provides a wide range of services, including family planning (FP) services, maternal and child health, antenatal care (ANC), outpatient and inpatient care, HIV/AIDS management, and emergency services. The health center caters to a large and diverse population with an estimated 1,500–2,000 clients accessing family planning services monthly, including men and their partners. The OPD ward at Ndejje Health Center IV is spacious, clean, and well-organized, designed to provide both outpatient and inpatient services for male clients. It is equipped with adequate hospital beds, examination couches, handwashing facilities, and essential medical supplies to support routine and emergency care. The ward has well-trained medical and nursing staff who offer services such as medical reviews, treatment of common illnesses, counseling, and health education. Male involvement in family planning decision-making remains low, with many men leaving contraceptive choices entirely to their partners, thus making it suitable for studying this research.

Study Population

The study targeted Men attending Ndejje Health Center IV, Wakiso District during the time of data collection.

Sample Size Determination

The sample size was calculated using the formula developed by Kish and Leslie (1965), given by: $n = \frac{z^2 pq}{d^2}$

Where;

n was the sample size required

P was the estimated proportion of males involved at Ndejje Health Centre IV in family planning decision making, 3% in 2024 (HMIS OPD 009 Health Unit Register, 2024)

p= 3 %, which was equivalent to 0.03

d=0.05 was the acceptable error of estimation at 95% confidence interval

Z was the confidence interval at 95% =1.96

q=1-p



Therefore;

$$n = \frac{z^2 p(1-p)}{d^2} = \frac{(1.96)^2 \times 0.03(1-0.03)}{(0.05)^2}$$

n=45

On the assumption of 10% non-response rate, the sample size was;

n= 45+4.5

n=49.52

n=50 men attending Ndejje Health Centre IV

Sampling Procedure

A convenience sampling technique was used to select study participants. This method was appropriate because it allowed easy access to men who were readily available and willing to participate while attending family planning services at Ndejje Health Centre IV. During the data collection period, men attending family planning services at the health centre were approached and invited to participate in the study. Only those who met the inclusion criteria and provided informed consent were included.

Data collection was conducted over five working days, sampling approximately 10 participants per day to reach a total sample size of 50 men. This approach was practical and efficient within the clinical setting, enabling completion of the study within the planned timeframe while ensuring adequate representation of the study population.

Inclusion Criteria

Adult (39 – 58 years) Ugandan men attending Ndejje Health Center IV, Wakiso District, who consented to participate in the study were included in the study.

Exclusion Criteria

Men attending Ndejje Health Center IV, Wakiso District, who consented but failed to participate in the study due to withdrawing from participating were excluded from the study, and those who were too ill and unable provide a response to the questions were also excluded from the study.

Dependent Variables

The dependent variable was the level of male partner involvement in family planning decision-making. This referred to the active participation of men in discussions, choices, and support regarding the use of contraceptive methods within their families.

Independent Variables

Individual-related factors: these are personal and social characteristics that influence male involvement in family planning decision-making, such as education, cultural norms, financial barriers, stigma, male experiences, and men's attitudes.

Socio-cultural factors: these are cultural characteristics that affect the influence of male involvement in family decision making, and these include stigma, cultural norms, gender imbalances, and religious tariffs.

Research Instrument and Rationale

A structured, interviewer-administered questionnaire written in English was used to collect data. It contained closed-ended questions aligned with the study objectives. The questionnaire consisted of three sections: Section A focused on the demographic characteristics of respondents, Section B addressed individual factors, and Section C covered socio-cultural factors.

For respondents who were unable to read or write, the questions were read aloud and translated into clear and simple language. Responses were then recorded to ensure inclusivity and accuracy.

Data Collection Procedure

Upon the proposal approval by the supervisor and the IRC, an introductory letter from the Dean, School of Nursing, Mild may Uganda School of Nursing and Midwifery was granted, which helped to ask permission from the administration of Ndejje Health Centre IV and she first made a self-introduction and explain the purpose of the study to get permission to carry out the study among respondents. The in-charge introduced the research to the study respondents, and the purpose of the study was explained to each respondent. The data collection took place within a period of five days, while sampling 10 respondents until a sample size of 50 respondents was achieved. Training of research assistants was conducted as these helped in translating English questions to the local language for illiterate respondents during the administration of the structured questionnaires at the facility with respondents. Verbal permission and informed consent were sought from respondents, and a clear explanation of the research purpose was provided. Each study respondent was made comfortable in a separate corner within the facility compound, assured of confidentiality, and requested to cooperate in the administered questionnaire.



Data Management

At the end of each day of data collection, all completed questionnaires were carefully reviewed to ensure completeness and accuracy. The collected data were then coded and cleaned prior to analysis. Hard copies of the questionnaires were securely stored in a lockable box to maintain confidentiality, while electronic data were kept on a password-protected device to ensure data security.

Data Analysis

The data were reviewed for accuracy and completeness before entry into Microsoft Excel (2022) for analysis. The findings were presented using frequency tables, graphs, and pie charts to clearly illustrate trends and patterns, followed by an interpretation of the results.

Validity

Validity was ensured by designing the questionnaire to directly reflect the research objectives. The research supervisor reviewed the tool to confirm that questions accurately capture information relevant to male involvement in family planning decision-making. The tool was further reviewed by a team of experts in obstetrics and statistics for face and content validity. Feedback from the supervisor helped in recording and adjusting the questions in the questionnaire.

Reliability

Reliability was assessed through pre-testing the questionnaire at Kisenyi Health Centre IV, with 8 men involved attending the male ward. Feedback from the pre-test was used to make necessary revisions to ensure consistency and clarity of the questions before the formal study.

Ethical Considerations

After approval of the proposal, an introductory letter was obtained from the Dean, School of Nursing, Mildmay Uganda School of Nursing and Midwifery, to seek permission from the administration of Ndejje Health Centre IV. The study purpose was clearly explained to both the health facility authorities and the respondents. Ethical principles were strictly observed by ensuring voluntary participation, obtaining informed consent from all respondents, and maintaining confidentiality and anonymity.

Males under 18 years who were household heads were considered emancipated minors and were therefore allowed to participate in the study. Respondents were informed of their right to withdraw at any time without penalty. All information collected was used solely for academic purposes and handled with respect for participants' privacy and dignity.

RESULTS

Socio-Demographic Data of Respondents

Table 1: shows the Demographic Data of Respondents.

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	18–38	13	26
	39–58	29	58
	59 and above	8	16
Relationship status	Married	8	16
	Divorced	6	12
	Co-habiting	20	40



	Single	16	32
Occupation	Businessman	23	46
	Casual worker	13	26
	Unemployed	4	8
	Civil servant	10	20
Education level	No formal education	7	14
	Primary education	10	20
	Secondary education	19	38
	Tertiary/university	14	28

Table 1 shows that the majority, 29 (58%) of men were aged between 39 and 58 years, and the smallest group, 8 (16%) were 59 years and above. Most respondents, 20 (40%), were co-habiting and 6 (12%) were divorced. Nearly half 23, 46%) of the respondents were businessmen, and 4 (8%) were unemployed. A small portion, 19 (38%), had completed secondary education, and 7 (14%) had no formal education.

Individual factors influencing Male Involvement in family planning decision-making among Men attending Ndejje Health Center IV, Wakiso District.

Figure 1: Shows Awareness of Contraceptive Methods of Family Planning Services N=50

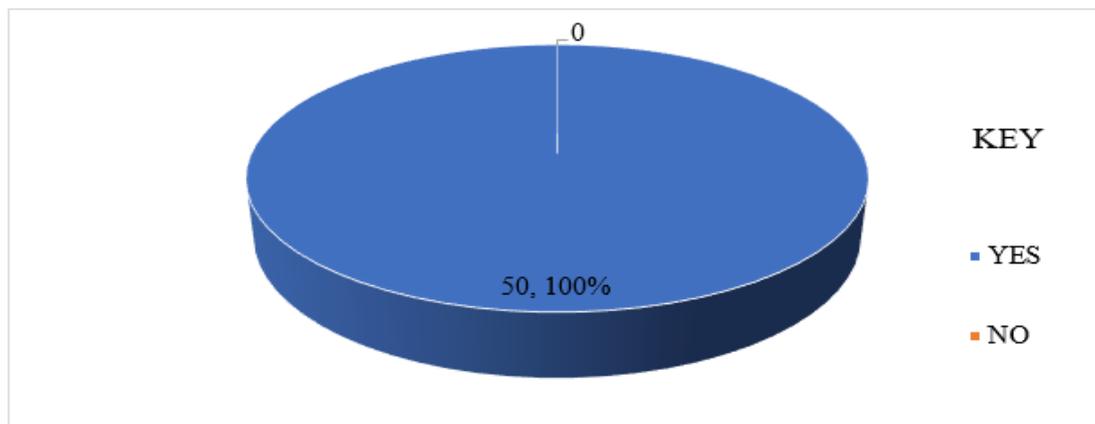




Figure 1 indicates that all respondents 50 (100%) had heard about contraceptive methods or family planning services.

Table 2 shows Income level, support of family planning, and presence of pre-existing health conditions, N=50

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Variable	Category	Frequency (n)	Percentage (%)
Income level	Stable income	9	18
	Unstable income	39	78
	No income	2	4
Personal support for family planning	Yes	41	82
	No	9	18
Pre-existing health condition	Yes	0	0
	No	50	100

Table 2 indicates that most men 39, 78%) reported having an unstable income, and 2 (4%) reported no income. A large majority, 41 (82%), personally supported family planning, while 9 (18%) did not. All respondents 50 (100%) reported having no pre-existing illness.

Socio-cultural factors influencing Male Involvement in family planning decision-making among Men attending Ndejje Health Center IV, Wakiso District.

Figure 2: Shows perception of responsibility for family planning decisions, N=50

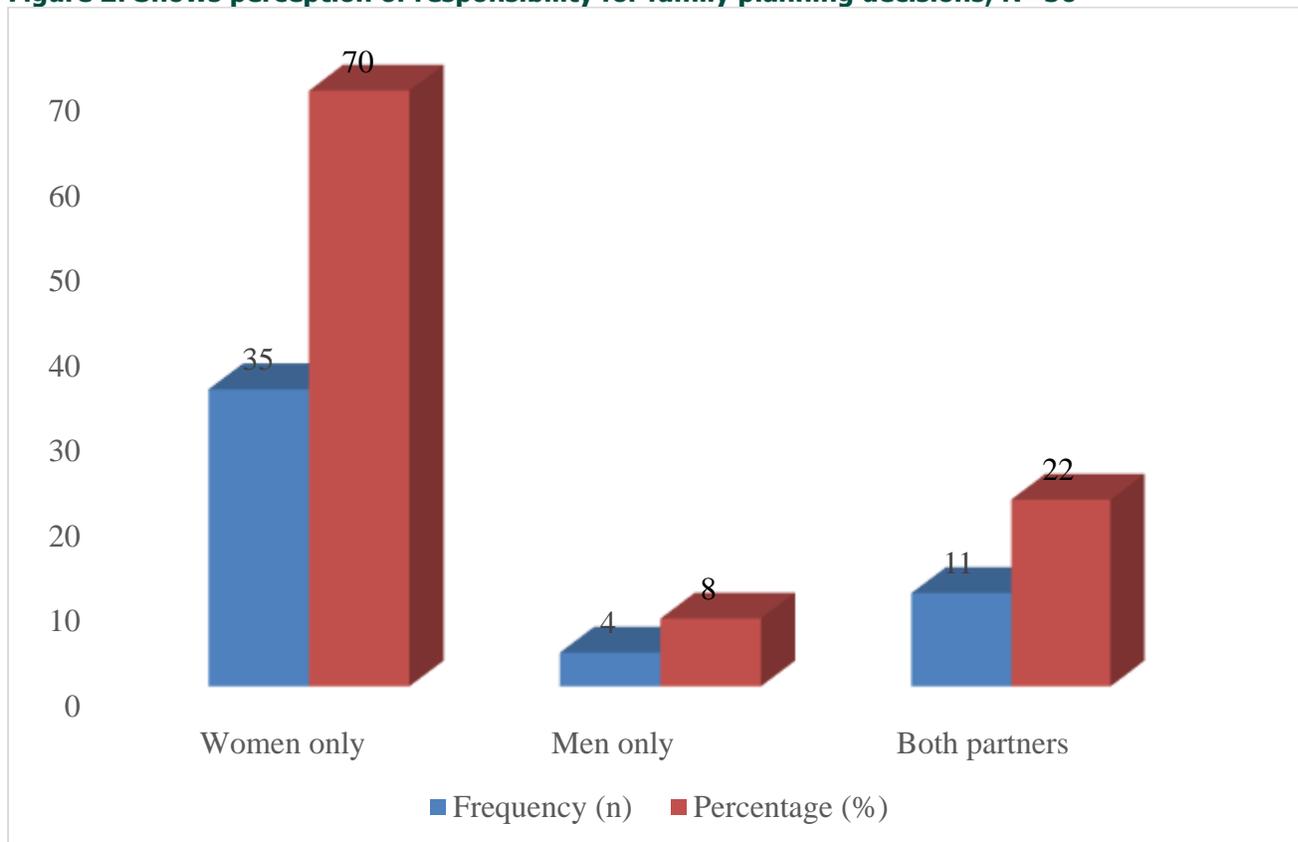


Figure 2 reveals that most respondents, 35 (70%), believed that women are mainly responsible for family planning decisions, while only 4 (8%) said men alone are responsible.



Table 3 shows perceived role of men in family planning, stigma around, social support for family planning, and influence of religious teachings on FP involvement, N=50

Variable	Category	Frequency (n)	Percentage (%)
The role men should play in family planning	Financial support only	9	18
	Joint decision-making	10	20
	No role	27	54
	Am unsure	4	8
Avoid FP talks due to stigma.	Yes	10	20
	Sometimes	38	76
	No	2	4
Social support for family planning	Yes	3	6
	No	47	94
Religious encouragement to be involved in FP	Yes	12	24
	No	38	76
TOTAL		50	100

Table 3 indicates that a majority, 27 (54%), felt that men have no role in FP, and 4 (8%) were unsure. Most respondents, 38 (76%), indicated that men sometimes avoid FP talks due to stigma, and 2 (4%) said no. Nearly all respondents, 47 (94%), reported that they do not receive social support for FP in their communities, while only 3 (6%) indicated support. The majority, 38 (76%), said that religious teachings do not encourage male involvement in FP, while 12 (24%) reported that religion promotes their participation.

DISCUSSION

The main purpose of this study was to find out the factors influencing Male Involvement in family planning decision-making among Men attending Ndejje Health Center IV, and the study findings indicated that all respondents (50, 100%) had heard about contraceptive methods or FP services. This could be because FP awareness campaigns at Ndejje Health Center IV and other community programs have reached a broad audience of men, which disagrees with the problem statement. This shows that while knowledge of FP exists, awareness alone may not translate into active participation, highlighting the need for interventions that focus on



behavioral engagement rather than knowledge alone. This was in disagreement with a study carried out by Sauerbrun-Cutler et al. (2023) which showed that 41% of men with low awareness participated in FP decisions.

The findings showed that a large majority (82%) of men reported personal support for family planning. This could be because men recognize the health and economic benefits of controlling family size, especially in households with multiple dependents. This implies that supportive attitudes exist but may not always be acted upon due to other socio-cultural or systemic barriers, which align with the problem statement. This was in consensus with a study done by Baglan & Esencan, (2025) which showed that 76% of men with positive attitudes toward contraceptives were involved in FP decision-making

The research intended to assess the socio-cultural factors influencing Male Involvement in family planning decision-making, and the findings showed that most respondents (35, 70%) believed that women are primarily responsible for FP decisions. This could be because FP is often socially and culturally perceived as a “women’s domain,” with men traditionally seen as financial providers rather than participants in reproductive health choices, thus supporting the problem of this study. This implies that socio-cultural norms significantly constrain male involvement, even when men are aware of or supportive of FP. This was in line with a study carried out by Levesque et al. (2024), which showed that 63% of men from patriarchal households viewed contraception as the sole responsibility of women.

The study findings revealed that most men (27, 54%) indicated that men have no role in FP, while only 10 (20%) endorsed joint decision-making. This could be because patriarchal attitudes and community expectations discourage men from participating in reproductive health discussions beyond financial support, and this aligns with the problems. This shows that societal norms continue to influence male behavior, underlining the need for culturally sensitive education campaigns to reshape perceptions about male roles in FP. The study results were in disagreement with a report done by Dombola et al., (2021), which showed that 71% of men believed their role was limited to financial support, while only 36% felt responsible for participating in contraceptive decisions

The study findings revealed that stigma also appears to influence behavior, with 38 (76%) reporting that men sometimes avoid FP discussions due to social stigma. This could be because community attitudes associate male involvement in FP with emasculation or interference in

women’s responsibilities, thus meaning that addressing stigma through community engagement and positive role modeling is essential to enhance male participation. This was in agreement with a study done by Biswas et al. (2022), which indicated that 54% of men avoided FP discussions due to fear of being perceived as controlled by their wives. The findings from the study above showed that socio-cultural factors influenced Male involvement in family planning decision-making among men.

CONCLUSION

The study findings showed that individual factors such as awareness and personal support for family planning were generally high, with all respondents aware of FP methods and personally supporting family planning. However, unstable income for most men may limit the extent of their active participation in decision-making.

Socio-cultural factors significantly constrained male involvement. The majority perceived family planning as primarily a woman’s responsibility, indicated that men have no role in FP, and reported avoiding FP discussions at times due to social stigma. Furthermore, almost all men reported lacking social support, and religious teachings were largely unsupportive.

RECOMMENDATION

The Ministry of Health should therefore prioritize the integration of male-focused reproductive health programs, including awareness campaigns that target men specifically, and allocate resources to increase staffing and infrastructure in health facilities to accommodate male clients.

Men themselves should be encouraged to actively engage in joint decision-making with their partners and seek information on FP services, as their involvement has been shown to enhance family health outcomes.

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May God richly bless them all

LIST OF ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Antenatal Care
FP:	Family Planning
FPCIP:	Family Planning Costed Implementation Plan
HIMS:	Health Information Management System
HIV:	Human Immunodeficiency Virus
IRC:	Institution Research Committee
OPD:	Outpatient Department
UHPAB:	Uganda Health Professions Assessment Board
WHO:	World Health Organization

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The study had no funding.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY

Data is available upon request from the author.

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AUTHOR CONTRIBUTIONS

JN: Collected data.

EIM: supervised the study.

IM: supervised the study.

JFN: supervised the study.

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