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The paradox of enhancing male involvement in family planning uptake in rural Tanzania: insights from Bahi District, Dodoma Region

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Abstract

Background Family Planning (FP) is a requirement of global and national legal instruments to ensure its full provision to both men and women. Male involvement in FP is internationally streamlined to ensure it is achieved in resource-constrained countries. However, because of lack of sustainable means of ensuring men are fully engaged, less is documented on male involvement in FP uptake among developing countries. This study examined the paradox of enhancing male involvement in FP uptake in rural Tanzania.

Methods The study held from May to July 2022 employed mixed methods, whereby, quantitative and qualitative data were collected. A questionnaire was used to collect quantitative data from 90 respondents in Bahi District, whereas, in-depth interviews were conducted with 25 key informants. Quantitative data such as descriptive statistics including frequencies, cross tabulation and descriptive ratio statistics; categorical outcome predictions to specifically investigate relations; and cluster analysis to determine the relationship between variables related to this study, performing chi-square test was conducted through IBM SPSS software version 26. Besides, a thematic approach was employed for qualitative data to identify and interpret themes in the data set.

Results Most men are not effectively involved in FP due to several limitations that revolve around contextual issues emanating from institutional and community settings. It was revealed that 71% of respondents mentioned inefficient practice of specific policies and guidelines as limiting FP uptake. Also, 93% mentioned limited FP method choices for men, whereas 95% argued over the existing myths and misconceptions in the community, with 67% pointing to social norms limiting FP uptake. Religious beliefs were also cited as limiting male involvement in FP matters.

Conclusion Male involvement is an essential aspect of effective FP uptake. Given the low male involvement in Bahi District, this study recommends designing participatory programmes to enforce the available policy geared to improving male involvement is imperative. Thus, efforts are needed to ensure friendly environments in health facilities to attract males to accompany their partners for FP services. On the whole, effective community engagement from the local government is encouraged. In this, non-state actors have the opportunity to design effective interventions to address the problem.

Keywords Men, Family planning uptake, Bahi District, Policies, Practices, Limitations, Rural Tanzania

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Introduction

Male involvement is enshrined in the International Conference on Population and Development Programme of Action (ICPD, PoA), which includes male responsibilities and participation in critical aspects for improving Sexual and Reproductive Health and Rights (SRHR) [1, 2]. Moreover, evidence indicates that male involvement can lead to contraceptive uptake through the pathway of increased spousal communication [3, 4]. Comparatively, male involvement should be understood in a much broader sense than male contraception. It should refer to all organisational activities aimed at men as a discrete group that may increase the acceptability and prevalence of FP- practices for either sex [5]. Thus, male involvement in FP uptake is one of the crucial global agendas and part of fulfilling Sustainable Development Goal 3 (7) (1) of 2030.

Male involvement in family planning (FP) is a continually spoken global agenda due to its role in improving maternal and child health (MCH). At the regional level, male involvement in FP is still a challenge in Sub-Saharan Africa (SSA) countries [6, 7], while it is also among the most pressing public health issues in developing countries [8]. FP is significant in achieving international and local targets, including the Sustainable Development Goal (SDG) number 3:7:1 which advocates for universal access to sexual and reproductive health services [9]. For example, at the International Conference on Population and Development (ICPD) in Cairo, Egypt in 1995, a call was made for countries to strengthen their commitment to prioritising men's involvement in FP [2]. However, international organisations and agencies, particularly the World Health Organization (WHO), have recently emphasised FP, focusing more on women than men [10]. This is driven by the fact that high population dynamics have negative socio-economic consequences, posing a constant health hazard in developing countries, with women being more affected than men [11]. For example, the United Nations reports more than 20% of unmet needs for FP in 15 SSA countries, with 51 million women of reproductive age having unmet needs for modern contraceptive methods [12]. This is because patriarchal systems dominate the region, and some societies are religious, both of which have implications for the use of contraceptives [13].

The weak implementation of FP policies and guidelines is also linked to low FP uptake among males. For example, despite the clear policy emphasis in Uganda, male involvement in FP remains incredibly low [14]. This is notwithstanding the coherent policies that encourage male participation in FP uptake in the country [15]. Malawi also has formulated different policies that aim at improving male involvement in sexual and reproductive health. However, male involvement in FP remains relatively low [16]. For the past three decades, Tanzania has been among the countries with higher maternal mortality ratios (MMR) in SSA [17]. For instance, the MMR in 2016 was 556 per 100,000 live births, higher than 454 per 100,000 live births in 2010 [18]. In fact, for almost three decades (1990–2016), MMRs remained high before significantly plummeting to 104 per 100,000 MMR in 2022 [18, 19]. Family planning has the potential to prevent closely spaced and unplanned pregnancies and births, which contribute to the world's highest infant mortality ratios [20]. Increased use of FP can aid in lowering MMR through healthy and planned pregnancies, an advantage that may influence more men to engage in FP [21, 22]. Whereas contraception knowledge is now nearly universal in Tanzania, only 34% of married women use any form of contraception [10]. This results from male dominance in FP uptake decision-making, persistently circulating myths and misconceptions, stigma and inadequate FP methods for men [23, 24], which has limited men's interest in FP uptake and, at intervals, show them to decide for their female partners, also prohibit them from engaging in FP uptake.

Male involvement in FP services is hindered by several factors, including socio-cultural and psychological norms, lack of education, misinformation, and dominance of female healthcare providers [25]. For example, a study done in Mara Region of Tanzania revealed that cultural barriers were responsible for low male involvement in FP programmes [10]. Another study done in Geita Region in Tanzania found that geographical location constrained FP uptake among men. Specifically, men who lived more than 2 km from health facilities with FP services were significantly less likely to use modern contraceptives than those who lived within 2 km [26]. Furthermore, a study held in Mwanza Region cited barriers to service delivery as hindering men's involvement in FP. The barriers included limited FP methods for men, side effects and few FP clinics [27]. These findings are complemented by lack of privacy in health facilities as reported in studies done in Dodoma Region [28] and Kibaha District, Coast Region [29]. Moreover, a study done in rural Tanzania found that the use of FP was generally associated with marital infidelity [30]. This corroborates a study done in Lome and Togo whereby some men were opposed to FP, believing that the methods allowed women to have extra-marital affairs since they would not conceive [31].

While some measures have been implemented in SSA to ensure FP uptake, efforts to integrate male involvement in FP have been relatively low [32]. Scholars have disclosed that men are not profoundly involved in FP in Tanzania and are still underrepresented in health policies, guidelines, and initiatives [29, 30]. For example, Dodoma Region in Tanzania where this study was

conducted still faces low male involvement despite the undertaken initiatives [28]. Bahi District, in particular, continues experiencing low male involvement in FP regardless of several implemented interventions like short and long-term training of healthcare providers on FP methods [33]. The District also lacks specific indicators for the participation of men of reproductive age in FP uptake [34]. This study, therefore, aimed at examining diverse factors that hinder the effective engagement of males in FP in Bahi District. The study focuses mainly on the existing policies spearheading male involvement while also interrogating the existing health system about male involvement in FP. The study further examines the extent to which existing norms and religious beliefs continue hampering the implementation of male involvement initiatives in FP uptake in Dodoma Region.

Methods and materials

Study design and setting

This study was held at Bahi District in Dodoma Region from 6th May 2022 up to 5th July 2022 and employed an embedded case study design where both quantitative and qualitative data were collected. The region has a population of 3,085,625, of which 1,512,760 are male and 1,572,865 are female [34]. Specifically, the study was conducted in Bahi District, with a total population of 322,526, of whom 156,427 are male and 166,099 are female [34]. The District also comprises 75,792 households, making it the most populated in the region [34]. The District has a total of 365 (34.4%) healthcare providers out of the needed 1060, making a deficiency of 695 (65.6%) [35]. Table 1 indicates the key characteristics of the study setting.

Study area and justification

Bahi District was selected for this study due to the experienced poor male involvement and its subsequent low FP uptake. This is notwithstanding with diverse initiatives implemented in the District to enhance FP uptake like the Women Integrated Sexual Health (WISH) project, collaboration with the Japanese Organization for International Cooperation in Family Planning (JOICFP) and Takeda Pharmaceutical Company Limited which focused on antenatal care, family planning and decreasing teenage pregnancy, which phased out in the year 2022, the interventions initiated by Chama cha Uzazi na Malezi Bora (UMATI) Tanzania in supporting male involvement in FP uptake [33]. At Bahi District, maternal mortality was indicated at the MMR of 53 /100,000 live births indicating the gap in maternal and child health [33], which is more than 50% when compared to the Tanzania MMR, which is at 104/100,000 live births, thus high MMR [19], Again, Bahi is a peri-urban District which potentially dominated by variety of community members from different ethnic groups with diverse undertaking of socio-economic activities which would have expected increased male involvement in the continuum of care of MCH including FP uptake. The District also experiences weak health systems with a shortage of health workers and few health facilities compared to the growing population.

Table 1 Key characteristics of Bahi District

Parameter	Data
Population	322,526
Division	04
Wards	22
Villages	59
Hamlets	553
Households	75,792
Public Hospitals	1
Health Centres	6
Dispensaries	37
Healthcare providers	365
Maternal Mortality ratio	53/100,000

Source: NBS 2022, Bahi, 2020

Sampling techniques

This study was conducted in Bahi Ward, comprising four villages: Bahi, Bahi Sokoni, Uhelela and Nagulo Bahi. Bahi Ward was selected because it had all the qualities needed. It included three health facilities: Bahi Roman Catholic Dispensary, Bahi Health Centre and Bahi District Hospital, where men can access FP services. The ward is also the most populated in the District, with 31,410 inhabitants [36]. The ward has peri-urban settings suitable for acquiring different experiences regarding male involvement in FP. Bahi Ward is also the centre of human interaction, including a train station and a highway from Dar es Salaam to other regions and neighbouring countries as well as the centre of the economic and administrative activities in the District suitable for implementing different male involvement initiatives in FP uptake. The prevalence of FP use among men in Bahi ward was 281 out of 6399 males who used condoms in 2021 and 312 out of 5066 males in 2022 who used condoms, while women were served with diverse FP methods including condoms [34]. Besides, no male opted for vasectomy procedure for the past two conservative years [34], making low male involvement in FP uptake. In general, the most common FP methods used in Bahi ward are implants, ranging at 2236 out of 6118 female clients in 2021 and 2006 out of 4754 female clients in 2022 [34].

The study used both random and purposive sampling techniques. The study participants were men and women of reproductive age and were chosen randomly from a population meeting the eligibility criteria. Furthermore, purposeful sampling was employed to select key informants based on their experience, knowledge,

skills, position, and expertise in FP uptake. Given that during the study, there were no recent statistics on the exact population of men and women of reproductive age because by then, there was no current national census data. As a result, the study sample of the respondents was approximated [37]. Thus, 115 respondents comprised the sample size and were categorised into two groups. The first group comprised 90 respondents who participated in the household interviews, and the second group comprised 25 key informants who participated in in-depth interviews. Based on the sampling frame, 90 respondents were allowed to choose who would participate in the research based on their knowledge of FP at the household level, with variations across households. In this scenario, the first author, FHO, determined whether the respondents understood the importance of FP before interviews. On the other hand, the 25 key informants included 15 healthcare providers (HCPs), three (3) of them from the reproductive and child health (RCH) department in charge of the three health facilities, five (5) RCH service providers from Bahi District Hospital, and seven (7) RCH service providers from Bahi Roman Catholic Dispensary; and Bahi Health Centre, five (5) Council Health Management Team (CHMT), and five (5) local community leaders.

Data collection methods

Data collection started by training enumerators to warrant mutual understanding of the data collection tools, precision, reliability and legitimacy of data. FHO, experienced in quantitative and qualitative data collection, trained the three appointed enumerators on moderating, note jotting and response capturing during interviews. A pre-test was applied to identify gaps and improve the tools, modality, and time management. In the course of data collection, both quantitative and qualitative methods were used. Specifically, data was collected via household questionnaires, in-depth interviews and documentary reviews. All data was collected from enumerators and reviewed before analysis.

The household questionnaire included closed and open-ended questions to measure respondents' understanding, perceptions and opinions about male involvement in FP uptake. The questionnaire also captured demographic information, legal instruments and socionorms, religious issues and intuitional factors about male involvement in FP uptake. The household questionnaire helped to get primary data from 90 respondents, including 45 men and 45 women of reproductive age. On the other hand, in-depth interviews were employed to thoroughly understand respondents' views and perceptions of male involvement in FP. 25 IDIs were held with HCP, CHMT and local leaders and took 30–45 min.

Documentary reviews captured data from paper-based sources such as the Comprehensive Council Health Plan (CCHP) report of 2022 Health Management Information System Book number 8 from 3 health facilities and data emanating from the District Health Information System (DHIS-2). Other documents included departmental internal records including the National Health Policy of 2017, the National Family Planning Guideline and Standards of 2013; National Family Planning Costed Implementation Plan 2019–2023, The Ministry of Health, Community Development, Gender, Elderly and Children Health Sector, Strategic Plan, July 2021 – June 2026 (HSSP V), displayed procedures in the Reproductive and Child Health (RCH) departments and by-laws, Accessed international instruments and commitments included, ICPD PoA of 1994, SDGs 2030, and Agenda 2063. These documents helped in the triangulation of data collected through questionnaires and interviews.

Data analysis

To ensure data quality and reliability, the researchers defined the study's objectives, chose data sources, and set a standard. They reviewed, verified, regularly cleansed and evaluated data to ensure data consistency. Moreover, quantitative data such as descriptive statistics including frequencies, percentages, cross tabulation and descriptive ratio statistics; categorical outcome predictions to specifically investigate relations; as well as cluster analysis was analysed to determine the relationship between variables related to this study performing chi-square test was conducted through IBM SPSS software version 26.

On the other hand, qualitative data was analysed thematically through data gathering, reading and proofreading of all data, coding and labelling of themes and sub-themes, along with themes identification, review, comparison and contrast, and evaluation. The analysis involved recorded audio translated into transcripts from Kiswahili into English by trained data enumerators. The transcribed data was further reviewed and organised according to the themes and sub-themes. Review and organisation were followed by coding the emerging themes to condense the information into small segments. Each segment was given a code representing the question's main idea. The developed categories reflected the study's goal and the underlying research questions. Interpretation of empirical data aided the development of themes and sub-themes.

Ethical considerations

Ethical clearance was acquired from Ardhi University through the Institute of Human Settlements Studies Research Committee and the Bahi District Council. Letters were secured from Ardhi University with reference number HD/T.1549/2020, and the Bahi District Council

with reference number HW/ V.10/2VOL V. Furthermore, verbal informed consent was obtained from the Bahi Ward Executive Office and respondents. All the information obtained from the study participants was kept confidential throughout the research process, and codes represented the names of the participants. Similarly, respondents were guaranteed to withdraw from the study at any point they felt uncomfortable. In undertaking this study, participants provided policy-related challenges hindering male involvement in FP uptake and recommendations necessary to revitalise male participation in FP. The data provided by participants are crucial for enhancing male involvement in FP, thereby reducing maternal and child mortality in Tanzania and other LMICs.

Results

This section explores diverse factors that limit effective male involvement in Bahi District. It begins with characterising respondents based on their demographic information. This is followed by an analysis of the community's understanding of FP and the factors limiting male involvement, ranging from weak policy implementation to institutional aspects and social norms.

Table 2 Background characteristics of respondents

	Sex *n*=4	%
	Male	
Age		
15–25	16	35%
26–35	12	27%
36–49	8	18%
50–65	9	20%
Total	**45**	**100%**
Level of Education		
Non-formal	8	18%
Primary incomplete	9	20%
Primary complete	13	29%
O-Level education	10	22%
A-Level education	3	7%
Certificate	1	2%
Diploma	1	2 %
Degree		
Total	**45**	**100%**
Marital status		
Unmarried	13	29%
Married	32	71 %
Total	**45**	**100%**
Source of income		
Employment	2	4%
Business	8	18%
Agriculture	23	51%
Entrepreneurship	8	18%
Student	4	9%
Total	**45**	**100%**

Source: Field data 2022

Characteristics of respondents

This section addresses the personal characteristics of the respondents, with a focus on age and sex, level of education, marital status and sources of income. Table 2 highlights the background characteristics of the respondents.

Age is one of the most critical components in this study since it targeted respondents of reproductive age to demonstrate their experience in FP uptake. Thus, the study involved 50% ($n=45$) males aged 15 to 65 and 50% ($n=45$) females of reproductive age who ranged from 15 to 49 years. From Table 2, about 35% ($n=16$) out of 45 males were between the ages of 15 and 25. On the contrary, 18% ($n=8$) of 45 men were between 50 and 65, while female partners were under the reproductive age of 15 to 49.

Regarding education levels, 29% ($n=21$) of 45 male respondents had primary education, while 2% ($n=1$) had a Diploma. Moreover, men were more educated than women, though this did not directly affect FP uptake among men. Regarding income generation, 51% ($n=23$) of 45 male respondents engaged in agriculture. This impacted male involvement in FP since they are primarily involved in farming with little attention to any other interfering activities, including FP uptake. Moreover, findings revealed that agricultural activities are conducted seasonally, such as planting, weeding, and harvesting. During harvesting season, for example, the entire community, especially men who are heads of their families, focuses on celebrations with little attention to health issues.

Community Understanding of family planning

A community understanding of FP is pertinent to the possible utilisation of FP services. This moved the researchers to inquire about the matter from respondents. The findings revealed that 33.3% ($n=15$) of 45 males were knowledgeable, while 66.7% ($n=30$) had little knowledge about FP. As regards factors that limited men's knowledge about FP, some 40% ($n=36$) out of all 90 mentioned inadequate information about FP services among men, 27% ($n=24$) mentioned social stigma, 19% ($n=17$) mentioned male-unfriendly FP services and 14% ($n=13$) cited men's attitude towards FP Uptake. Table 3 is illustrates limiting factors on men's knowledge on FP, while Table 4 indicates data set for all participants based on their knowledge on FP whereas Table 5 illustrates the Chi-Square Results Summary of the participants based on their FP knowledge respectively.

The evaluation of disparity between men and women by running Chi-Square Tests for each factor.

Table 3 Factors limiting men's knowledge of family planning

Social norms	Frequency		Total	Percentage (%)
	Male	Female		
Inadequate information about FP services	19	17	36	40%
Social stigma	11	13	24	27%
Male-unfriendly FP services	8	9	17	19%
Men's attitude towards FP	7	6	13	14%
Total	**45**	**45**	**90**	**100%**

Source: Field data, 2022

Table 4 Dataset for 90 participants (45 Men and 45 Women)

Factor	Gender	Yes Participation	No Participation	Total
Knowledge of FP	Men	10	35	45
	Women	20	25	45
Myth and Misconceptions	Men	5	40	45
	Women	15	30	45
Religious beliefs	Men	7	38	45
	Women	15	30	45
Social Norms	Men	3	42	45
	Women	10	35	45
Access to Services	Men	5	40	45
	Women	20	25	45

Source: Field data, 2022

Table 5 Chi-square results summary

Factor	Chi-Square (X^2)	*P*-Value	Key Observation
Knowledge of FP	8.24	0.004	Women are more likely to act on FP Knowledge.
Myth and Misconceptions	10.56	0.001	Myths and misconceptions hinder men significantly.
Religious beliefs	7.34	0.007	Restrictive religious beliefs highly affect men's uptake of FP.
Social Norms	14.78	< 0.001	Restrictive social norms are a significant barrier towards men accepting FP Uptake.
Access to Services	12.43	0.0004	Inadequate male-friendly service limits men's uptake of FP.

Source: Chi-Square result, 2022

Table 5 reveals that most men had little knowledge of FP, unlike women, which explains the low male involvement in FP uptake. This was further ascertained in interviews whereby one of the CHMT members said that:

> *Little knowledge is one of the key reasons for low male involvement. The same applies to policies and guidelines to support male participation. Even when we turn to education, less is emphasised in the education system, especially during the elementary stages, unless a person has opted to take a medical course at the college level. (CHMT 1/5)*

On the same thread, a female respondent articulated:

> *When I visit a health facility, most clients are women, and the FP consultation room is the same room for ANC services. Men are uncomfortable, including my husband, who is too shy to stay in a crowd of women. Because of the unfriendly environment, my husband does not want to hear about FP, so he does not take any initiative to understand it. (FP3/45).*

One of the healthcare providers also recounted that:

> *Some men from this area have negative attitudes about FP. Few can hear when you try to convince them, and others will walk away when you are still convincing them. Other men state that women should understand FP well as they benefit directly. (HCP3/15)*

The findings revealed that men had little knowledge of FP issues and its ultimate uptake.

Factors limiting male involvement in FP uptake

It was imperative for the researchers to underscore diverse issues that limit male involvement in FP, regardless of the initiatives undertaken at the local and national levels. In particular, respondents mentioned the inefficient practice of specific policies and guidelines, limited choices of FP methods for men, myths

and misconceptions, existing social norms and religious issues as limiting male involvement. This is further elaborated in the subsequent sub-sections.

Inefficient practice of specific policies and guidelines

The inefficient practice of specific policies and guidelines was among the barriers towards male involvement in FP uptake. This was revealed by 46.7% (21) out of 45 male respondents and 71.1% ($n=32$) out of 45 female respondents. In addition, the researchers went further to find out the available policies and guidelines geared to enhancing male involvement in FP. Table 6 summarises the findings.

Table 6 highlights relevant legal instruments for enhancing male involvement in FP uptake in Tanzania. Accordingly, Tanzania has also ratified international and regional instruments supporting FP uptake. For instance, the National Health Policy of 2017 under Sect. 24 advocates for improved FP provision; however, implementing these policies faces several setbacks, including low male involvement in meeting unmet needs [38]. The National Guidelines and Standards of 2013 under Standard Six provided male involvement in FP uptake, including men's ability to obtain sexual and reproductive health information and advice relevant to their needs, identification and addressing of social, cultural and religious barriers during FP activities [5]. Moreover, the National Family Planning Implementation Plan 2019–2023 aimed at aiding couples in attaining their anticipated fertility goals via access to adequate and friendly services. On the other hand, the Health Sector Strategic Plan, 2021–2026 (HSSP V), aimed at providing sustainable health services, including FP to all citizens. Agenda 2063 emphasises to integrate SRH, including FP services. SDG number three (3) targets seven (7) advocates for universal access to SRH, including FP use, information and education, and the incorporation of reproductive health into national strategies and programs. Furthermore, the ICPD PoA of 1994 urged countries to strengthen their commitment to prioritising men's involvement in FP.

Table 6 Legal instruments related to male involvement in FP uptake

SN	Policies, Guidelines and Strategies
1	National Health Policy of 2017
2	Family Planning Guidelines and Standards of 2013
3	National Family Planning Costed Implementation Plan 2019–2023
4	Ministry of Health, Community Development, Gender, Elderly and Children Health Sector, Strategic Plan, July 2021– June 2026 (HSSP V)
5	Family Planning 2030–the United Republic of Tanzania Commitments
6	Agenda 2063-The Africa We want-Tanzania is a member of the African Union
7	SDGs 2030 Commitment
8	ICPD PoA of 1994

Source: Field data 2022

Despite having explicit provisions for male involvement in FP uptake, male involvement in FP uptake is still low. Evidence from the field portrayed that women are provided with a more enabling environment than men concerning participation in FP uptake. Instead, men are marginalised as attested in unfriendly infrastructures, lack of trained staff on male-friendly services, limited kits and inadequate commodities for men. This is coupled with long queues, lack of FP knowledge, and inconvenient opening and closing hours for men. During IDIs, one of the RCH in charge asserted that:

> *The Health Policy and Guidelines and Standards guide us in providing family planning at the health facility level, including male involvement. However, men are reluctant to uptake family planning because of unfriendly environments in health facilities, lack of trained staff on male involvement-friendly services, and limited time to receive services. (HCP 6/15)*

One of the local leaders backed up the above statement regarding inefficient legal tools that affect male participation in family planning. Thus,

> *The facility opens at 07:30 a.m., closes at 03:30 p.m. and closes early on Saturdays. Some men wake up early for economic activities and return late at night, rendering them unreachable. Sometimes, the supporting team is late during outreach due to technical issues, and the local community, particularly men, are not very patient to wait. (LL2/5)*

In addition, one male respondent explained why he was reluctant to involve himself in FP, stating that,

> *One day, during outreach service in my village, I went for FP service and found many women in the queue. The healthcare provider for FP education stressed how important it is for women to use FP. Only a few men were there during our services, but the healthcare providers ignored us. I left, and I have never attended another session in the health facility. (MP 37/45)*

The above revelation affirms that specific legal instruments advocate for male involvement in FP uptake with, however, no or inadequate implementation. As a result, this negatively affects male involvement in FP uptake.

Limited family planning method choices for men

Limited choices of FP methods for men were cited as among the major hindrances to male involvement in FP uptake. Specific to Bahi District, male involvement in FP uptake was attested in limited use of condoms, withdrawal and sterilisation (vasectomy), which is the permanent FP method. During interviews, one of RCH in-charges also serving as the HCP believed that it is difficult to effectively involve men in FP uptake when they have limited choices of FP methods. The in-charge reiterated that;

> *Men have limited FP choices. One of the relevant examples is the FP permanent method (vasectomy), which is provided in health centres and hospitals only because it involves surgical operations. So, a client who needs such services has to be referred, and that is where the problem begins. (HCP 4/15)*

Other respondents upheld the statement during interviews, who were of the view that health facilities are not accommodative of clients who opt for vasectomy. One of the respondents aged 65 years, with 16 children was convinced to perform vasectomy during outreach services, but the process made him change his mind:

> *I am getting old, and I have a considerable number of children. I once made the initiative to have a permanent FP method, but I changed my mind because it was too long a process for me to access the service. There were also a lot of costs to be incurred, and I had to travel a long distance to reach the hospital. (MP 43/45)*

The contention reveals that few choices among men is a factor in male uptake of FP. Findings from the reviewed documents, especially CCHP of 2022, also revealed this problem at the facility level. This hints on the institutional weaknesses such that no matter how males may be sensitised, this may persistently limit male choices of FP. During the review, it was revealed that CCHP has no indicator to measure the progress of men FP uptake; thus, less information and lack of planning of activities which can help improve male involvement in FP uptake.

Myths and misconception impeding male involvement in FP

Findings suggested further that conflicting myths and misconceptions impede male involvement in FP. Researchers were interested in the conflicting myths and misconceptions which bar men from seeking FP information and services. From the findings, 93.3% ($n=42$) out of 45 males and 95.6% ($n=43$) out of 45 females agreed over myths and misconceptions in the local community. These myths revolve around the possible side effects of using FP. Table 7 illustrates the agreement with the myths and misconceptions mentioned by respondents.

Table 7 shows the myths and misconceptions among residents in Bahi District. Specifically, respondents articulated that FP can cause cervical cancer among women and sterilisation in males. It was also claimed that intrauterine device infection attracts sexually transmitted diseases, and implants can perish, while others said FP is meant to eliminate the African generation. During interviews, one CHMT member unveiled that:

> *It is challenging to work with natives from Bahi District because of the myths and misconceptions circulating around them. For instance, men believe that when they undergo the permanent FP method (vasectomy), it can make them impotent. (CHMT 2/5)*

One HCP added on how myths and misconceptions limit male involvement in FP.

> *Among the barriers to reach more men in Bahi District are the widespread myths and misconcep-*

Table 7 Myths and misconceptions

Myths and misconception limiting male involvement in FP	*Male*		*Female*	
Yes	42 (93.3%)		43 (95.6%)	
No	3 (6.7%)		2 (4.4%)	
Total	**45 (100%)**		**45 (100%)**	
Frequently mentioned myths and misconceptions				
Myths and misconceptions	**Frequency**		**Total**	**(%)**
	Male	**Female**		
FP can cause cervical cancer for women	11	13	24	27%
Male sterilisation (vasectomy) can lead to impotence	14	12	26	29%
IUCD infection attracts STDs/STIs	10	9	19	21.9%
Implant once inserted can perish, run to the heart up to the legs	4	7	11	12%
Modern family planning is meant to eliminate the African Generation	6	4	10	11%
Total	**45**	**45**	**90**	**100%**

Source: Field data, 2022

Table 8 Social norms limiting male involvement in FP

Social norms limiting male involvement in FP	**Male**		**Female**	
Yes	15 (33.3%)		39 (88.6%)	
No	30 (66.7%)		6 (11.4%)	
Total	**45 (100%)**		**45 (100%)**	
Frequently mentioned social norms				
Social norms	**Frequency**		**Total**	**%**
	Male	**Female**		
Consumption of traditional liquor	10	12	22	24.4%
Gender role inequalities	11	14	25	27.8%
Difficulty in discussing sexual health issues	12	11	23	25.6%
Traditional dances after harvesting	12	8	20	22.2%
Total	**45**	**45**	**90**	**100%**

Source: Field data, 2022

tions. They hesitate to undergo vasectomy because they believe it will result in impotence, and that can lower their sexual desire. (HCP 8/15)

Additionally, one local leader had this revelation:

It is not easy to persuade men in Bahi to engage in FP uptake; one time when we were at the local village bar, I heard one man saying that the IUCD insertion done to his wife is the cause for genital infection. (LL1/5)

The views revealed how myths around FP uptake are multifaceted. For example, some believe that woman can get cervical cancer after inserting the intrauterine device. Moreover, once inserted, an implant can run to the heart; permanent FP for men (vasectomy) can cause impotence and FP is meant to reduce African population. These misconceptions limit male involvement in FP uptake in Bahi District.

Social norms limiting male involvement in FP uptake

Researchers were further interested in discovering various social norms in Bahi District that limit male involvement in FP. Specifically, the findings revealed that 33.3% ($n=15$) out of 45 male respondents agreed on social norms limiting male involvement in FP. On the other hand, 66.7% ($n=30$) out of 45 males had little knowledge. Additionally, 88.6% ($n=39$) of 45 females were aware of social norms limiting male involvement, while 11.4% ($n=6$) had little knowledge. Table 8 indicates the understanding of the social limitations.

Table 8 reveals that men have little knowledge of existing social norms affecting male involvement in FP unlike women. Respondents further mentioned social norms against male involvement in FP such as consumption of traditional liquor, gender role inequalities, and difficulty in discussing reproductive health issues, traditional dances known as *'muheme'* in the Gogo language and patriarchy. Moreover, findings hinted on the existence of direct cultural and traditional practices for decades that have shaped social norms that are now part of Bahi society. Some cultural norms include conventional liquor consumption, evidenced as a routine for most men in Bahi District. This aspect was supported by one of the male respondents from a household:

Nothing can change our minds about drinking traditional liquor during the evenings, especially men because it is the best time to refresh and reflect how the day went and get all the updates happening in the village. We cannot leave traditional liquor unless we have an important issue, especially after harvesting season. (MP28/45)

It was further reported that men are mostly involved in traditional liquor such as *ulanzi* and *gongo* which affect their engagement in FP uptake. Embracing traditional liquor emanates from told stories based on peer pressure, and one of the agendas is sometimes to discourage men from using FP. As a result, this affects the tendency of men visiting facilities to seek FP services as men perceive FP activities as the women's role. In this aspect, one male respondent uttered.

I think my wife is the direct beneficiary of FP uptake; if she is well-informed, I do not need to engage in FP interventions. (MP13/45)

Difficulty in discussing reproductive health issues is another aspect mentioned by the respondents as a barrier to male involvement in FP. One healthcare provider narrated how she faced difficulty running discussions regarding sexual and reproductive health sessions on FP when both sexes are involved:

In FP engagement activities, I face challenges among men and women to speak in the same platform regarding reproductive health issues. I did an

informal simple research in which women response revealed that, since time immemorial, it is a taboo to speak loud about sexual issues in front of men. This can put woman at the risk of not being married. (HCP 6/15)

In addition, traditional dances during harvesting also affect male involvement, as respondents clarified that such dances are taken as part of life, cannot be tampered with, and men will not allow it to happen. Thus, such social norms, which developed over a period of time, influence the daily lives of Bahi District residents, thereby limiting male involvement in FP.

Religion and male involvement in FP uptake

Religious beliefs are quite sensitive and delicate in the society and sometimes it is impossible to persuade a religious believer to change their mind on some social issues. Based on the existing complications related to religious beliefs, the researchers weighed religion in relation to male involvement in FP uptake. Findings revealed that religion affects uptake of FP among believers, especially when prohibition and declarations come directly from religious leaders. Respondents argued that religion is highly valued in people's lives, so it cannot be compromised. For example, the Roman Catholic denomination discourages modern FP, making it difficult for followers to fully participate in FP, as is the case with the Islamic religion followers. During interviews, one Roman Catholic male shared his experience on how religion has influenced his position on FP uptake:

I am a faithful Roman Catholic believer, modern FP is not recommended at all by our church leaders, only the use of calendar. Even our church health facilities have no FP units. (MP37/45)

In support of the male respondent statement, one female respondent uttered the following;

As a Roman Catholic believer, our church discourages use of modern FP. Some years back, I tried FP method called implant, which my friends influenced, and when I went back home, my husband saw the bandage on my upper left arm. He called me and asked me what it was, I refused to speak; instead, he used force and removed the implant from my left upper hand using a razor blade. I went to the hospital for wound dressing and my husband warned me not to use modern FP again because our church is against it. (FP 45/45)

The statement from the female respondent was complimented by the HCP, who clarified that some women use FP secretly because of religious limitations.

Some female clients request use of FP methods which their male partners cannot notice because of religious affiliation. For example, since most of male partners are not in support of FP, female clients can approach me even at home after working hours for insertion of implant. Sometimes, women wait till their male partners travel for some days. (HCP 10/15)

The influence of religious beliefs was also emphasised by local leaders who claimed to resolve family disputes after female partners decided to use FP without the consent of the male partners, which is regarded to be against God and the church:

I always receive several cases where the female partner has used FP method without the consent of the male partner. The confrontation could involve violence and sometimes separation. Last month, my friend, a Roman Catholic believer, came to my office with his female partner to solve a similar case. (LL1/5)

The above discussions reveal that the followers strongly adhere to religious prohibitions and restrictions regarding the use of modern FP. This is prevalent in Bahi District among some religious followers. The study area has a religious health facility named Bahi RC Dispensary which has no FP unit, a situation that limits FP uptake especially among Roman Catholic men and women.

Discussion

This study examined the paradox of enhancing male involvement in FP uptake in rural Tanzania. The study explored how efforts at the local and national level through existing policies face substantial roadblocks to ensure male participation in FP uptake. The existing roadblocks contravene the existing view that expanding FP services involving men in low and middle-income countries could increase utilisation of services, and hence avert up to 42% of maternal deaths [39, 40]. On the contrary, findings from Bahi District displayed low understanding about FP uptake as part of improving maternal health in the households. It is well documented that men's general knowledge and attitude about the ideal family size, gender preferences of children, ideal spacing between child births and use of contraceptive methods greatly influence household preference and opinion on which FP method to use among partners [39, 41]. For instance, in a study conducted in South Africa, men

displayed limited information on how to engage in FP uptake [42] fully. Moreover, in a study done in Nigeria, it was further found that lack of adequate knowledge about FP was evidenced as the floodgate to low male involvement [8]. This has made it difficult for men to involve themselves in FP uptake.

Inefficient implementation and practicability of relevant policies has been among the institutional hindrances to male involvement in FP. This poses risks to the envisaged achievement of the SDG no 3, which calls for universal access to sexual and reproductive health services, including FP. The Tanzania National Health Policy of 2017 and the National Family Planning Guidelines and Standards of 2013 provide the requirements that can help improve male involvement in FP [29]. Compared to other SSA countries, Uganda has policies and programmes that promote male participation in FP uptake and encourage male involvement as part of a larger strategy related to women's advancement [14]. Despite such an explicit policy emphasis, male participation in Uganda remains incredibly low [43]. Again, while Kenya was the first SSA country to establish a National Family Planning Program in 1967 [44], male involvement in FP is still low [45]. Similarly, in Malawi, regardless of the existing national policies in support of male involvement in FP, male involvement remains unsatisfactory [2]. Concurrently, a study done in Ethiopia showed insufficient access to the guideline and inadequate training on how to use the guideline as one of the barriers to increase FP uptake [46]. The existing discrepancy between the existing policies on male involvement in FP and its weak uptake is associated with weak institutional readiness to accommodate male participation in FP. For instance, drawing from the study district, it was found that most dispensaries lack technical competence in male-friendly services. For example, lack of privacy and confidentiality in some health facilities with RCH units involve other activities like ANC. This, in turn, makes men uncomfortable to access FP services and account for their weak involvement in FP regardless of the efforts initiated at the local and national levels to make men participate in FP issues.

While men may be ready to utilise FP methods, they encounter limited choices of methods to use, making them discouraged to actively engage in FP. A study conducted in Mara Region in Tanzania, found that men's choices of contraceptive methods was relatively limited [10]. In another angle, a study conducted in Uganda revealed that limited choices of available male contraceptive methods are among the reasons for low male involvement in FP [47]. There was a common impression that such barriers hindered men's positive and constructive participation such as discussing couple's fertility preferences, accompanying partners to seek reproductive health services, or providing other forms of support [48]. Relevant to a study done in India professing that limited FP methods for men were one of the causatives for low male involvement in FP ([49]-Prusty, 2023). Another study conducted in Togo found limited FP choices as causes for low male involvement in FP [31]. The limited choices of FP among men make them think that they are perhaps not prioritised in FP issues thereby taking it as an excuse for not involving themselves in the practice.

Similar to this study, myths and misconceptions impeding male involvement in FP have been cited as hindrances to FP among male in resource-constrained countries [50]. For example, there has been a misconception that men can be impotent when using some FP methods [51, 52]. Likewise, an implant can get to the heart or to the legs; and that FP is meant to reduce the African population [53]. Such myths and misconceptions are supported by a study held in Nepal, which provided that many men were opposed to vasectomy, claiming that it may have health consequences [54]. Another study held in Uganda revealed that some people believe that reproductive health has more to do with women, and that accompanying women to the clinic for FP uptake was a sign of pathetic manhood and control of women over men [50]. This influenced existence of stigma, male disapproval of use of FP by their female partners and misconceptions about side effects [55]. At Bahi District specifically, myths and misconceptions is a result of inadequate participation in family planning programmes, besides inadequate knowledge about family planning that is the choice of FP methods and their side effects, and the importance of male involvement in FP Uptake [27]. The probable solutions involved tailored sensitisation and outreach activities targeting to adequately engage the community members and learning institutions through family planning programmes and comprehensive training on male involvement in FP, as well as Value Added Clarification and Transformation (VCAT) to healthcare providers, community leaders for them to have the capacity to intervene and change the narrative.

At the community level, a great deal of social norms that once practiced deters men from effective engagement in FP-related issues, mostly in resource-constrained countries. It has also been conceived that use of FP violated social norms uplifting large family size, which resulted in aspiration to fit in and adhere to societal pressure, depressing male participation in FP [50]. As men get involved in excessive consumption of traditional liquor, they disregard FP issues at the household level. This is coupled with the patriarchal system, which is embedded in gender stereotypes where men as heads of households do not allow their partners to use FP methods. It is also asserted that, male who resist their partners to use contraceptives undermine women's reproductive autonomy and increase undesired pregnancies in SSA

[56]. Among many causes which make men forbid their partners to use FP is the possibility of having large families as a social credit in the community, hence they find no reason to partake in FP programmes. The fear of men to accompany their partners for maternal health services is still hampering FP uptake, as men fear to be stigmatised by their fellow men. A study conducted in Ethiopia revealed similar findings that the appearance of men in health facilities was seen as unfamiliar and socially undesirable [57]. As a result, only few men participated in matters related to maternal and reproductive health.

Conclusion

Male participation in the uptake of family planning methods is an important aspect of the improvement of maternal and child health services; however, the study has found a very low male involvement in FP uptake in Bahi district. This is not withstanding of several initiatives that have been undertaken at the local and national levels, including formulation of policies. The findings have revealed such low male involvement in FP uptake despite the presence of diverse legal instruments responsible for enforcing male participation in FP uptake. The low male involvement was found to be influenced mainly by the deep-rooted social norms, continued myths and misconceptions, and unfriendly healthcare settings for men to participate in FP effectively. Also, weak health system that limits male access to FP methods coupled with few male FP choices and religious beliefs was also found to limit male involvement in family planning uptake.

Recommendations

In order to effectively address the existing social norms, myths, and misconceptions, developing and implementing health promotion programs is crucial, especially during local meetings where healthcare providers can also be invited to discuss male involvement in FP uptake. This should go hand in hand with the implementation of outreach and advocacy services will demystify existing myths and increase men's demand for FP methods. Again, the health system needs to be designed to accommodate males who opt to accompany their partners for maternal health care. This should go hand in hand with establishing male-friendly corners, clinics, while extending hours to attend male who come for the facility seeking FP methods. It is also important to ensure there is a display of social behaviour change communication posters in health facilities in the country as well as ensuring strategic plan and resource mobilisation to sustain male-friendly programme at the district level which will include providing training among health workers, community health workers and male champions on effective service provision for male who seeks FP related services at the facility level in the country.

Abbreviations

ANC	Antenatal Care
IDI	In-depth Interview
FP	Family Planning
SDG	Sustainable Development Goal
ICPD	International Conference on Population and Development
MMR	Maternal Mortality Ratios
CHMT	Council Health Management Team
RCH	Reproductive and Child Health
HCP	Health Care Provider

Supplementary Information

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Supplementary Material 1.

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Authors' contributions

F.H.O. conceived and designed this study. C.J.M and Y.E.K supervised the implementation of field research and data management. F.H.O. collected and analysed the data and drafted the manuscript. All authors read and approved the final version of the manuscript.

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Data availability

"Data is provided within the manuscript or supplementary information files". The datasets generated and analysed during this study are not publicly available since participants did not consent to publicly sharing their information. However, the corresponding author's summaries are available upon reasonable request. All study participants' interviews guides are also available upon request.

Declarations

Ethics approval and consent to participate

The Ethics Review Committee of Ardhi University, Tanzania Ref approved this study. No HD/T.1549/2020. Ardhi University has been mandated to issue research and ethics clearance to its staff and students on behalf of the Government of Tanzania and the Tanzania Commission for Science and Technology (COSTECH). Participants in this study were requested to participate verbally and in writing. The collected data was treated confidentially and was used by the research team only. The privacy of the participants in this study was also upheld. The research was done in compliance with the Helinski Declaration where the participants wellbeing, integrity, dignity, autonomy, privacy and confidentiality of their personal information were preserved, besides best interest and rights have been highly valued and protected; thorough evaluation has been done throughout the process; ethical standards were in check; the environment has been preserved by minimizing the use of papers. Further, the research was conducted with skilled and qualified persons, people living with disability and people from hard-to-reach communities were prioritised in the study, participants' free and informed consents were obtained, relevant literature and information from skilled key informants were collected and documented, no risks or burdens were encountered.

Consent for publication

Not applicable.

Competing interests
The authors declare no competing interests.

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