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Disengaged and Misinformed: How Male Absenteeism from Health Programs and Alcohol Abuse Undermine Family Planning in Uganda

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Abstract

Male involvement is crucial for successful family planning, yet men in Sub-Saharan Africa, particularly Uganda, often remain disengaged from reproductive health services, contributing to high rates of unintended pregnancies and maternal mortality. The aim of this study was to explore how male absenteeism and alcohol use influence women's access to family planning services from the perspective of married women in Rubanda District, Uganda. This qualitative, phenomenological study in Rubanda District, Uganda, explored women's lived experiences regarding their husbands' involvement in family planning. Through two focus group discussions (FGDs; total n=24, segmented by age) with married women, three critical themes emerged: systemic failures to reach men with health education, as information is typically delivered in female-oriented spaces; the destructive impact of alcohol abuse, leading to male disengagement from family duties and financial neglect; and fear and misinformation regarding family planning methods. The findings highlight that male resistance to contraception is an active process of disengagement reinforced by both systemic gaps and behavioural patterns. We conclude that current family planning messages are not effectively reaching men, and that alcohol abuse further prevents them from acting as responsible partners. Recommendations include creating male-centric outreach programmes, integrating family planning into broader men's initiatives, and launching "responsible fatherhood" campaigns to foster a more engaged and supportive male role in family planning.

Keywords: male engagement; health education; alcohol abuse; family planning; health systems; behavioural interventions; Uganda

1. INTRODUCTION

Male involvement is widely recognized as a crucial factor for the success of family planning initiatives (Omona & Mahoro, 2023; Osuafor et al., 2023; Tekakwo et al., 2023). Yet, across much of Sub-Saharan Africa, men often remain disconnected from reproductive health services

(Okonofua & Ntoimo, 2022; Sarfraz et al., 2023; Wambete et al., 2024). This is especially true in Uganda, where this lack of engagement contributes to high rates of unintended pregnancies (Makumbi et al., 2024; Uganda Bureau of Statistics [UBOS], 2023) and elevated maternal mortality (Ministry of Health, Uganda, 2023; UBOS, 2023). While cultural norms are influential, this study offers a novel contribution by providing a phenomenological exploration of how three specific factors, namely systemic failures in health education, the behavioural factor of alcohol abuse, and fear and misinformation regarding family planning methods, intertwine to actively sideline men from their families' reproductive health decisions in a rural Ugandan context.

In this study, we define male involvement as the active, supportive, and informed participation of men in family planning processes, including decision-making, service utilization, and communication (Nkonde et al., 2023; Oni et al., 2024). There are varied interpretations of male engagement, ranging from passive presence to shared responsibility (Oni et al., 2024; Roudsari et al., 2023). While positive involvement fosters joint action, coercive forms such as mandating male attendance at clinics have drawn criticism for compromising women's autonomy (Akoth et al., 2021). In East Africa, including Uganda, such policies have sometimes discouraged service uptake among women (Tumlinson et al., 2021). We acknowledge these tensions and argue that male involvement must be voluntary, equity-centred, and grounded in respect for women's reproductive autonomy. In this paper, the term 'family planning' encompasses both contraceptive use and broader discussions around the timing and spacing of children (World Health Organization [WHO], 2023).

Throughout this manuscript, we use "family planning" to refer both to the use of contraceptive methods and to broader decisions around the timing, spacing, and number of children (Tumlinson et al., 2021; WHO, 2023). The term "responsible partner" is used from the perspective of participants, referring to male behaviours that contribute to joint planning, emotional and financial support, and shared accountability in reproductive health decisions. It is understood contextually rather than normatively defined by the authors.

This study is situated in Rubanda District, a rural region in south-western Uganda characterised by limited access to health education, high fertility preferences, and high alcohol consumption among men. These contextual features made it a relevant site to explore the phenomenon of male disengagement and its intersection with alcohol abuse.

2. METHODS

2.1 Study Design and Philosophical Orientation

This study adopted a qualitative, descriptive phenomenological design, carried out in Uganda's Rubanda District. Rooted in Husserlian phenomenology, the research aimed to reach the essence of lived experiences by encouraging reflection and bracketing preconceived notions. While traditional phenomenological work often relies on in-depth individual interviews, we opted for focus group discussions (FGDs). This choice allowed us to gather collective insights and better understand the social norms shaping women's experiences, particularly regarding male absenteeism and alcohol abuse within reproductive health settings.

Rather than interpreting participants' stories through a heavy theoretical lens, we focused on capturing what the women themselves expressed, adhering closely to their own words and meanings. Although thematic analysis is not typically associated with classic phenomenology, we found it useful in organising the FGD data in a way that preserved clarity without sacrificing depth.

2.2 Study Area and Context

Rubanda District is a rural area in south-western Uganda characterised by high fertility rates, entrenched gender norms, low male participation in reproductive health programmes, and pervasive alcohol consumption among men. Compared to other parts of the country, Rubanda records lower male turnout in family planning services and higher rates of unintended pregnancies. These contextual challenges made it an ideal setting for this inquiry.

2.3 Participants and Sampling

Twenty-four married women aged 18–40 years were purposively selected with assistance from community health workers. The sampling strategy included segmenting the FGDs by age (younger vs. older women) to enrich exploration of social norms. One focus group consisted of women between 18 and 25 years, while the second comprised women above 25 years of age. Participants were recruited from the community (not health facilities) and met the following inclusion criteria: currently married, residing in the district for at least one year, and having at least one biological child. The selected age range represented women in their reproductive years most likely to have experienced challenges related to family planning access and partner dynamics.

2.4 Sample Size and Saturation

Two FGDs were conducted, each comprising 12 participants. Though classical phenomenological work often calls for individual interviews, we found that two well-segmented FGDs yielded saturation, with no new themes emerging from the second group. This decision was influenced by the cultural comfort of women speaking in groups and the need to explore social norms rather than deeply personal trauma.

2.5 Data Collection

FGDs were moderated by a trained female qualitative researcher fluent in Rukiga and experienced in community-based health research. The discussions followed a semi-structured guide exploring male involvement, alcohol use, decision-making dynamics, and perceptions of family planning. The guide was pre-tested in a neighbouring village and revised accordingly. The sessions lasted 50 and 65 minutes respectively, conducted in private community spaces with no interruptions. Verbal and written informed consent was obtained from all participants prior to discussion and audio recording. Field notes were taken to supplement audio data.

2.6 Ethics Approval and Consent to Participate

This research was conducted in strict compliance with both international and national ethical standards governing studies involving human participants. Ethical approval was secured from the University of South Africa's Department of Health Studies Research Ethics Committee (UNISA REC); The AIDS Support Organisation Research Ethics Committee (TASO REC); and the Uganda National Council for Science and Technology (UNCST). Before data collection commenced, participants were thoroughly briefed on the study's purpose, procedures, potential risks, and their rights. Informed consent, both written and verbal, was obtained from every participant prior to involvement and the commencement of audio recording. No personal identifiers were recorded or transcribed, and all data were stored securely with access limited to authorised research personnel. Transcripts were anonymised using coded labels. Each participant received a modest transport refund (˜UGX10,000) in line with local ethical norms. A referral system was arranged with a nearby health facility in case any participant experienced emotional distress during or after the discussions.

2.7 Data Analysis

We applied Braun and Clarke's (2006, 2019) six-step thematic analysis framework to analyse the data. Two researchers independently coded the transcripts and held regular debriefing sessions to resolve discrepancies and agree on emerging themes. Codes were grouped inductively into broader categories and themes. To ensure credibility, multiple strategies were used: an audit trail of analytical decisions, reflexive memo writing, and peer debriefing. In addition, informal member checking was conducted with selected participants after transcription and preliminary analysis, allowing us to confirm the resonance of emerging themes with participants' lived realities and refine interpretations where needed. Our analysis emphasised how women constructed meaning through their narratives, rather than testing causal relationships or seeking generalisability.

3. Results

3.0 Participant Characteristics

Participants ranged from 18 to 40 years of age (mean 29 years), were predominantly rural-based, and had varied education levels and household sizes. Most women had 2 to 5 children and had been married for more than 5 years. The majority had only primary education, and several reported that their partners consumed alcohol regularly. No participant reported that her husband had ever attended a family planning information session. The accounts shared by the women painted a consistent and troubling portrait of male disengagement and neglect.

3.1 A System That Fails to Reach Men

A primary source of frustration for the women was that family planning information rarely reaches their husbands. They observed that health messages are typically delivered in spaces men do not occupy, such as church services or antenatal care clinics. This systemic oversight ensures that men remain uninformed, leaving their views to be shaped by community rumours and myths rather than accurate health knowledge.

> *"Our husbands do not go to church or other places where some family planning teachings are given, so they don't even hear about these things." (Woman, 32 years)*

> *"My husband never went to school. He doesn't grasp how family planning functions and won't even engage in conversations about it." (Woman, 27 years)*

> *"I asked the nurse why they never hold meetings for men too, and she said men never come to the health facility. But if you never try, how do you know they won't?" (Woman, 23 years)*

3.2 Alcohol Abuse and the Abdication of Family Duty

The most powerful behavioural theme to emerge was the destructive role of alcohol. Woman after woman described husbands who dedicate their evenings to drinking in village bars, contributing minimally to the household either financially or emotionally. This pattern has a direct and devastating impact on family planning, as these men are neither physically present nor mentally available for any constructive discussion. They often refuse to allow their wives to use contraceptives, compounding the burden on women.

"Our husbands spend most of their time in trading centres drinking waragi. They don't even know how food reaches the table." (Woman, 30 years)

"My husband doesn't know what school fees are. He does not even know which class our children are in because he is always drunk." (Woman, 40 years)

"When he is drunk, he shouts if I mention anything about using a family planning method. He says I am disrespecting him and tells me that the reason I am in his house is to produce children." (Woman, 25 years)

3.3 Fear and Misinformation Regarding Family Planning Methods

Another significant theme was the prevalence of fear and misinformation surrounding various family planning methods. Women reported that their husbands often expressed concerns about potential side effects such as infertility or decreased libido, and were influenced by rumours and myths circulating within the community.

"He trusts his friends more than me when it comes to family planning. They fill his head with wrong information and bad things about family planning." (Woman, 34 years)

"My husband says children are a blessing, so he doesn't want to hear about family planning. It's my body, but his decision." (Woman, 30 years)

"He said if I use an implant, I might not be able to give birth again. That I will bring shame to his clan." (Woman, 29 years)

This fear and misinformation often led to outright rejection of family planning, even when women desired it. This dynamic places the full responsibility for child-rearing and family planning on women, who must find both the financial means and the personal courage to seek out services on their own.

4. DISCUSSION

This study explored the ways in which male absenteeism and alcohol use influence women's access to and utilisation of family planning services. What emerged was a complex picture: male disengagement is not solely the result of ignorance; it is also driven by entrenched beliefs, prevailing social norms, and substance abuse. These findings make clear that male resistance is not just passive indifference; it is actively shaped by disinformation, withdrawal, and longstanding systemic neglect. Male partner disapproval continues to be identified as one of the leading obstacles to contraceptive use across Sub-Saharan Africa (Engelbert Bain et al., 2021).

Rather than viewing this resistance as a cultural relic, the data suggest it operates as an active behavioural pattern, one rooted in both institutional failure and individual habits. Contemporary research consistently shows that young people across Sub-Saharan Africa still face persistent, multifaceted barriers to contraception (Engelbert Bain et al., 2021). Among the most striking observations from participants was the health system's failure to engage men effectively. Several women pointed out that by keeping reproductive health education confined to female-centred spaces, these programmes inadvertently exclude men, perpetuating misinformation in the

process (Okonofua & Ntoimo, 2022; Tekakwo et al., 2023; Wambete et al., 2024). Indeed, recent work has shown that covert contraceptive use remains widespread, with many women hiding their contraceptive choices from partners out of fear of backlash (Tesfa et al., 2022).

Moreover, widespread myths and misconceptions about modern contraceptives continue to contribute to low usage rates, particularly in Uganda (Namanda et al., 2023). This underscores the need for family planning initiatives to engage men meaningfully at every stage, from education to implementation, in order to dispel misunderstandings and improve acceptance in rural communities (Kwawukume et al., 2022). Data from 23 African nations point to a concerning gap in both research and programming when it comes to men's involvement in family planning (Vouking et al., 2014).

The issue of alcohol abuse also surfaced as a key behavioural factor. It is more than a personal failing; it is a public health concern with ripple effects that extend into family dynamics and healthcare access. High levels of hazardous drinking among Ugandan men, and the country's ranking among Africa's highest in per capita alcohol consumption, are well documented and require citation from national alcohol surveillance data in this section. The link between heavy drinking and the neglect of reproductive responsibilities illustrates how behavioural patterns can drive deep-rooted health disparities (Oni et al., 2024; Tesfa et al., 2022). What is often framed as a disagreement about contraception may, in fact, stem from broader patterns of neglect and abdication of responsibility.

These findings must be contextualised within broader debates on masculinities, which often link traditional gender roles to health-seeking behaviours and power dynamics within relationships. The results add to a growing body of evidence that male engagement strategies, while crucial, carry a potential risk of inadvertently undermining women's autonomy if not carefully implemented. The nuanced data demonstrate how male disengagement is not a simple refusal, but a complex interaction of systemic failures, personal behaviours, and rigid beliefs about gender roles. Future policies should therefore not only seek to include men but also adopt a gender-transformative approach that challenges harmful norms and safeguards women's decision-making power.

This study also revealed that male resistance is embedded in a tangle of negative perceptions and rigid belief systems. Cultural and religious influences frequently reinforced resistance, including a desire for large families and opposition from religious leaders. Recent qualitative research from Uganda echoes these findings, showing that some men believe contraceptive use encourages promiscuity and extramarital affairs, further dampening male involvement (Vouking et al., 2014). A demographic and health survey analysis found that despite high fertility rates and a pronounced unmet need for contraception, modern contraceptive use remains low across much of Sub-Saharan Africa (Boadu, 2022). These layered belief systems present more than just informational deficits; they constitute active barriers that must be addressed through deeply contextual, not merely informational, interventions.

Finally, our findings resonate with studies from Ethiopia, Nigeria, and Kenya, where similar forces, including misinformation, entrenched cultural expectations, and substance abuse, undermine male engagement in reproductive health. This study adds to a growing body of evidence advocating for context-specific, gender-transformative solutions.

Reflexivity

The researchers brought prior experience in public health and gender studies, which informed our interpretations. Regular team debriefs and reflexive memoing were used to examine positionality and minimise bias. We recognise our role in shaping data analysis and interpretation.

Limitations and Delimitations

This study is limited by its reliance on FGDs, which may restrict the depth of personal narratives due to group dynamics. The findings reflect the context of Rubanda District and may not be transferable to other settings. However, the focus on shared experiences allowed rich exploration of social norms. Trustworthiness was enhanced through data triangulation, reflexivity, and contextual depth.

5. CONCLUSION

In Rubanda District, family planning messages are not reaching men, and destructive social behaviours, particularly alcohol abuse, are preventing them from acting as responsible partners. To break this damaging cycle, public health interventions must become more strategic and behaviourally informed.

6. RECOMMENDATIONS

To address the intersecting issues of male absenteeism and alcohol abuse in family planning, this study proposes the following multi-level recommendations, grounded in participant narratives and informed by recent evidence.

Male-centric outreach: Deliver family planning information in male-dominated spaces such as markets, boda-boda stages, and bars. Ensure approaches promote shared responsibility without reinforcing harmful masculinities.

Integrated programming: Embed family planning within existing male-targeted initiatives such as agriculture extension, financial literacy, and alcohol rehabilitation, to tackle multiple barriers simultaneously and encourage cross-sectoral collaboration.

Community dialogues to dispel myths: Use structured forums, male peer educators, and cultural leaders to address misinformation respectfully. Train health workers to support joint decision-making without undermining women's autonomy.

Responsible fatherhood campaigns: Promote positive masculinity rooted in care, partnership, and family wellbeing, not control. Leverage respected male figures to reshape public attitudes toward male involvement.

System and policy reforms: Institutionalise male engagement in national and district family planning policies. Redesign services to be more male-inclusive and invest in rural alcohol harm-reduction programmes to support household stability. Sustainable progress in contraceptive uptake requires actively engaging men where they are, physically, socially, and emotionally, while safeguarding women's rights and autonomy.

7. DECLARATIONS

Ethical Compliance: This study strictly adhered to the ethical guidelines set forth by the Declaration of Helsinki. Approvals were obtained from the University of South Africa's Department of Health Studies Research Ethics Committee (Reference: UNISA Rec-240816-052), The AIDS Support Organisation Ethics Committee, Uganda (Reference: TASO-2021-56), and the

Uganda National Council for Science and Technology (Reference: HS2152ES). All participants provided voluntary written informed consent before any data collection.

Consent for Publication: All participants gave express written permission for their anonymised stories and quotations to be shared in academic publications.

Data Availability Statement: The raw data are maintained by the research team. To protect participant privacy and confidentiality, the dataset is not publicly accessible. Reasonable requests for access may be directed to the corresponding author.

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