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A Phenomenological Study of The Sociocultural Factors Influencing Men's Participation in Family Planning Programs

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ABSTRACT

Background
This phenomenological study explored sociocultural factors influencing men's participation in family planning (FP).

Methods
A descriptive qualitative phenomenological study was conducted in X Jakarta, Indonesia, from February to March 2026. Participants were recruited using purposive sampling. Data were collected through semi-structured in-depth interviews and analyzed using Colaizzi's seven-step phenomenological method. Trustworthiness was ensured through member checking, peer debriefing, audit trails, and reflexive journaling. Ethical approval was obtained, and written informed consent was secured from all participants before data collection.

Results
Four interrelated themes emerged from the analysis. Men's understanding of FP was shaped by unequal reproductive health socialization and limited access to male-oriented reproductive health information, resulting in FP being perceived primarily as a woman's responsibility. This perception was reinforced by socio-cultural norms and traditional gender expectations. Despite these influences, contraceptive decision-making was generally characterized by communication and mutual agreement between spouses. However, men's participation remained constrained by psychological concerns regarding contraceptive safety,

unequal access to reproductive health information, and prevailing masculinity norms.

Conclusion

Men's participation in FP is influenced by gendered reproductive health socialization, socio-cultural norms, marital communication, and multiple barriers to engagement. Gender-inclusive FP programs, including male-focused education and couple-centered counseling, are needed to promote shared reproductive responsibility.

Background

The Family Planning (FP) program is a key component of global reproductive health strategies aimed at preventing unintended pregnancies, improving maternal and child health, and supporting sustainable development (World Health Organization 2023; Ross, *et al.,* 2023). Despite substantial progress in contraceptive coverage, men's participation remains disproportionately low worldwide. According to the *United Nations World Contraceptive Use 2024,* modern contraception continues to be dominated by female methods, whereas vasectomy accounts for less than 3% of contraceptive use globally (United Nations, Department of Economic and Social Affairs, Population Division, 2024). Similarly, the *FP2030 Indonesia Country Fact Sheet (2024)* reports that male sterilization represents only 0.2% of modern contraceptive use in Indonesia, while injectable contraception (50.6%) and oral pills (21.1%) remain the predominant methods (National Population and Family Planning Board/BKKBN, Statistics Indonesia/BPS, Ministry of Health of the Republic of Indonesia, & ICF International, 2018). This persistent imbalance not only reflects the unequal distribution of contraceptive responsibility between women and men but also limits shared reproductive decision making and reduces the effectiveness of FP programs in achieving gender-equitable reproductive health outcomes (Adane, *et al.,* 2024).

Previous studies have consistently identified multiple determinants associated with men's participation in FP, including educational level, knowledge, attitudes, accessibility of reproductive health services, religious beliefs, partner support, patriarchal gender norms, and other sociocultural influences (Newmann *et al.,* 2021; Hook *et al.,* 2021; Feriani *et al.,* 2024). These studies demonstrate that prevailing gender norms continue to position contraception primarily as a woman's responsibility, while stigma surrounding male contraceptive use and limited access to male-friendly reproductive health services further discourage men's involvement (Newmann *et al.,* 2021; Gómez-Torres *et al.,* 2023). Although these studies have contributed substantially to understanding determinants of contraceptive behavior, they have primarily focused on statistical associations rather than exploring how men experience, interpret, and assign meaning to their participation within their everyday social and cultural environments (Aventin *et al.,* 2023; Feriani *et al.,* 2024). Consequently, important dimensions remain insufficiently understood, including how men construct the meaning of masculinity in relation to contraceptive use, how family relationships and community expectations shape reproductive decision-making, and how sociocultural values influence their willingness to participate in FP (Aventin *et al.,* 2023). Because contraceptive decisions are embedded within interpersonal relationships, family dynamics, and cultural expectations, understanding men's lived experiences is essential for developing culturally responsive and contextually appropriate reproductive health interventions (Aventin *et al.,* 2023;

Öhlén & Friberg, 2023). Phenomenology provides an appropriate methodological perspective because it seeks to understand individuals' lived experiences and the meanings they attribute to those experiences within their life contexts (Sundler *et al.,* 2019; Öhlén & Friberg, 2023). Rather than examining causal relationships among variables, phenomenological inquiry addresses different research questions by exploring how participants perceive, interpret, and experience a phenomenon from their own perspectives (Sundler *et al.,* 2019; McLeod, 2024).

FP in Indonesia is implemented under the national reproductive health program coordinated by the National Population and Family Planning Board (BKKBN). The program is part of the national strategy to improve reproductive health outcomes and regulate population growth through expanded access to contraceptive services and community-based interventions (National Population and Family Planning Board/BKKBN, Statistics Indonesia/BPS, Ministry of Health of the Republic of Indonesia, & ICF International, 2018; Utomo *et al.,* 2022). Although contraceptive services are widely available across the country, evidence indicates that contraceptive use remains predominantly undertaken by women, while male participation is still limited.

Previous studies in Indonesia show that men are generally positioned as supporters rather than active contraceptive users or primary decision-makers in FP practices (Murti, Rahmawati, & Pasiriani, 2023). This situation reflects persistent gender norms and socio-cultural expectations that shape reproductive decision-making and continue to place greater responsibility for contraception on women. Evidence also suggests that male involvement in FP remains low due to limited knowledge, cultural stigma, and restricted acceptance of male contraceptive methods (Murti, Rahmawati, & Pasiriani, 2023; Elfiyan, 2024).

A similar pattern is also observed in DKI Jakarta, the capital city of Indonesia. As a highly urbanized area with relatively strong health infrastructure and broad access to primary health care and integrated FP services, Jakarta is expected to demonstrate more balanced participation between men and women in contraceptive use. However, recent studies indicate that even in urban settings, contraceptive use remains largely dominated by women, while male involvement in FP continues to be suboptimal (Elfiyan, 2024; Murti, Rahmawati, & Pasiriani, 2023). This suggests that improved access to services alone is not sufficient to increase male participation, as socio-cultural and gender-related factors continue to play a dominant role in shaping reproductive behavior even in urban contexts.

In line with this national and local context, a preliminary field assessment was conducted in X Jakarta, to explore in greater depth the socio-cultural dynamics influencing men's participation in FP at the community level. A preliminary field assessment conducted through informal interviews with reproductive-age men and health workers in Community X, Jakarta, revealed that male participation in FP services remains limited. Most participants perceived contraception as primarily a woman's responsibility, while concerns regarding masculinity, social stigma, and the limited availability of male-oriented reproductive health services discouraged active involvement. These preliminary findings reinforce the need to explore how sociocultural contexts shape men's lived experiences beyond measurable behavioral determinants. Unlike previous determinant-based studies, this study explores the lived experiences and meanings that men attribute to their participation in FP within their sociocultural context. The findings are expected to contribute to reproductive nursing by expanding phenomenological evidence regarding men's reproductive health experiences and informing the development of culturally sensitive, gender-responsive, and male-inclusive FP services within public health practice. Therefore, this study aims to explore and describe the lived experiences and meanings of men's participation in FP within the sociocultural context.

Methods

This study employed a descriptive qualitative phenomenological design based on Husserl's philosophical perspective to explore and describe the lived experiences and meanings of men's participation in the FP program within their socio-cultural context. A phenomenological approach was chosen because it seeks to understand how individuals perceive, interpret, and ascribe meaning to their lived experiences, rather than examining relationships between variables (Sundler *et al.,* 2019; Öhlén & Friberg, 2023). The study was conducted in Jakarta, Indonesia, from February to March 2026. The setting was purposively selected based on reports from local health services indicating consistently low male participation in FP programs, limited use of male contraceptive methods, and strong socio-cultural norms positioning FP as a woman's responsibility.

Participants were recruited using purposive, experience-based sampling. Inclusion criteria were married men aged ≥30 years who resided in the study area, had lived experience related to household FP decision-making (including contraceptive users, joint decision-makers with their spouses, non-users, or those who had considered contraceptive use), were willing to provide informed consent, and were able to communicate verbally. Exclusion criteria included severe communication impairments that prevented participation in in-depth interviews, inability to complete the interview process, and participants who, despite providing informed consent and being able to communicate verbally, expressed that they were not emotionally prepared to discuss their FP experiences during the interview. These criteria were applied to ensure that participants could provide rich, relevant, and meaningful data consistent with the study objectives while safeguarding their psychological well-being.

Participants were recruited through community health cadres and primary health center staff who conducted the initial screening based on the study eligibility criteria. The researcher was not involved in the initial recruitment process to maintain transparency and reduce potential researcher influence during participant selection. No prior personal, professional, or research-related relationship existed between the researcher and the participants. The principal researcher acted as the primary research instrument and was responsible for conducting all interviews, data collection, data analysis, and the initial interpretation of the findings. Initial participant recruitment was conducted by community health cadres. The co-authors contributed to the study design, provided methodological supervision, discussed and validated the interpretation of the findings, and critically reviewed and revised the manuscript.

To ensure rigor and reduce bias, the researcher applied bracketing (epoché) by suspending personal assumptions regarding men's roles in FP. Reflexivity was maintained through a reflexive journal and regular peer debriefing sessions with the research team to minimize interpretive bias. Data were collected through semi-structured in-depth interviews, conducted once with each participant. Some of the guiding questions included: (1) How would you describe your experiences and perspectives regarding FP within your family and community?; (2) How have cultural values, customs, or beliefs influenced your experiences and decisions regarding FP?; (3) How would you describe the support you have received from your spouse, family, and health workers regarding FP?; and (4) What challenges have you experienced in participating in FP? Probing questions were used as needed to encourage participants to elaborate on their experiences.

Interviews were held in private rooms at the primary health center or other locations chosen by participants to ensure comfort, privacy, and confidentiality. Each interview lasted approximately 45–60 minutes and was audio-recorded with participants' consent. Field notes were taken to document non-verbal expressions, contextual factors, and initial analytical reflections. All interviews were transcribed verbatim, anonymized using codes (P1–P10), stored in an encrypted system, and accessed only by the research team.

The interview guide served only to facilitate data collection, whereas the final themes were derived inductively from participants' narratives through Colaizzi's seven-step phenomenological analysis as follows: (1) reading all transcripts repeatedly to obtain a general understanding; (2) extracting significant statements; (3) formulating meanings from significant statements; (4) organizing meanings into themes; (5) developing an exhaustive description of the phenomenon; (6) identifying the fundamental structure of the phenomenon; and (7) validating the findings through member checking (Colaizzi, 1978). Member checking was conducted with 10 participants by sharing a summary of the identified themes and the researchers' interpretations. Participants were asked to review whether the findings accurately reflected their experiences and were invited to provide feedback or clarification. The participants confirmed that the findings accurately represented their experiences, and no substantial revisions to the themes were required.

Trustworthiness was ensured through four criteria. Credibility was established through member checking conducted after all interviews had been completed, transcribed, and analyzed. A summary of the identified themes and the researchers' interpretations was shared with all 10 participants to confirm that the findings accurately reflected their experiences. Participants were invited to provide feedback or clarification, and all confirmed that the findings accurately represented their experiences. Dependability was ensured through an audit trail documenting all research procedures from participant recruitment to data analysis. Confirmability was achieved through maintaining a reflexive journal and conducting peer debriefing to minimize researcher bias. Transferability was enhanced by providing a thick description of the socio-cultural context, participant characteristics, and research procedures. Data saturation was determined when no new meaning units emerged in subsequent interviews, meanings became repetitive across participants, and the themes remained stable during the final stage of analysis. Ethical approval was obtained from the Institutional Research Ethics Committee (Approval No: 12/Tar/II/2026). All participants provided written informed consent prior to data collection.

Results

The study was conducted in Jakarta, Indonesia, an urban community served by a primary health center and supported by an active network of community health cadres involved in implementing FP programs. This community was selected because it has an established FP program with active community participation through health cadres; however, male participation in FP remains relatively low. The residents represent diverse socioeconomic and educational backgrounds, and FP services are routinely provided through the primary health center and community-based health programs. Despite the availability of these services, FP decision-making continues to be shaped by socio-cultural values, gender norms, and family dynamics. Men are generally regarded as the primary decision-makers within the household, whereas contraceptive use is still widely perceived as the responsibility of women. This socio-cultural context provided an appropriate setting for exploring men's lived experiences of FP decision-making within the household.

Table 1 presents the characteristics of the 10 participants included in this study, with ages ranging from 32 to 55 years. Regarding educational attainment, 50% of the participants had completed senior high school, 30% had completed junior high school, 10% held a diploma, and 10% had a bachelor's degree. Participants represented diverse occupations, including private employees (20%), entrepreneurs (20%), traders (10%), laborers (10%), drivers (10%), teachers (10%), farmers (10%), and fishermen (10%). Most participants (70%) had two to three children, whereas 30% had four to five children. Regarding FP participation, 40% were not participating in any FP method, 30% supported their wives' contraceptive use, 20% used condoms, and 10% had undergone vasectomy (male sterilization). The diversity of participants' educational backgrounds, occupations, family sizes, and levels of involvement in FP provided rich experiential data for understanding men's participation in FP within different sociocultural and socioeconomic contexts.

Theme 1: Internalization of Gendered Reproductive Responsibility through Social Learning

Participants described that their understanding of FP responsibility was gradually shaped through everyday social experiences within their families and communities. Since childhood, they had predominantly observed women using contraceptive methods, while men's involvement in FP was rarely visible. These repeated experiences normalized the perception that contraception was primarily a woman's responsibility rather than a shared responsibility between partners. As one participant explained,

"I have only seen women using family planning methods in my family." (P1)

Another participant similarly reflected that this perception had been formed early in life because FP had always been associated with women.

"Since I was young, family planning has always been associated with women." (P3)

Participants further explained that this perception was reinforced by the absence of male role models in contraceptive use. Most had only witnessed mothers or other female family members using contraception, while men were generally absent from reproductive health practices and discussions. Similar experiences were also evident within the community, where women were consistently viewed as the primary participants in FP. As one participant stated,

"My mother used contraception, but I never saw any man using it." (P5)

Another participant described how these beliefs were reinforced by community expectations.

"Most people around me think contraception is for women." (P8)

Likewise, another participant explained,

"In my neighborhood, only women usually discuss family planning." (P10)

In addition to socialization within families and communities, participants described unequal access to reproductive health information as another factor that strengthened these perceptions. FP education and counseling were commonly directed toward women, leaving men with limited opportunities to obtain information about contraception or participate in contraceptive decision-making. As one participant explained,

"Men are rarely involved in contraception decisions." (P2)

Another participant shared a similar experience.

"Health education is mostly provided to women." (P4)

Several participants also reported that information regarding male contraceptive methods was rarely available, resulting in limited knowledge of contraceptive options among men.

"I never received specific information about male contraception." (P6)

Participants further explained that health education activities generally invited mothers rather than fathers, further limiting men's exposure to reproductive health information.

"Information sessions usually invite mothers rather than fathers." (P7)

Consequently, some participants relied on their wives as their primary source of information regarding FP.

"Most information I know comes from my wife." (P9)

These findings suggest that the internalization of gendered reproductive responsibility was shaped through continuous exposure to unequal reproductive health socialization and unequal access to FP information. Together, these experiences reinforced the perception that contraception is predominantly a woman's responsibility while simultaneously limiting men's knowledge, involvement, and participation in FP.

Theme 2: Normalization of Female-Centered Fertility Governance within Socio-Cultural Systems

Participants described that FP was widely perceived as a woman's responsibility because this belief had become deeply embedded within community and cultural norms. Across different social settings, women were consistently expected to manage fertility and contraceptive use, whereas men's involvement in FP was considered uncommon or socially inappropriate. These expectations gradually normalized the perception that contraception was primarily a woman's responsibility. As one participant explained,

"People usually expect women to use contraception." (P1)

Another participant similarly reflected that male participation in contraception was viewed as unusual within the community.

"Men using contraception is considered unusual in my community." (P5)

Participants further explained that these community expectations were reinforced within families through long-standing family values and cultural traditions. Across participants, older family members frequently encouraged women to use contraception, while discussions about male contraceptive use were uncommon. Consequently, women were widely regarded as the primary individuals responsible for FP within the household. As one participant stated,

"Most families think women should manage family planning." (P3)

Another participant similarly described that conversations about male contraception rarely occurred within the community.

"Our community rarely discusses men using contraception." (P8)

This perception was further reflected in the belief that women were the more socially acceptable users of contraception.

"It is more acceptable if women become family planning users." (P10)

Participants also described that cultural expectations shaped gender roles related to reproductive responsibility. Older family members often advised women to use contraception, whereas men were expected to prioritize their role as economic providers rather than actively participate in reproductive decision-making. As one participant explained,

"Older family members always advise women to use contraception." (P2)

Another participant shared a similar experience.

"Men are expected to focus on earning money, not family planning." (P4)

"My wife had more knowledge, so I trusted her opinion." (P7)

Several participants further emphasized that cultural traditions explicitly positioned reproductive matters as women's responsibility, including decisions related to birth spacing.

"Our traditions consider reproductive matters as women's responsibility." (P6)

Likewise, another participant stated,

"Women are expected to take care of birth spacing." (P9)

These findings suggest that female-centered fertility governance is sustained through interconnected community norms, family values, and cultural expectations that consistently assign responsibility for FP to women while simultaneously limiting the social acceptance of men's involvement in contraception.

Theme 3: Relational Construction of Contraceptive Decision-Making within Marriage

Participants described that contraceptive decision-making was commonly constructed through ongoing communication between husbands and wives. Rather than being viewed as an individual responsibility, decisions about FP emerged as a collaborative process in which both partners discussed their needs, preferences, and family circumstances before reaching an agreement. Open communication enabled couples to consider different contraceptive options while balancing their expectations and responsibilities within marriage. As one participant explained,

"We decided together as husband and wife." (P6)

Another participant described how discussions about the advantages and disadvantages of contraception helped both partners reach a mutual decision.

"We discussed the advantages and disadvantages before deciding." (P2)

Participants further explained that communication about FP became a routine part of their marital relationship. Regular discussions allowed couples to exchange opinions, consider practical issues, and jointly determine the most appropriate contraceptive method for their family. Financial circumstances were also incorporated into these conversations, reflecting that contraceptive decisions were closely connected to broader family responsibilities. One participant stated,

"My wife and I always communicate about family planning." (P4)

Another participant explained,

"We considered our financial condition together." (P8)

Similarly, one participant emphasized that every contraceptive decision was preceded by discussion between husband and wife.

"Every decision was discussed before choosing contraception." (P9)

As participants reflected on these experiences, they described that communication gradually developed into a process of shared authority and mutual respect within marriage. Many participants explained that they valued their wives' opinions because they believed their wives possessed greater knowledge about FP. Consequently, contraceptive decisions were generally reached through mutual agreement rather than unilateral choice. As one participant explained,

"My wife encouraged me to use contraception." (P4)

Another participant stated,

"The final decision was made after mutual agreement." (P1)

Participants also emphasized the importance of listening to each other's perspectives throughout the decision-making process. One participant described,

"I listened to my wife's opinion before deciding." (P5)

Another participant expressed confidence in his wife's knowledge about contraception.

"My wife had more knowledge, so I trusted her opinion." (P7)

Similarly, another participant highlighted the importance of respecting each other's preferences.

"We respected each other's preferences." (P10)

"My wife encouraged me to use contraception." (P3)

These findings suggest that men's involvement in FP was constructed through collaborative marital relationships characterized by open communication, shared decision-making, and mutual respect. Rather than representing individual choices, contraceptive decisions emerged as negotiated

processes in which husbands and wives actively contributed to decisions that reflected their shared needs, preferences, and family circumstances.

Theme 4: Multi-Dimensional Constraints on Men's Engagement in FP

Participants described that their involvement in FP was influenced by multiple barriers operating at the individual, healthcare, and sociocultural levels. Many participants expressed uncertainty about using male contraceptive methods because they were concerned about their potential effects on health and physical well-being. Although they recognized the importance of FP, these concerns often reduced their confidence in considering male contraception. As one participant explained,

"I worry contraception will affect my health." (P2)

Other participants described similar concerns about possible side effects and changes in their physical condition following contraceptive use.

"I am afraid of possible side effects." (P5)

"I am concerned about my physical condition after contraception." (P7)

Several participants also questioned whether male contraception was sufficiently safe or worried that it might reduce their physical strength.

"I worry that contraception may reduce my strength." (P9)

"I am still unsure whether it is safe." (P10)

Participants further explained that these concerns were intensified by limited access to reproductive health information. FP education and counseling were commonly directed toward women, leaving men with few opportunities to receive accurate information about male contraceptive methods or to discuss their concerns with healthcare providers. As a result, many participants felt that they lacked sufficient knowledge to make informed decisions about contraception. One participant explained,

"Family planning information is mostly given to women." (P1)

Another participant similarly stated,

"Health workers usually explain contraception to wives." (P4)

Participants also emphasized the limited availability of information specifically intended for men.

"There is very little information for men." (P6)

Likewise, participants described that counseling sessions generally targeted women, resulting in limited opportunities for men to receive FP education directly.

"Most counseling sessions target women." (P8)

"My wife encouraged me to use contraception." (P3)

As participants reflected on these experiences, they explained that limited knowledge was further reinforced by prevailing sociocultural expectations regarding masculinity. Many believed that male contraceptive use was inconsistent with traditional masculine roles and could expose men to negative social judgment. These perceptions discouraged men from considering contraception despite recognizing its potential benefits. As one participant explained,

"Using contraception may make men look less masculine." (P7)

Another participant similarly stated,

"Some people think contraception is not appropriate for men." (P2)

Participants also described concerns about ridicule and negative reactions from others if men chose to use contraception.

"Men may be ridiculed if they use contraception." (P5)

"People believe real men do not need contraception." (P9)

One participant expressed this concern by stating,

"I am afraid of negative opinions from others." (P10)

These findings suggest that men's engagement in FP is constrained by interconnected psychological concerns, unequal access to reproductive health information, and sociocultural expectations surrounding masculinity. Together, these barriers reduce men's confidence, limit their knowledge, and discourage their active participation in contraceptive decision-making and use.

Table 1. Distribution of Respondent Characteristics (n=10)

Respondent Code	Age (Years)	Education	Occupation	Number of Children	FP Participation Status
P1	32	Senior High School	Private Employee	2	Supports wife's contraception
P2	35	Junior High School	Trader	3	Not participating
P3	38	Senior High School	Laborer	2	Supports wife's contraception
P4	40	Diploma	Entrepreneur	2	Uses condoms
P5	42	Senior High School	Driver	4	Not participating
P6	45	Bachelor's Degree	Teacher	2	Uses condoms
P7	47	Junior High School	Farmer	5	Not participating
P8	50	Senior High School	Private employee	3	Supports wife's contraception
P9	52	Junior High School	Fisherman	4	Not participating
P10	55	Senior High School	Entrepreneur	3	Vasectomy (MOP)

Table 2. Coding Tree of Men's Lived Experiences in FP Participation

Theme	Category	Code	Meaning Unit (Participant Quote)
Internalization of Gendered Reproductive Responsibility through Social Learning	Unequal reproductive health socialization	Gendered exposure to contraceptive practices	*"I have only seen women using family planning methods in my family." (P1)*
		Female-centered reproductive learning	*"Since I was young, family planning has always been associated with women." (P3)*

		Observation of maternal contraceptive use	*"My mother used contraception, but I never saw any man using it." (P5)*
		Social perception of contraception as women's responsibility	*"Most people around me think contraception is for women." (P8)*
		Female-centered discussion of FP	*"In my neighborhood, only women usually discuss family planning." (P10)*
	Information asymmetry in FP knowledge	Limited male involvement in contraceptive decisions	*"Men are rarely involved in contraception decisions." (P2)*
		Female-focused health education	*"Health education is mostly provided to women." (P4)*
		Lack of information on male contraception	*"I never received specific information about male contraception." (P6)*
		Male exclusion from reproductive education	*"Information sessions usually invite mothers rather than fathers." (P7)*
		Reliance on spouse for reproductive information	*"Most information I know comes from my wife." (P9)*
Normalization of Female-Centered Fertility Governance within Socio-Cultural Systems	Community-regulated reproductive norms	Male contraception perceived as unusual	*"Men using contraception is considered unusual in my community." (P5)*
		Community expectation for women to use contraception	*"People usually expect women to use contraception." (P1)*
		Family expectation of women's responsibility	*"Most families think women should manage family planning." (P3)*
		Limited discussion of male contraception	*"Our community rarely discusses men using contraception." (P8)*
		Greater acceptance of female contraceptive users	*"It is more acceptable if women become family planning users." (P10)*
	Culturally reinforced gender expectations	Family belief that contraception is women's responsibility	*"My family believes contraception is mainly for women." (P3)*
		Advice directed toward women	*"Older family members always advise women to use contraception." (P2)*

		Male breadwinner expectation	*"Men are expected to focus on earning money, not family planning." (P4)*
		Reproductive matters viewed as women's domain	*"Our traditions consider reproductive matters as women's responsibility." (P6)*
		Women responsible for birth spacing	*"Women are expected to take care of birth spacing." (P9)*
Relational Construction of Contraceptive Decision-Making within Marriage	Marital communication dynamics	Joint decision-making	*"We decided together as husband and wife." (P6)*
		Discussion before choosing contraception	*"We discussed the advantages and disadvantages before deciding." (P2)*
		Spousal communication	*"My wife and I always communicate about family planning." (P4)*
		Financial consideration in decision-making	*"We considered our financial condition together." (P8)*
		Shared discussion before selecting contraception	*"Every decision was discussed before choosing contraception." (P9)*
	Distributed reproductive authority	Wife's encouragement	*"My wife encouraged me to use contraception." (P3)*
		Mutual agreement	*"The final decision was made after mutual agreement." (P1)*
		Considering wife's opinion	*"I listened to my wife's opinion before deciding." (P5)*
		Trust in wife's knowledge	*"My wife had more knowledge, so I trusted her opinion." (P7)*
		Respect for each other's preferences	*"We respected each other's preferences." (P10)*
Multi-Dimensional Constraints on Men's Engagement in FP	Psychological barriers	Concern about health effects	*"I worry contraception will affect my health." (P2)*
		Fear of side effects	*"I am afraid of possible side effects." (P5)*
		Concern about physical condition	*"I am concerned about my physical condition after contraception." (P7)*
		Concern about physical strength	*"I worry that contraception may reduce my strength." (P9)*
		Uncertainty about safety	*"I am still unsure whether it is safe." (P10)*

	Structural information inequality	Female-focused FP information	*"Family planning information is mostly given to women." (P1)*
		Counseling directed to wives	*"Health workers usually explain contraception to wives." (P4)*
		Limited information for men	*"There is very little information for men." (P6)*
		Women-targeted counseling sessions	*"Most counseling sessions target women." (P8)*
		Limited direct education for men	*"I rarely receive family planning education directly." (P3)*
	Socio-cultural masculinity norms	Fear of losing masculinity	*"Using contraception may make men look less masculine." (P7)*
		Male contraception perceived as inappropriate	*"Some people think contraception is not appropriate for men." (P2)*
		Fear of ridicule	*"Men may be ridiculed if they use contraception." (P5)*
		Masculinity associated with not using contraception	*"People believe real men do not need contraception." (P9)*
		Fear of negative social judgment	*"I am afraid of negative opinions from others." (P10)*

Discussion

The findings of this study identified four interrelated patterns explaining men's participation in FP. Participants perceived FP as primarily a woman's responsibility because of unequal reproductive health socialization, limited access to male-oriented reproductive health information, and socio-cultural gender norms. Nevertheless, contraceptive decision-making within marriage was generally characterized by communication, mutual agreement, and shared consideration between spouses. Men's participation remained constrained by psychological concerns regarding contraceptive safety and side effects, unequal access to reproductive health information, and prevailing masculinity norms. Overall, these findings indicate that men's involvement in FP is shaped by the interaction of gendered socialization, socio-cultural expectations, marital communication, and structural barriers within reproductive health services.

Participants' perceptions of FP were largely developed through unequal reproductive health socialization. Since childhood, contraception had been observed and discussed primarily as a woman's responsibility, while men rarely received direct education regarding reproductive health or male contraceptive methods. Consequently, many participants regarded contraception as an issue that primarily concerned women rather than a shared reproductive responsibility. These findings are consistent with previous studies reporting that reproductive health services and FP programs in many low- and middle-income countries remain predominantly women-centered, limiting men's knowledge and reinforcing traditional gender roles in reproductive health (Aventin *et al.,* 2023; Newmann *et al.,* 2021). Ditekemena *et al.,* (2020) found that gendered socialization throughout life shapes men's perceptions of reproductive responsibility, whereas Packer *et al.,* (2020) reported that limited male-focused reproductive health education contributes to poor awareness and low participation in FP.

Participants also described how socio-cultural norms reinforced the belief that FP is primarily a woman's responsibility. Community expectations, family traditions, and prevailing gender roles encouraged women to manage contraception, whereas men were expected to fulfill their role as economic providers. Such expectations normalized women's responsibility for fertility regulation while reducing men's involvement in reproductive health. Similar findings have been reported in previous studies demonstrating that traditional gender norms remain among the strongest determinants of male participation in FP (Seth *et al.,* 2022; Moyo *et al.,* 2024). Cultural and religious beliefs may further strengthen these norms by defining contraception as a woman's responsibility and limiting men's engagement in reproductive health decision-making (Abdi *et al.,* 2020; Newmann *et al.,* 2021).

Although traditional gender expectations remained influential, participants described contraceptive decision-making as a collaborative process within marriage. Decisions regarding FP were commonly reached through discussion, mutual agreement, and consideration of each partner's opinions and circumstances. Several participants acknowledged relying on their wives' reproductive health knowledge before selecting contraceptive methods, illustrating the importance of trust and shared responsibility within marital relationships. These findings support previous evidence indicating that effective couple communication increases men's participation in reproductive health decisions and improves contraceptive uptake (Assefa *et al.,* 2021; Kassa *et al.,* 2021). Shared decision-making enables couples to negotiate reproductive choices more equitably and promotes greater acceptance of FP as a joint responsibility.

Despite this collaborative decision-making process, participants continued to experience multiple barriers to active involvement in FP. Psychological concerns regarding contraceptive safety and side effects were frequently reported, alongside limited access to reproductive health information specifically targeting men. Participants also expressed concern that male contraceptive use could be negatively perceived because of prevailing masculine norms within their communities. These findings are consistent with previous research identifying fear of side effects, inadequate counseling, unequal access to reproductive health services, and social constructions of masculinity as important barriers to men's participation in FP (Amuzie *et al.,* 2022; Robinson *et al.,* 2021). Previous studies have further shown that comprehensive counseling, accurate reproductive health information, and male-inclusive FP services can reduce misconceptions and increase men's acceptance of contraception (Aventin *et al.,* 2023; Kassa *et al.,* 2022).

Taken together, these findings demonstrate that increasing men's participation in FP requires interventions that address both individual and structural determinants. Expanding male-inclusive reproductive health education, challenging gender norms that assign reproductive responsibility primarily to women, strengthening couple communication, and ensuring equitable access to FP information and services are essential for promoting shared reproductive responsibility. Such comprehensive approaches may improve men's engagement in FP while supporting more equitable reproductive health outcomes.

The findings also have important implications for community and maternity nursing practice. Nurses are well positioned to facilitate male engagement by providing evidence-based reproductive health education, encouraging couple-centered counseling, addressing misconceptions regarding male contraception, and advocating for gender-equitable FP services. Integrating male-friendly approaches into routine reproductive health programs may strengthen shared decision-making and increase men's participation in FP.

This study was conducted among a relatively small number of participants within a specific socio-cultural context. Therefore, the findings are intended to provide an in-depth understanding of participants' lived experiences rather than statistical generalization. Future research should include both husbands' and wives' perspectives, evaluate family-centered nursing interventions designed

to increase male participation in FP, examine healthcare providers' experiences in engaging men in reproductive health services, and explore how different cultural constructions of masculinity influence men's involvement in FP across diverse socio-cultural settings.

Conclusion

This study found that men's participation in FP is shaped by unequal reproductive health socialization, socio-cultural gender norms, marital communication, and multiple barriers to engagement. Participants perceived FP primarily as a woman's responsibility because of limited male-focused reproductive health information and long-standing gendered socialization. Although contraceptive decision-making was generally based on communication and mutual agreement between spouses, men's involvement remained constrained by psychological concerns, unequal access to reproductive health information, and prevailing masculinity norms. These findings highlight the importance of developing gender-inclusive FP programs that strengthen male-targeted reproductive health education, promote couple-centered counseling, and encourage shared reproductive responsibility. Healthcare providers should actively involve men in FP counseling through male-targeted reproductive health education and couple-centered counseling. Future studies should evaluate the effectiveness of male-inclusive interventions in increasing men's participation in FP.

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