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Are traditional honour ideologies associated with fertility goals and contraceptive use? Findings from a cross-sectional study with a national sample of women and men in Uganda

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Abstract

We used data from a nationally representative sample of men and women of childbearing age in Uganda to assess the association between traditional honour ideologies and fertility goals and contraception use. We used multivariable regression analysis to assess the associations between honour ideologies and a) the ideal number of children, b) male control over contraceptive decision-making, and c) male/female-controlled contraceptive use. Results show that men desired more children and were less likely to use contraception compared to women. For men, honour ideologies about women are linked to both larger desired family size and lower likelihood to use male-controlled contraceptives. Additionally, men's honour ideologies for both genders were associated with a higher likelihood of male control over contraceptive decision-making. We conclude that traditional honour norms not only lead to a preference for more children but also entail male control over contraceptive decisions, undermining women's contraceptive use autonomy. *(Afr J Reprod Health 2025; 29 [4]: 96-107).*

Keywords: Honor Ideologies; Traditional; Fertility; Contraception; Uganda

Résumé

Nous avons utilisé des données issues d'un échantillon national représentatif d'hommes et de femmes en âge de procréer en Ouganda pour évaluer l'association entre les idéologies traditionnelles de l'honneur et les objectifs de fertilité ainsi que l'utilisation de la contraception. Nous avons utilisé une analyse de régression multivariable pour évaluer les associations entre les idéologies de l'honneur et a) le nombre idéal d'enfants, b) le contrôle masculin sur la prise de décision contraceptive, et c) l'utilisation de contraceptifs contrôlés par les hommes/femmes. Les résultats montrent que les hommes désiraient plus d'enfants et étaient moins susceptibles d'utiliser la contraception par rapport aux femmes. Pour les hommes, les idéologies de l'honneur concernant les femmes sont liées à la fois à un désir de famille plus nombreuse et à une probabilité plus faible d'utiliser des contraceptifs contrôlés par les hommes. De plus, les idéologies de l'honneur des hommes pour les deux sexes étaient associées à une plus grande probabilité de contrôle masculin sur la prise de décision contraceptive. Nous concluons que les normes traditionnelles de l'honneur conduisent non seulement à une préférence pour plus d'enfants mais impliquent également un contrôle masculin sur les décisions contraceptives, compromettant l'autonomie des femmes en matière de contraception. *(Afr J Reprod Health 2025; 29 [4]: 96-107).*

Mots-clés: Idéologies de l'honneur, Traditionnel, Fertilité, Contraception, Ouganda

Introduction

Growing research suggests that social norms are a lynchpin to improving family planning and increasing the uptake of contraceptives among women and couples in low- and middle-income settings.[1] Numerous studies from across national settings have found that social norms related to family planning practices and expectations, including both contraceptive use and fertility norms, are significantly correlated with women's use of contraceptives.[1–6] Further, research indicates the utility of measuring and targeting family planning social norms to support women in achieving reproductive agency and their reproductive health outcomes.[1] However, changing social norms to

support contraception and smaller families may not align with improving women's reproductive agency. Restrictive gender norms can compromise women's reproductive choices by defining women's value through motherhood and men's value through virility and dominance over their wives.[7–9] Less research has focused on assessing associations between gender norms and family planning.

The call for research on gender norms and their association with family planning is not new. Researchers recognize that norms related to gender equity are distinct from but related to norms related to family planning.[10] Unfortunately, prior work in this realm has largely conflated attitudes and norms, both in terms of gender equity and family planning, though this work does show that both more equitable gender attitudes and more positive beliefs about contraceptive use are associated with a greater likelihood of contraceptive use, for women and men.[11–16] Norms and attitudes are often confused. Attitudes reflect personal beliefs, like "contraceptives cause infertility" or "contraception users are immoral." Social norms capture perceived behaviours (descriptive norms) or expectations (injunctive norms) of others, such as "My community expects married couples to have children" or "Important people expect me to marry." These measures have gained more ground in recent years,[1] but study of norms is more nascent.

In the interplay between norms, attitudes and family planning, the concept of honour and its cultural manifestations emerge as pivotal factors shaping choices and behaviours. Honor ideologies significantly shape fertility choices and gendered dynamics. These traditional values, emphasizing male dominance and female purity, define acceptable behaviour and reinforce gender roles. Honor ideologies impact individual attitudes and societal acceptance of fertility and contraceptive practices. Understanding how honour culture codifies gender expectations is crucial for analysing its effects on reproductive decisions. This exploration reveals the complex interplay between honour, gender norms, and family planning choices. Most published measures capturing honour ideologies come from the U.S. and cover traditional notions of male honour, rooted in norms of male dominance and self-reliance, as well as female honour, rooted in norms of female purity and family focus.[17,18] Analysis of these scales highlight that traditional honour ideologies are associated with higher odds of violence perpetration, injury and self-harm, and risky behavioural practices for men, and to some degree for women as well[19–23]. Findings were largely attached to traditional norms regarding male honour, rather than female honour, and for men appear to be very connected to beliefs regarding the connection of these norms to their social status.[21] While these scales have been applied to other national contexts with success and yielding similar findings,[24,25] they have not been examined in Uganda nor in terms of their correlation with family planning outcomes.

However, there is reason to suspect that honour norms impact family planning attitudes. For instance, female's honour ideologies were negatively related to supporting human papillomavirus (HPV) screening and vaccination because of concerns that these behaviours imply sexual promiscuity.[26] In addition to the norms surrounding female sexual purity and family loyalty,[27,28] honour norms impact naming practices of male children (but not female children)[29] as well as attitudes and behaviours associated with sexual assault.[30,31] While this evidence was obtained exclusively using U.S. samples, similar relationships might exist between honour and family planning in Uganda.

Uganda faces significant challenges related to high fertility and low birth spacing, which have implications for maternal and neonatal health. The country has one of the highest fertility rates in East Africa, coupled with short birth spacing intervals.[32,33] A combination of these factors contributes to maternal and neonatal health concerns, as evidenced by Uganda's persistently high maternal and neonatal morbidity and mortality ratios.[34,35] These issues are compounded by limited access to healthcare due to poor health systems and infrastructure, which have implications for maternal and infant health outcomes.[36] The government has implemented reforms to improve access to healthcare, such as decentralization of health service delivery and removal of user fees in public health facilities, aiming to achieve equitable access to quality healthcare.[37] Addressing these challenges requires a multifaceted approach that considers the sociocultural, economic, and healthcare system

factors influencing fertility, maternal health, and access to healthcare in Uganda.

Furthermore, Uganda is characterized by restrictive gender role ideologies aligned with above noted notions of honour[38–41] as well as ongoing unmet need for contraceptive use[42,43] and norms of male control over family planning,[44–46] which makes it an interesting setting for this study.

This study examines how traditional honour ideologies relate to family planning outcomes in Uganda, using brief vignettes. We assess associations between honour and fertility preferences, male control over contraceptive decisions, and current contraceptive use (male-controlled, female-controlled, or non-use) in a nationally representative sample of married adult men and women in Uganda.

Methods

Study setting and sample

We used data from a nationally representative survey of married Ugandans conducted in March-April 2023, excluding three northern districts. We sampled 300 parishes (PSUs) using probability proportionate to size. [47] We used a two-stage sampling approach. First, we selected 10 households from each PSU. Second, we listed all married members and their ages. In three households, we interviewed one married woman (15-49 years) and her husband (15-54 years). In the remaining seven, we randomly selected either a married woman or man. After excluding pregnant couples, our final sample was 1173 women and 1098 men.

Data collection

Trained enumerators collected data using electronic tablets. Consenting participants from selected households were included. Data were uploaded daily to an encrypted repository for quality checks and analysis. No personally identifiable information was collected.

Measures

Outcome variables

Our outcomes were: a) ideal number of children desired, b) male control over contraceptive decisions, and c) current use of male/female-controlled contraceptives. We asked about total desired children as a continuous measure. We created a binary variable for male control over contraceptive decisions, based on who usually makes these decisions in the household. We further asked those who reported that they make these decisions jointly with their partner: "when making this decision with your partner, would you say that your opinion is more important, equally important, or less important than your partner's decision?" Male control over decision-making was coded as 1 if the male partner decided alone or jointly with greater importance, and 0 otherwise. We asked about current contraceptive methods used to avoid pregnancy. Respondents were asked to choose the current method of contraceptive that they primarily use from the following: Female sterilization, Male sterilization, Intrauterine Device (IUD), Injectable, Implant, Oral Contraceptive Pill (OCP), Male and Female condoms, Emergency contraceptive pills, Standard days method (SDM), Lactational amenorrhea method (LAM), Rhythm method, and Withdrawal.

We created a nominal variable classifying current contraceptive methods as: no method (0), male-controlled (1), or female-controlled (2). For sensitivity testing, we created another variable categorizing methods as modern or traditional, based on WHO and DHS guidance. Modern methods included sterilization, IUD, injectable, implant, OCP, condoms, SDM, and LAM. [48,49] We created a three-level nominal variable: no method (0), traditional methods (1), and modern methods (2).

Independent variables

Our independent variables comprised endorsement of male and female honour ideology by respondents. We used two separate measures – the Feminine Honor Prototype (FHP) and the Masculine Honor Prototype (MHP) – to assess respondents' levels of endorsement of male and female honour ideologies.[50] Additionally, we combined the two prototypes by taking the average of their unit-weighted scores and created a single measure of honour endorsement – the Combined Honor Prototype (CHP).[50] These measures were developed

for use in large, population-level surveys where time and space are limited, and multi-item measures are prohibitive. The measure that captured male honour ideology read as follows: "John is tough, loyal, brave, self-reliant, and willing to do whatever it takes to defend his reputation and his family, even to the point of being violent. John believes that having others respect him as a man is among the most important things he can achieve in life". The measure that captured female honour ideology read: "Mary is pure, honest, sexually virtuous, and has an unwavering loyalty to her family and husband. Mary believes that avoiding anything that would damage the reputation of herself, her family, or her husband is among the most important things she can do in life". Both male and female respondents were read both statements and were asked to indicate the extent to which they agreed that men should be like John and women should be like Mary. Response options to both vignettes were on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). We retained these as continuous measures in our analyses. Thus, higher scores on the FHP, MHP, or the CHP indicated higher honour endorsement in the respective measures.

Potential Confounders

Confounders included: age (continuous), education (3 levels), paid work (binary), religion (4 categories), area of residence (rural/urban), and region (4 categories). Education levels included: primary, secondary, higher. Religion categories comprised Catholic, Anglican, Pentecostal, Muslim, and Other. Regions included: Central/Kampala, Northern, Eastern, Western.

Statistical analysis

We calculated unweighted Ns, weighted proportions for categorical variables, and weighted means/standard deviations for continuous variables, separately for males and females. We developed four multivariable regression model sets, each with three models for men and women using FHP, MHP, or CHP as exposure. These included OLS regression for ideal child number, logistic regression for male contraceptive decision control, and multinomial logistic regression for contraceptive method use. All models included confounders. Analyses were performed in R 4.3.1.

Ethical approval

This study is a secondary data analysis of de-identified data collected from human participants. Secondary analysis of this de-identified data was given ethical review exemption by the University of California San Diego Institutional Review Board (180070XX). Additionally, security clearance was obtained from the Ministry of Security, Uganda, by our in-country data collection partner, Consumer Consult (U) Ltd. Participants gave informed consent to participate in the study.

Results

Sample characteristics

Women averaged 32 years old (Mean: 31.55, SD: 7.98), men 36 (Mean: 36.11, SD: 9.92). Fewer women completed higher education (12.61% vs 19.95% men). Both had similar children (Women: Mean 2.60, SD 1.77; Men: Mean 2.42, SD 1.88). Women desired fewer children (Mean: 4.08, SD: 1.71) than men (Mean: 5.47, SD: 3.06). 35.70% of women and 56.51% of men used no contraceptives. Both reported similar male-controlled method use (16.63% women, 15.54% men), but more women used female-controlled (47.67% vs 27.95%) and modern methods (54.49% vs 38.59%). 12.40% of women reported husband-controlled contraceptive decisions; 26.76% of men were primary decision-makers. Both genders had similar honour prototype scale scores (Table 1).

Multivariable models

Our multivariable models indicate that the FHP and the CHP were associated with the desire for higher number of children among both women (FHP: β = 0.09, 95% CI = 0.02, 0.16; CHP: β = 0.08, 95% CI = 0.01, 0.15) and men (FHP: β = 0.12, 95% CI = 0.02, 0.21; CHP: β = 0.12, 95% CI = 0.02, 0.22). We did not find MHP to be predictive of the desire for a larger family size for either sample (Table 2).

We also found that men's scores on all three scales were positively associated with higher male control over contraceptive decision-making (FHP: AOR = 1.18, 95% CI = 1.08, 1.29; MHP: AOR = 1.12, 95% CI = 1.04, 1.21; CHP: AOR = 1.18, 95% CI = 1.08, 1.30).

Table 1: Descriptive statistics for the total sample of men and women

	Women's Sample [N = 1173]	**Men's Sample [N = 1098]**
Outcome variables		
Ideal number of children (continuous)	4.08 (1.71)	5.47 (3.06)
Male control over contraceptive decision-making		
No	1049 (87.6 %)	822 (73.24 %)
Yes	124 (12.4 %)	276 (26.76 %)
Use of male/female-controlled contraceptive methods		
No methods	423 (35.70 %)	597 (56.51 %)
Male-controlled methods [a1]	163 (16.63 %)	170 (15.54 %)
Female-controlled methods [a2]	587 (47.67 %)	331 (27.95 %)
Use of traditional/modern contraceptive methods		
No methods	423 (35.70 %)	597 (56.51 %)
Traditional methods [b1]	89 (9.81 %)	65 (4.9 %)
Modern methods [b2]	661 (54.49 %)	436 (38.59 %)
Primary independent variables		
Feminine Honor Prototype (FHP)	5.81 (1.47)	5.51 (1.78)
Masculine Honor Prototype (MHP)	4.86 (1.96)	5.11 (1.96)
Combined Honor Prototype (CHP)	5.34 (1.44)	5.31 (1.65)
Socio-demographic variables		
Respondent's age (continuous)	31.55 (7.98)	36.11 (9.92)
Total number of children (continuous)	2.6 (1.77)	2.42 (1.88)
Educational attainment		
No education	93 (9.42 %)	85 (8.11 %)
Completed primary education	408 (30.94 %)	274 (25.25 %)
Completed secondary education	539 (47.03 %)	522 (46.7 %)
Completed higher education	133 (12.61 %)	217 (19.95 %)
Engaged in work in the past 12 months		
No	216 (15.65 %)	34 (6.01 %)
Yes	957 (84.35 %)	1064 (93.99 %)
Religion		
Catholic	458 (41.95 %)	403 (35.01 %)
Anglican	400 (32.57 %)	381 (35.96 %)
Pentecostal	128 (11.85 %)	112 (11.1 %)
Muslim	110 (8.1 %)	123 (10.65 %)
Other	77 (5.53 %)	79 (7.28 %)
Area of residence		
Rural	883 (78.36 %)	828 (77.84 %)
Urban	290 (21.64 %)	270 (22.16 %)
Region of residence		
Central and Kampala	344 (24.8 %)	317 (24.62 %)
Northern	236 (21.84 %)	231 (22.93 %)
Eastern	303 (27.34 %)	286 (26.07 %)
Western	290 (26.02 %)	264 (26.39 %)

a1: Male-controlled methods: male sterilization, male condom, or withdrawal
a2: Female-controlled methods: female sterilization, intrauterine device, injectable, implant, oral contraceptive pill, emergency contraceptive pill, female condom, standard days method, rhythm method, and lactational amenorrhea method
b1: Traditional methods: rhythm method, withdrawal
b2: Modern methods: female or male sterilization, intrauterine device, injectable, implant, oral contraceptive pill, male or female condom, standard days method, and lactational amenorrhea method

Table 2: Models with Ideal Family Size as the dependent variable (Model-set-1)

	Women's Response β **(95% CI)**	**Men's Response** β **(95% CI)**
Feminine Honor Prototype (FHP)	**0.09**	**0.12**
	(0.02, 0.16)	**(0.02, 0.21)**
Masculine Honor Prototype (MHP)	0.04	0.08
	(-0.01, 0.10)	(-0.01, 0.17)
Combined Honor Prototype (CHP)	**0.08**	**0.12**
	(0.01, 0.15)	**(0.02, 0.22)**

Models for men and women adjusted for their age, educational attainment, engagement in work in the past 12 months, religion, area of residence, and region of residence

Table 3: Models with male control of contraceptive decision-making as the dependent variable (Model-set-2)

	Women's Response Adj. Odds Ratio (95% CI)	**Men's Response** Adj. Odds Ratio (95% CI)
Feminine Honor Prototype (FHP)	0.89 (0.80, 1.00)	**1.18 (1.08, 1.29)**
Masculine Honor Prototype (MHP)	1.05 (0.95, 1.17)	**1.12 (1.04, 1.21)**
Combined Honor Prototype (CHP)	0.97 (0.86, 1.11)	**1.18 (1.08, 1.30)**

Models for men and women adjusted for their age, educational attainment, engagement in work in the past 12 months, religion, area of residence, and region of residence

Table 4: Models with use of male/female-controlled methods as the dependent variable (Model-set-3)

Exposure	**Male- or female-controlled method**	**Women's Response** Adj. Odds Ratio (95% CI)	**Men's Response** Adj. Odds Ratio (95% CI)
Feminine Honor Prototype (FHP)	No methods	**Ref**	**Ref**
	Male controlled methods	1.04 (0.91, 1.18)	**0.87 (0.79, 0.96)**
	Female controlled methods	1.01 (0.92, 1.11)	0.96 (0.88, 1.05)
Masculine Honor Prototype (MHP)	No methods	**Ref**	**Ref**
	Male controlled methods	0.92 (0.83, 1.02)	0.97 (0.88, 1.06)
	Female controlled methods	0.98 (0.91, 1.06)	0.99 (0.93, 1.07)
Combined Honor Prototype (CHP)	No methods	**Ref**	**Ref**
	Male controlled methods	0.95 (0.83, 1.08)	0.90 (0.81, 1.00)
	Female controlled methods	0.99 (0.90, 1.09)	0.98 (0.90, 1.07)

Models for men and women adjusted for their age, educational attainment, engagement in work in the past 12 months, religion, area of residence, and region of residence

None of the three scales was associated with male control over contraceptive decision-making as reported by women (Table 3).

Our models also indicate that men's response to FHP was associated with a lower likelihood of use of male-controlled methods as compared to no contraceptive method at all (FHP: AOR = 0.87, 95% CI = 0.79, 0.96); we did not see an association between FHP and female-controlled contraceptive use for men or women respondents. We also did not find an association between MHP or CHP reported by men and women and the use of male/female-controlled contraceptive methods (Table 4).

Table 5: Models with use of modern/traditional methods as the dependent variable (Model-set-4)

Exposure	Traditional or Modern method	Women's Response Adj. Odds Ratio (95% CI)	Men's Response Adj. Odds Ratio (95% CI)
Feminine Honor Prototype (FHP)	No methods	**Ref**	**Ref**
	Traditional method	1.07 (0.90, 1.26)	0.90 (0.78, 1.04)
	Modern method	1.01 (0.92, 1.10)	0.93 (0.86, 1.01)
Masculine Honor Prototype (MHP)	No methods	**Ref**	**Ref**
	Traditional method	1.02 (0.90, 1.16)	1.01 (0.88, 1.15)
	Modern method	0.96 (0.89, 1.03)	0.98 (0.92, 1.05)
Combined Honor Prototype (CHP)	No methods	**Ref**	**Ref**
	Traditional method	1.05 (0.89, 1.25)	0.95 (0.81, 1.11)
	Modern method	0.97 (0.88, 1.06)	0.95 (0.88, 1.03)

Models for men and women adjusted for their age, educational attainment, engagement in work in the past 12 months, religion, area of residence, and region of residence

None of the honour prototypes were associated with modern/traditional contraceptive use (Table 5).

We conducted one final exploratory analysis to assess whether the inclusion of a) ideal family size and b) male control over contraceptive decision-making affected the observed association between FHP and male-controlled contraceptive use for male respondents. We found no meaningful change in this observed association after including these covariates (AOR: 0.88, 95% CI: 0.80, 0.97) and (AOR: 0.88, 95% CI: 0.80, 0.97)

Discussion and conclusion

In our sample, both genders desired high fertility, averaging four or more children. Over a third of women and half of men used no contraception. Those holding traditional feminine honour norms preferred more children. Honor-oriented men were less likely to use male-controlled contraceptives (condoms, withdrawal, sterilization), which may threaten pleasure or virility. This suggests these methods are less desirable to honour-oriented men than using no method.

Fertility desires have been strongly linked to contraceptive use in Uganda and other sub-Saharan African settings.[43] Consequently, our research reveals a significant association between individuals expressing stronger adherence to traditional concepts of honour and their desire for a larger average number of children. This discovery holds crucial implications for ongoing family planning initiatives in Uganda. It is essential to acknowledge that while women should have the autonomy to make choices regarding the number of children they wish to have, the ideal family size of their male partners may exert undue pressure on women to continue childbearing, even after they have achieved their own desired family size.[51] This dynamic can result in women refraining from contraceptive use,[52,53] leading to a higher number of pregnancies and shorter birth intervals, both of which pose considerable risks to maternal and newborn health.[54,55] The average preferred number of children reported in our study was 5.47 for men and 4.08 for women, highlighting the potential discrepancies in desired family size between genders, further emphasizing the importance of addressing this issue in family planning programs. Our findings reinforce those of prior studies indicating that traditional expectations of women affect fertility preferences[56] and may restrict male support for contraceptive use.[6] This association points to a potential undermining of women's choice in family planning. In sum, these findings suggest that traditional norms and expectations of women's honour may be associated with increased fertility but that this is an insufficient reason for this norm to be a target for interventions with women. However, this normative ideology for men may be impeding their contraceptive use and resulting in their efforts to control their female partner's fertility practices.

Men's endorsement of traditional notions of male honour was only associated with male control over contraceptive decision-making but not with

other reported use or fertility desires in this sample. This is interesting as prior research from the US has revealed norms on male honour to have greater influence over health practices and well-being,[23,57] while the associations between female honour and its effect on health remain understudied.[58] This may be because prior research has looked at violence, suicidality, and mental health,[22,23,57] but not family planning and fertility, which are issues that are more typically related to expectations of women.

Our results reveal an interesting trend in contraceptive use reporting between men and women in that women were significantly more likely to report using female-controlled methods than were men. This discrepancy in reporting of contraceptive use among men and women might be indicative of covert contraceptive use by women, which has been shown to be relatively common (~14% of women covertly use contraceptives) in Uganda.[59–62] These findings, in line with other research demonstrating that covert, female-controlled methods of contraceptive use in Uganda as common,[60] highlight that men might have less control over contraceptive use than they think. It is imperative that in this context where male control over contraception and masculine norms around family planning are extremely prominent, efforts are put in place to ensure women have ongoing access to female-controlled methods. Also, as covert contraceptive use comes with many challenges (e.g., fear of partner or community finding out),[60] efforts to shift norms around family planning, family size, and women's roles in society and the household are needed to support more open family planning communication between partners in this and other global settings.[63]

Our findings support ongoing efforts in sub-Saharan Africa to engage men through mass media campaigns to increase contraception use.[64] Further, these educational campaigns that have shown effectiveness in the country may additionally benefit from addressing traditional gender norms that men hold surrounding women's honour in society and the household.

Strengths and limitations

This is a population-level study of women and men's endorsement of honour, fertility preferences, and contraceptive use in Uganda. This study provides quantitative findings on the association between honour ideology and important measures of family planning, which is an area that has been largely understudied, especially in a sub-Saharan African setting.

While the study has several notable strengths, there are several limitations of note. Data collected for all variables included in our analyses were self-reported, thus subject to recall and response bias. While findings around contraceptive use were only significantly associated with male-controlled methods, our results of male-reported female-controlled methods should be taken with caution and may not be fully reliable. While we saw an overall difference in male and female reporting of contraceptive use, which may be indicative of covert use, we did not directly assess covert contraceptive use. Further, we only assessed the ideal family size that men and women desire and not the desired gender of children. Thus, future research should explore links between honour endorsement, fertility preference, sex preference of children, and covert contraceptive use. Future qualitative work should explore the validity evidence of these vignettes in sub-Saharan African settings.

Program implications

The findings suggest that family planning programs in Uganda need a dual approach. First, they must ensure continued and expanded access to female-controlled contraceptive methods, particularly given the evidence of covert contraceptive use by women. Second, there's a need for educational campaigns and interventions that specifically target traditional gender norms and honour ideologies among men, as these beliefs appear to influence both fertility preferences and contraceptive decision-making. The study also indicates that simply targeting women's beliefs about honour and fertility may be insufficient or inappropriate. Instead, policy efforts should focus on shifting men's attitudes and norms around family planning while simultaneously protecting women's autonomy in reproductive decision-making. This could include expanding existing mass media campaigns to address traditional gender norms and honour ideologies, while maintaining strong support systems for women's access to contraception.

Conclusion

This study explores the association between endorsement of traditional honour ideology and fertility and contraception choices using a novel measure of norms through a vignette. Our study finds that when women and men hold traditional norms regarding women's honour as linked to their purity and family loyalty, they are more likely to prefer a greater number of children. Unfortunately, these same beliefs can be tied to male control over contraceptive decision-making, which would undermine the centrality of women's choices in family planning.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Conflict of interest

The authors declare that there are no conflicts of interest regarding the publication of this paper. Neither financial nor personal relationships have influenced the outcomes of this research. The authors have no affiliations with or involvement in any organization or entity with any financial or non-financial interest in the subject matter or materials discussed in this manuscript. This includes but is not limited to employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding

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