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Exploring healthcare professionals' experiences and opinions on male involvement in family planning in Lubombo, Eswatini: A qualitative study

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Abstract

Family planning enables individuals and couples to choose if and when to have children, limiting the health risks associated with early childbearing, close birth spacing and unwanted pregnancies. Male partners are increasingly seen as an opportunity to increase contraception use. As Eswatini, located in southern Africa, is a patriarchal society, increasing male involvement could improve the country's sexual and reproductive health. Twelve healthcare professionals were interviewed in Lubombo, eastern Eswatini, to further study this. Most participants felt male involvement in family planning was rare, but all supported it for reasons including more effective contraception use and better access to family planning services. Many barriers were mentioned, such as limited male responsibility in sexual health, fears of contraception, and dislike of health services. To overcome these, participants recommended education and male-only health services. This study adds an important healthcare professional perspective in a relatively little studied context. *(Afr J Reprod Health 2026; 30 [5]: 55-63).*

Keywords: Family planning, contraception, male involvement, Eswatini.

Résumé

La planification familiale permet aux individus et aux couples de choisir d'avoir des enfants et, le cas échéant, à quel moment, limitant ainsi les risques sanitaires liés aux grossesses précoces, aux naissances rapprochées et aux grossesses non désirées. L'implication des hommes est de plus en plus perçue comme un levier pour améliorer l'utilisation de la contraception. L'Eswatini, société patriarcale située en Afrique australe, pourrait voir sa santé sexuelle et reproductive s'améliorer grâce à une participation accrue des hommes. Douze professionnels de santé ont été interrogés à Lubombo, dans l'est de l'Eswatini, afin d'approfondir cette question. La plupart des participants ont constaté que l'implication masculine dans la planification familiale était rare, mais tous y étaient favorables, notamment pour une utilisation plus efficace de la contraception et un meilleur accès aux services de planification familiale. De nombreux obstacles ont été mentionnés, tels que la faible responsabilité des hommes en matière de santé sexuelle, la crainte de la contraception et une certaine réticence à l'égard des services de santé. Pour les surmonter, les participants ont recommandé des actions de sensibilisation et la mise en place de services de santé réservés aux hommes. Cette étude apporte un éclairage important sur le point de vue des professionnels de santé dans un contexte encore peu exploré. *(Afr J Reprod Health 2026; 30 [5]: 55-63).*

Mots-clés: Planification familiale, contraception, implication masculine, Eswatini

Introduction

Family planning involves individuals and couples using contraceptive methods to enable them to choose if and when to have children. This choice can improve women's health and quality of life by decreasing the risk of health problems associated with early childbearing, close spacing of births, and unwanted pregnancies.[1,2] Smaller families also have a health benefit for women, with evidence suggesting that women with fewer than four children are at less risk of maternal mortality.[1] In addition, women's ability to choose how and when to have children have important economic and social benefits, as well as being a crucial element of women's rights.[3] Family planning improves the lives of the entire family as smaller families reduce the need to share family resources and mothers have more time to spend with their children, at work and/or school, thus reducing the risk of family

poverty.[2] Furthermore, contraceptive methods, such as condoms, reduce the risk of transmission of sexually transmitted infections (STIs), including HIV.[2]

Male involvement

Traditionally, male partners have been regarded as a potential barrier to female contraception use in patriarchal countries, where conventional gender norms dictate that men hold the decision-making power in the household and fertility is associated with male strength.[4] Consequentially, family planning programs have directed their focus on women and have in the past tended to ignore men's role in sexual health.[4] However, over the last two decades, growing evidence has highlighted the benefits of male involvement in reproductive health, following the recommendation by the 1994 International Conference on Population and Development for governments to encourage male involvement in order to improve gender equity by reducing women's responsibility to control their family size.[5,6]

Male involvement in family planning includes a range of practices, such as male support for their female partners' needs and choices of contraception, financial support for their partners to access family planning services, as well as consistent condom use.[7,8] Evidence from Kenya and India found that family planning programs that involved men were associated with more women using contraception effectively.[9,10] Further research has found that male involvement led to couples having fewer conflicts and achieving the number of children they desire.[6] Despite benefits such as these, male involvement in family planning in many sub-Saharan African countries remains uncommon.[6]

Eswatini context

Eswatini (previously known as Swaziland) is a small country in southern Africa with a population of 1.2 million.[11] Traditional Swazi culture has been relatively conserved, resulting in the sustained existence of strong patriarchal family structures and polygamous relationships.[12] Eswatini is also currently the country with the highest prevalence of HIV in the world,[13] with 27% of people aged between 15 and 49 living with HIV in 2018.[14]It is estimated that the percentage of adult women married or in a union using a modern contraceptive method is 66%, with 15% of this population having an unmet need for contraception, defined as those who do not want to become pregnant but are not using a modern method of contraception.[15] However, women who are single or in their adolescence tend to have a greater unmet need than this[15] and crucially this group of women are missing from this statistic. Because of their unique position in society, healthcare professionals can have an important understanding of the unmet need of family planning and male involvement in their communities.[9] They are therefore integral in gaining a better awareness of the potential benefit male involvement could provide in family planning services and play a key part in enabling this to happen.

Purpose of study

Determining ways to decrease this unmet need for contraception is vital to improve the lives of women and their families and to decrease the transmission of HIV in Eswatini. This research aims to understand healthcare professionals' perception and experiences of male involvement in family planning in the Lubombo region of Eswatini and their opinions to establish if and how men could become more involved to improve family planning nationally.

Methods

Research design

A qualitative study design was chosen for this research, aiming to explore participants' beliefs and attitudes. Semi-structured interviews were used to allow participants to express their views in their own way and allow the discovery of new information.

Study setting and population

The study was conducted in three healthcare clinics in Lubombo, the eastern region of Eswatini. The clinics were purposively selected for their interest in participating and for the fact they provide family planning services to different areas and populations of Lubombo. One clinic was based in the town of Siteki, which has a population of approximately 6,000.[17] The other two clinics were in different rural parts of the region (North and South of Siteki) and serve different populations over a more widespread area. Twelve healthcare professionals from the

Table 1: Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Working in Lubombo as a healthcare professional, for example a nurse or nursing assistant Aged 18 or over Speaks sufficient English to participate in an interview in English	Not willing to consent or participate in the study

selected clinics were selected from a convenience sample based on the criteria shown in Table 1.

Data collection and analysis

Twelve interviews were conducted. The interviews were conducted in a private room at the participants' workplaces. Interviews were in English and no interpreter was needed. Interviews lasted roughly 30 minutes and were led by a single interviewer. All interviews were audio-recorded. A pilot interview was conducted to test the interview guide. Data collection was an iterative process, where new questions were added to the question guide following the responses of previous participants. After each interview, the audio-recording was transcribed verbatim. The transcripts were analyzed using a thematic approach. This initially involved broad themes from a-priori codes that were found from a literature review and used to guide the interview. Following more in-depth familiarization with interview transcripts, the themes were refined and emerging codes were also developed. This method of analysis was chosen to allow new and recurrent themes, in addition to relationships between the themes to be discovered.[16]

Ethical consideration

Ethical approval was obtained from the University of Leeds (FMHREC-18-0.2) and the Eswatini National Health Research Review Board (SHR08111/2019). Informed written consent was obtained from all twelve participants prior to any data collection. Paper consent forms were kept in a locked cabinet and electronic data on password-protected devices only.

Results

The findings are described under the following three themes that arose from the analysis: healthcare professionals' experiences and opinions; barriers to male involvement in family planning; and healthcare professionals' recommendations to improve male involvement.

Participant demographics

Nine out of the twelve participants recruited were female. The average age was 38 years. Detailed participant demographics are shown in Table 2.

Healthcare professionals' experiences

Interviewed healthcare professionals were aware of the concept of male involvement, but all agreed that men accompanying their female partners to family planning services was rare, as captured by this quotation:"From my own experience, it is very scarce to see [men] coming. If you see one, two in a month, that will be quite a lot. Otherwise, sometimes a month will be and you'll end up seeing no man." – Female nurse

Two nurses mentioned that male involvement in family planning might be happening, but that it may be in the home, rather than at health facilities. When explored further, the participants stated they could not be definite about this though as they felt that asking about male support at home was rarely relevant to their patient care.

One participant saw her role as providing women with contraception only and felt that knowing about their partner would not change their service for the woman.

M2M are a cadre of healthcare professionals who are mothers and have previously been diagnosed with HIV. They receive basic training and work in health services to support pregnant women living with HIV with reproductive, maternal, and child health.Most participants claimed that it was common for women to use contraception without their partners' knowledge. Some described how health professionals helped women hide their contraception if they were worried about their partners discovering it, for example through

Table 2: Participant demographics

	Number of participants (n=12)
Sex	Female = 9
	Male = 3
Age	20-24 = 1
	25-29 = 1
	30-34 = 3
	35-39 = 1
	40-44 = 3
	45-49 = 3
Profession	Nurse = 9
	Nurse manager = 1
	Nursing assistant =1
	Mother-to-mother (M2M)* = 1
Marital status	Married = 7
	Single = 5
Religion	Christian = 12
Years working in healthcare	0-4 = 2
	5-9 = 3
	10-14 = 2
	15-19 = 3
	20-24 = 2
Clinic working at	Rural = 8
	Urban = 4

keeping appointment cards in the clinic or encouraging the use of the contraceptive injection.

"In some cases, you hear the woman saying, 'If I put the implant on, is he going to feel it?' They want to hide. They even tell you, 'Please give me something that I will take for long – the three-month injection – because I must find an excuse to go to the hospital.'" – Female nurse

Healthcare professionals' opinions

All participants supported male involvement in family planning. Most mentioned the potential benefits for women, citing three ways in which male involvement can improve family health, namely: i) improvements to effective contraception use due to the increased financial support from partners and better access to family planning facilities; ii) an increase in dual protection, where contraceptive methods that protect against pregnancy and STIs are used; and iii) improvements to women's rights and mental health because of the increased control over her own body and improvements to relationships through joint decision-making. *"Some of [the women] pay bus fare to come to hospital. If the partner doesn't know, where are you going to get the money from if you're not working? But if the partner knows, he will give you the money to hospital."* – Female mother-to-mother (M2M) peer supporter

"It will also encourage the oneness between the couple because such issues are also very couple-oriented." – Female nurse manager

When participants were asked to name potential negatives of increased male involvement in family planning, only two did so. The first participant, a male nurse, feared that family planning clinics did not have the space to manage increased numbers of men accompanying their partners to clinics:"You can talk maybe of the spacing in our clinics. If every male came with his wife, you see the clinic is too small. It will be packed." – Male nurse

The second responder was concerned that increased male involvement could unexpectedly discourage the use of condoms, as more couples may use methods of contraception that do not offer dual protection: "Males will stop using the condom. 'It's OK, we won't have any babies.' Yet, we need the condoms so that we can prevent STIs and HIV." – Female nurse

Barriers to male involvement

Barriers to male involvement clustered around three subthemes: personal ideas about contraception, interpersonal factors between partners, and service level provision.

Personal ideas about contraception

Many participants spoke about limited male responsibility in sexual health, causing men to lack knowledge of modern family planning. This was reported to also exacerbate male fears of the side effects and myths of modern contraception, and thus causing some men to rely on traditional, less effective contraceptive methods.

Some of the myths given include loss of libido, infertility, women becoming "wet" during intercourse, and men becoming "weak". Furthermore, some participants said that male fear of female promiscuity associated with contraception use and traditional attitudes that men should have large families also acted as barriers. "Some men may come and say, 'You want to use contraception so you can sleep with so many men.'" – Female nurse"Some of them believe that it makes women to be wet so that they don't enjoy the sex if the woman is taking contraception." – Female nurse

"All Swazi men feel they should have plenty of children so that they can work on the farm and so that they can work around the homes. It's an old Swazi style." – Male nurse

Interpersonal factors between partners

A few participants felt that limited communication about sexual health between couples was a barrier for male involvement in family planning. "Sex is done behind closed doors. There's no need to talk about that… Here in Swaziland, talking about sex is insane." – Female M2M peer supporter

Furthermore, all three male participants and one female participant claimed that female partners can act as a barrier for male involvement by perpetuating the limited communication through choosing to use contraception secretly. "There are men, I can say, that don't support their wives in family planning. I cannot blame them because even the women don't involve their husband. Most of them just take the decision from them." – Male nurse.

However, some female participants stated that women do not involve their husbands because if their beliefs about contraception differ, they cannot negotiate contraception use or, importantly, may put themselves at risk of abuse by trying.

Service level provision

The most common service level barrier mentioned was male dislike and thus disuse of health services. Most participants said that many men believe that services are for women and children. "Coming into hospital, it is taken as an inferiority thing. As a man, I have to behave like a man – I'm not sick. If I'm sick in hospital, it'll be like now I'm weak" – Female nurse

Limited accessibility of health services was also discussed. Long queues, compounded by reports that men are "impatient" and "restless", means services are less accessible for men. To overcome this, some services see men first if they attend. However, one participant felt it was unjust for women when men are prioritized above them in facilities. "The problem is that according to rights, I wake up early in the morning, I will not allow that man who comes now at 11 to overtake me on the queue when I've woken up early. It's unfair." – Female M2M peer supporter

Healthcare professionals' recommendations

Five recommendations provided by participants and discussed below are: male education, male corners in family planning clinics, female empowerment, invites to men to attend clinics, and outreach services to the community.

Male education on family planning

All participants stressed that male education on family planning was needed to teach men about the importance of and facts about family planning and to encourage support for female partners. It was recommended that this was best achieved by male healthcare workers educating groups of men at gatherings, such as workplaces, football matches, or churches. Some also suggested a media awareness campaign. It was discussed that informing men of the socioeconomic benefits of family planning could make the education more effective in encouraging male involvement.

"You can't just say, 'Let's talk about family planning', because they will say 'No, that doesn't involve us. That involves the women.' ... You must come in with a strategic way to meet with them. Like, for us, the most challenging things are the financial issues. So maybe if you put it that way, like give them the benefits of having a lower number of kids financial-wise." – Male nurse

A few participants felt an incentive would be needed to encourage men to listen."If there is some small incentive, like maybe you can say, 'Come men, let's eat this meat.' But while they're eating you can share something. You can't just go there and say, 'Listen, listen, listen.' They will be bored." – Female nurse

Male corners

Concerning service level factors, some participants recommended introducing male corners, described as separate rooms in facilities for male healthcare professionals to see male patients, to make them more comfortable to discuss family planning. *"Inside the facility, [male clinics do] have that impact but not very much, because the men still have to come inside to be seen by everybody. Maybe if it was at the far end, just a stand-alone room, they'd be more comfortable because, he knows,*

'I'm going to find other men there' and it will encourage them." – Female nurse

Female empowerment

Empowering women through education to start contraception discussions with their partners was also recommended. *"If we can give the women the education on how to approach their partners, people are different, but each woman knows how to approach her partner best. If we have given her the right information, maybe she can approach him better than we can do."* – Female nurse

However, one participant did note that this might not be successful as women are not always in a position to negotiate contraception use. *"We find that the problem with females trying to involve their husband, you will find that the argument will end in a bad way. The husband will say, 'Do you have someone else?' So, it is still very difficult to leave the burden on the females."* – Male nurse

Invites for men

A few participants recommended giving small gifts (for example, a pen or cup) to men who attend health facilities to encourage them to come with their partner. Some recommended invites with an information leaflet for women to give to their male partners. *"I think some leaflets could help us. I think if something on family planning could be printed and the lady can take and give their husbands so that they can take it and read it on their own."* – Female nurse

Outreach family planning services

One participant recommended making family planning one of the key services in their outreach services to make it more accessible to men. However, another discussed the importance of encouraging men to come to the health clinics and hospitals instead. *"It's very important for them to come and use the hospital because we've got some registers… We have to sensitize them to come to the hospital settings so that they know that they have to come to the hospital. Once we start giving the commodities in the community setting, we have to go there every time."* – Male nurse.

Discussion

This study suggests that male involvement in family planning is acceptable to healthcare professionals in Eswatini. In addition, key barriers and enablers to implementing interventions to improve this involvement in their settings were identified. This study found that it was rare for men to accompany their female partners for family planning. This aligns with previous research from 2016 which showed that 0.4% of Swazi men had used family planning services that year.[18] Secret contraception use, as reported in this study, has also been reported in many sub-Saharan African countries.[19]

The strong support from healthcare professionals for male involvement in family planning is important and echoes research conducted in Kenya, where healthcare providers advocated for the need to engage men in family planning.[9] Recommendations from the World Health Organization on male involvement in maternal and neonatal health warned of the potential risk that male involvement strategies can have in reducing women's decision-making powers and thus worsening strong patriarchal structures if not implemented strategically.[20] This risk of gender imbalance was discussed by some participants in this study.

Several participants mentioned that women currently are often not able to discuss contraception options with their partners, with some suggesting that women can be at risk of abuse if they were to negotiate contraception use. It is vital that any efforts to improve male involvement in family planning are sensitive to these risks and ensure that women are still included in decision making about family planning. Barriers to male involvement are a focus in existing research, with barriers discussed in this study replicated in other settings. Limited male responsibility in their own sexual health, for example through not being involved in family planning, was found in Malawi,[21] Uganda[22] and Kenya,[9] and male fears of side effects and myths were discovered in Togo[23] and Nigeria.[24] Little communication about family planning between partners was also found in Nigeria, where most men claimed they had never initiated a family planning discussion with their partner.[6] Previous research from Eswatini, albeit from 2007, found that men with few children were stigmatized and disgraced, leading to pressure to not use contraception.[12]

Responses from this study indicate that this may still be the case, as large families were cited as more desirable for many men in Eswatini.

Participants in this study reported poor healthcare use by men. A large body of evidence from many other settings has found that men tend to have limited or delayed health-seeking behaviours.[25-27] In Kenya, men were found to present much later to hospital for tuberculosis treatment compared to women, with social norms around masculinity acting as the major cause of delay.[25] One study in Uganda also found that many men would often not go for a medical assessment even when ill because they felt it was not necessary for them to go.[26] More specifically to sexual health, a study in Ghana found that 64% of men had delayed getting treatment for a STI over a month even when symptomatic and whilst continuing to have sexual intercourse.[27] Male underuse of health services is a key issue as delays in medical treatment can exacerbate symptoms and increase the risk of transmission and of poor health outcomes.[28] In Eswatini, further research is needed to determine male health-seeking behaviors and the barriers that have led to the poor healthcare use by men.

This study also highlighted the existence of 'dry sex' in Eswatini and that contraceptive products may affect this. This involves women using drying substances or chemicals to dry the vagina for sexual intercourse. This practice has been reported in sub-Saharan Africa for many years,[29,30] however more research is required on this topic. 'Dry sex' can increase the risk of STIs, including HIV, because of the increased risk of vaginal abrasions.[29] Furthermore, the drying substances can damage the vaginal lining and further increase the risk of STI transmission.[30] There is currently no research into the prevalence of 'dry sex' or its consequences in Eswatini, however this is concerning considering the high prevalence of HIV and signifies a need for male involvement in family planning to dispel this myth and increase the use of male-controlled contraceptive methods, such as condoms.

Increased male education on family planning was the most commonly given recommendation by participants and is found in existing research from similar settings.[22,23,31] Most participants in this study recommended group male education from male healthcare workers, however these workers are currently lacking in Eswatini.[18] An education strategy that has been successful in increasing contraception use in Malawi involved community male volunteers instead to educate other men about family planning.[32] Research from Togo involving married men also recommended that this type of education could be more effective if it focused on the socioeconomic benefits of family planning,[23] as was mentioned by participants in this study. Participants in this study also discussed many myths about family planning as barriers to male involvement. This type of education can also have a key role in dispelling these myths. Furthermore, the recent announcement of the reduced price of lenacapavir as a pre-exposure prophylaxis for HIV, now marked at 40USD/year and known to be highly effective, could also be beneficial in Eswatini and increased male education on contraception could advertise this medication.[33,34]

Many participants also recommended 'male corners' in health facilities to allow men to be seen by male providers and to improve privacy for men. Research conducted in 2011 found these factors to be key reasons for the lack of sexual health-seeking behavior in Eswatini.[35] To overcome these barriers, research conducted in Eswatini in the past has recommended male-only parts of facilities.[18] Whilst there is currently no research on the impact these facilities could have on male involvement in family planning in Eswatini, a study in rural Kenya found that male clinics did encourage men to seek healthcare and led to an increase in male service use.[36]

Study limitations and the implications of the results for policy and practice

As this is a small qualitative study, we recognize limitations to influence health policy and practice, however in-depth understanding and analysis of healthcare professionals' perspectives are commonly underrepresented in research on this topic and so this research can elicit new important findings on the subject. In addition, this study adds data to a relatively little studied context of rural Eswatini. Only healthcare professionals were included, which limits any assessment of wider public opinion on this topic. This would require more research involving participants from a range of backgrounds, which we recommend for this context. Furthermore, as only healthcare

professionals were recruited, only a small number of male participants were included, as nursing and allied healthcare is a female dominated profession in Eswatini.

Another limitation arises from the interviewer's presence. As the interviewer was from a different culture to participants, some participants may not have felt entirely comfortable talking about a sensitive topic like contraception, leading to some respondent bias. However, the interviewer spent time with the participants at each clinic to lessen this outsider influence.

Conclusion

In this study, healthcare professionals reported a scarcity of male involvement in family planning. All participants however supported engaging men to improve effective contraception use and women's health. Many barriers to male involvement have been outlined, including limited male responsibility in sexual health, myths, male desire to have large families and male reluctance to attend health services. In order to overcome these barriers, participating frontline healthcare professionals suggested improving male awareness of the health and socioeconomic benefits to family planning, systematically dispelling myths and improving male attendance to healthcare facilities by, for example, introducing male-led services at facilities. Further research is needed to determine the best way to engage men in this education and to determine the barriers to male health-seeking behaviors in Eswatini, to improve sexual and reproductive health and rights, and to ensure that women's choice and wellbeing are protected

Contribution of authors

Conceptualization KM; Methodology KM, BT and NP; Data collection KM; Formal analysis KM; Writing - original draft preparation KM; Writing - review and editing BT and NP; Supervision NP. All authors have read and agreed to the published version of the manuscript.

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