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A secret for survival: covert contraceptive use and the burden of male resistance to family planning in Kigezi, Uganda

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Abstract

In the rural highlands of Uganda's Rubanda District, a region with a critically high maternal mortality rate, women's attempts to plan their families are often shrouded in secrecy due to spousal opposition.While male opposition is a well-documented barrier to contraceptive use in sub-Saharan Africa, the literature lacks a deep, context-specific understanding of the dynamics driving this resistance in critically high-burden settings like the Rubanda District, Uganda, where women are compelled to resort to covert contraceptive use.This qualitative study explores the lived experiences of women to understand the underlying drivers of male resistance to Long-Acting Reversible Contraceptives (LARCs). Data were collected through a combination of eight in-depth interviews (IDIs) with individual participants and two focus group discussions (FGDs) comprising seven and nine women respectively. The findings indicate that male resistance is not monolithic but stems from a complex interplay of factors: deep-seated misinformation due to exclusion from health education, powerful socio-cultural norms that equate masculinity with high fertility, and the pervasive impact of alcohol abuse, which leads to the abdication of familial responsibilities. These barriers compel women to adopt contraception covertly, placing them at risk of marital conflict and domestic violence. This secrecy arises from the lack of husbands' engagement in health programs and reflects women's determination to safeguard their health and secure the wellbeing of their children. The paper amplifies these women's voices, illuminating their silent struggle and emphasizing the urgent need for systemic interventions and health programs that actively involve men, challenge harmful social norms, and remove barriers to equitable and collaborative family planning.

Keywords Covert contraception, Male resistance, Family planning, Contraceptives (LARCs), Alcohol abuse, Gender norms

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Background

Globally, a woman dies from causes related to pregnancy and childbirth approximately every two minutes [1]. This global crisis is acutely felt in Uganda's Kigezi region, where the maternal mortality ratio (MMR) in districts like Rubanda significantly exceeds the national average. Rubanda registers approximately 500 deaths per 100,000 live births, compared to the national average of 189 deaths per 100,000 live births [2]. A primary driver of this preventable tragedy is the high rate of unintended pregnancies [3, 4], which perpetuates cycles of malnutrition, unsafe abortion, and intergenerational poverty [5–7].

Although proven interventions such as Long-Acting Reversible Contraceptives (LARCs) offer a reliable means of preventing unintended pregnancies [8], their uptake in Rubanda District remains alarmingly low at 14% [9]. While research across sub-Saharan Africa has consistently identified male opposition as a key barrier to contraceptive use, there is a need for deeper contextual understanding of how these dynamics operate in specific high-burden settings [10]. Studies have consistently shown that men in the region tend to desire more children than their wives, and a husband's opposition to family planning can prevent a woman from using a method even when she wants to stop childbearing [10]. This study sought to identify and understand the underlying reasons why women in Rubanda District, Uganda, adopt and use family planning methods covertly without their partners' knowledge.

This research is framed within theoretical understandings of gender, power, and masculinity that shape reproductive health decisions [11]. The concept of "hegemonic masculinity," where social status is tied to virility and fertility, provides a lens for understanding why men may resist contraception, viewing it as a threat to their identity and authority [12]. This dynamic is compounded by structural factors that limit women's agency, a central concern in the "unfinished agenda" of family planning, which highlights the persistent gap between women's desire to control their fertility and their ability to do so [13]. Despite progress, in many low-income countries, contraceptive use remains low while fertility and the unmet need for family planning are high [13]. Furthermore, by engaging with Uganda's National Family Planning Costed Implementation Plan (FP-CIP II), this study provides critical insights for policymakers, revealing how grassroots realities of gender inequality and social norms can undermine national health objectives [14]. To deconstruct the complexities of this male opposition family planning, this study centers the perspectives of women. By analyzing their narratives, we sought to illuminate the real-world impact of their husbands' resistance and to understand the daily struggles of women navigating a landscape of misinformation, rigid cultural norms, and systemic neglect.

Methodology

Study design

This study employed a qualitative, phenomenological research design to gain a deep and nuanced understanding of the lived experiences of women facing spousal resistance to family planning. This approach was selected for its suitability in exploring personal perspectives, social contexts, and the meanings individuals ascribe to their experiences [15].

Study setting and sampling of participants

The study recruited 24 married women aged 18 to 40 from the rural sub-counties of Nyamweru and Muko, Rubanda District, an area chosen for its high rates of maternal mortality 541 per 100,00 live birth and low contraceptive uptake. The research team used a purposive sampling strategy to select participants who met the following initial criteria: they had to be currently married and current users of any modern contraceptive method. This focused the study on women in their prime reproductive years who were already navigating family planning decisions in this specific high-risk setting.

Recruitment was facilitated through established networks, including health facility registers and referrals from Village Health Workers (VHTs), and was supplemented by informal peer referrals (resembling snowball sampling). While the selection criteria were straightforward, the study's central and emergent finding was the prevalence of covert contraceptive use women using methods without their husbands' knowledge. This sensitive practice was not an initial screening requirement but became the dominant theme explored during data collection. The sampling intentionally did not filter based on factors like education level, number of children, or type of contraceptive (LARCs), ensuring the final sample captured the diverse reality of contraceptive users in the area.

Data collection

Data were collected through a combination of eight in-depth interviews (IDIs) with individual participants and two focus group discussions (FGDs) comprising seven and nine women respectively. The women who participated in the IDIs were different from those in the FGDs, ensuring a wider range of perspectives and preventing overlap of responses. The IDIs allowed for deeper exploration of highly personal and sensitive experiences that women might not have felt comfortable sharing in a group setting, while FGDs created space for interactive dialogue and the emergence of collective community perspectives. Together, these approaches complemented one

another and strengthened the phenomenological design of the study.

To promote trust and open participation, all study sessions were held in secure and easily accessible community locations. The researchers used a semi-structured interview guide with open-ended questions to explore key themes while allowing for emergent topics. The discussions were conducted in the local language, Rukiga, by the researcher to ensure participants could fully express themselves. All sessions were audio-recorded with explicit participant consent. The audio recordings were then transcribed verbatim and translated into English for analysis.The research approach aimed to capture both deeply personal experiences and collective insights.

Data analysis

A systematic thematic analysis was conducted to identify, analyze, and report patterns within the data [16, 17]. The analysis process involved the researchers familiarizing themselves with the transcripts through repeated reading, generating initial codes, and organizing them into potential themes. This was followed by an iterative refinement to ensure the themes accurately reflected the participants' narratives. To enhance the trustworthiness of the findings, two researchers independently reviewed the codes, discussed any discrepancies, and resolved them to reach a consensus on the final thematic structure.

Ethical considerations, rigor, and limitations

The study was conducted in accordance with the Declaration of Helsinki. Ethical clearance was granted by the University of South Africa (UNISA Rec-240816-052) and The AIDS Support Organisation Uganda (TASO-2021-56). Final research approval was obtained from the Uganda National Council for Science and Technology (UNCST, HS2152ES). All participants provided written informed consent prior to data collection, and anonymity was maintained throughout the research process [18].

Protecting participants was paramount due to the sensitive nature of covert family planning. We ensured all interviews occurred in private, confidential settings selected by the women. Trained female interviewers led the discussions, fostering a comfortable atmosphere, and pseudonyms protected identities. Furthermore, a critical safety measure involved immediate referral to appropriate psychosocial and health support services for any participant experiencing distress. Data security was maintained by restricting access to the core research team.

Ensuring qualitative rigor, the researchers engaged in continuous reflexivity, acknowledging our positions as academic researchers and the influence this could have on interpreting women's narratives. The principal investigator, a trained nurse with expertise in community and reproductive health, conducted the interviews. While this background effectively built rapport and offered a nuanced understanding of participants' perspectives, it simultaneously posed a risk: participants might view the investigator as an agent of the health system and thus be cautious when disclosing sensitive issues. To address this, the investigator actively counteracted potential gender and professional hierarchies by ensuring strict confidentiality, using neutral settings, and maintaining a reflexive stance throughout to critically evaluate how professional assumptions might color the findings.

The study also acknowledges key methodological limitations: its exclusive focus on women's perspectives a gap future research should fill by including men's viewpoints for a holistic understanding and potential challenges associated with translating complex social and emotional experiences from Rukiga to English, alongside the inherent power dynamics present in research settings like focus group discussions.

Findings

The findings, summarized in Table 1 below, highlight significant barriers women face in obtaining support from their husbands regarding the use of Long-Acting Reversible Contraceptives (LARCs). The responses reveal the role of cultural beliefs, misinformation, and social behaviors in shaping male opposition to family planning.

Demographic profile of study participants

The study involved women aged 18–45 years residing in two sub-counties of Rubanda district. Participants varied in marital status, parity, and education level, with the majority being married and having between three and eight children. Most participants had limited formal education, and many reported their husbands had no formal education. Socio-economic conditions were generally low, with most households reliant on subsistence farming. This demographic context is important for understanding the barriers women faced regarding Long-Acting Reversible Contraceptive (LARC) use.

From Table 1 above, it is evident that women's experiences clustered around four major themes: limited male engagement and misinformation, cultural and social barriers, alcohol use and lack of responsibility, and covert use of family planning due to male resistance as per details below.

Limited male engagement and misinformation

Women reported that their husbands rarely participated in family planning sensitization programs. Many men did not attend church, where some awareness efforts were held, and therefore had limited exposure to health education. Low education levels further contributed to their lack of understanding about reproductive health

Table 1 Summary of the theme, categories and sub-categories emerging from focus group interviews in two sub-counties of Rubanda district

Theme	Sub-Themes	Categories
Limited Male Engagement and Misinformation	Lack of participation in sensitization programs	Men do not attend church-based family planning sessions
	Low education levels and misinformation	Men lack understanding of contraceptive methods; believe LARCs cause infertility or harm the uterus.
Cultural and Social Barriers	Fertility as a sign of masculinity	Men believe having many children defines manhood
	Social expectations for large families	Children are seen as wealth and social status
	Perceptions of infidelity	Men think contraceptive use encourages women to cheat
	Religious and traditional beliefs	Men believe contraception interferes with God's plan
Alcohol Use and Lack of Responsibility	Frequent drinking in village bars	Men prioritize alcohol over family responsibilities
	Financial neglect of children	Women struggle alone to provide food, school fees, and healthcare
Covert Use of Family Planning Due to Male Resistance	Fear of domestic violence	Women use LARCs secretly to avoid conflict
	Hidden contraceptive use	Women seek family planning services without informing their husbands
	Male dominance in reproductive decisions	Men do not allow wives to use contraceptives

and contraceptives. One woman, aged 32, said in an FGD, *"Our husbands do not go to church where some family planning teachings are given, so they don't even hear about these things."* Another woman, aged 28, explained in an FGD, *"My husband never went to school and doesn't understand how family planning works. He refuses to even talk about it."*

Participants also highlighted common misconceptions their husbands had about contraceptives. Some men believed that family planning led to infertility or damaged the uterus, while others associated contraceptive use with infidelity. A 24-year-old woman stated in an FGD, *"My husband told me that if I use family planning, my womb will get spoiled, and I will never have children again."* Another, aged 34, said in an IDI, *"He says if I prevent pregnancy, it means I want to sleep with other men."* This finding was more common among women aged 24 years and above.

Cultural and social barriers

There was a strong cultural expectation that men should father many children to affirm their masculinity. Women indicated that their husbands believed a large family was a sign of strength and social status. Any attempt to limit childbirth was viewed as a challenge to their role as men. One participant, aged 25, explained in an IDI, *"Here, a man is respected if he has many children. If you try to stop giving birth, he thinks you are disrespecting him."* Another, aged 29, shared in an IDI, *"Men believe that children are wealth and prestige. The more children you have, the more respected you are in the village."*

Women overwhelmingly reported that their husbands did not support them in using LARCs. Some participants reported that decisions about childbearing were often controlled by men, leaving women with limited autonomy. A 29-year-old woman, mother of five, explained in an FGD, *"Even when I explain that I am the one suffering with the children, he still refuses to let me use family planning."* Another participant, aged 33 and a mother of four, shared, *"My husband says family planning is against our culture. He wants more children even when we can hardly feed the ones we have."* Similarly, a 22-year-old woman, mother of three, remarked, *"He believes that as long as he paid my dowry, I have no right to decide for myself about using family planning and the number of children."* This finding cut across all age categories of participants.

Alcohol use and lack of responsibility

A recurring theme was men's frequent alcohol consumption, which significantly undermined their involvement and responsibilities in family matters. Women consistently reported that their husbands prioritized spending time drinking in village bars over attending to household duties or contributing financially. Consequently, women shouldered the entire financial and caregiving burden for their children.

This situation revealed a critical analytical frame that directly necessitated covert action. Men's neglect of the traditional male provider role led to profound financial hardship, which stood in direct contradiction to their simultaneous demand for high fertility. Since women were solely responsible for the financial welfare and survival of their existing children, they viewed limiting family size as an economic necessity. Therefore, covert use of LARCs became the only available strategy to control the household budget, ensuring the welfare of their families while bypassing their husbands' irresponsible and contradictory reproductive demands.

This failure to provide was powerfully illustrated by a 30-year-old woman in an FGD, who said, *"Our husbands spend the whole evening drinking in bars. They don't even know how food reaches the table."* Another participant, aged 25 and a mother of three, shared, *"When children fall sick, I struggle alone; my husband just drinks and tells me to figure it out."* Faced with such circumstances,

women expressed that using contraceptive methods covertly was the only way to protect themselves and their children from further hardship.

As one 25-year-old mother of three explained, *"If I have more children, I will suffer alone. That's why I started family planning without telling him."* For many, secrecy was not an act of rebellion but a rational and protective response to economic neglect and male irresponsibility. Covert contraceptive use, particularly long-acting methods, allowed them to quietly control fertility, safeguard their health, and ensure the survival of their existing children amidst persistent financial and emotional abandonment. This finding was mainly reported among women aged 25 years and above.

Covert use of family planning due to male resistance

Covert contraceptive use was adopted out of necessity, driven by the fear of adverse spousal reactions. Participants consistently reported that revealing their contraceptive use could incite domestic violence, including physical abuse or escalating conflict within the home. Beyond these immediate safety concerns, women viewed secrecy as a critical measure to protect their physical well-being and to control family size, as men were not financially supportive and left all the burden of provision to the women. This prioritization of their children's health and welfare was deemed essential.

A 23-year-old woman said in an IDI, *"I had been using family planning for three years, but my husband never knew. If he found out, he would beat me."* A 31-year-old mother of eight explained in an FGD, *"We hide these things because if our husbands know, they will say we are disrespecting them."* Another participant, aged 28 and a mother of five, said, *"I had too many pregnancies close together, and my health was failing. I had to use family planning secretly to rest my body."* Additionally, a 24-year-old stated, *"If I told him, he would stop me, yet I was tired and sick after the last baby. I used family planning quietly for my health."*

Findings further indicated that women made deliberate decisions to discontinue contraceptive use when they considered it the appropriate time to have another child or when they wished to conceive.

Discussion

The findings of this study illuminate the complex web of socio-cultural, educational, and behavioral factors that fuel male resistance to LARCs in Rubanda District, forcing women into precarious positions.

The theme of male disengagement from health information directly confirms existing research indicating that men's limited exposure to health education and low literacy levels are significant barriers to family planning acceptance [19–22]. Our study adds a critical dimension by reframing this disengagement: it is not merely a systemic gap, but an active exercise of power. By maintaining a state of willful ignorance and relying on pervasive misinformation, men strategically reinforce their patriarchal right to be the ultimate decision-makers on fertility. Capturing the women's profound frustration with this "wall of silence" frames it as an intentional impediment to marital partnership rooted in a fundamental imbalance of gender power.

The cultural equation of masculinity with high fertility is a powerful deterrent, a finding that resonates strongly with research across sub-Saharan Africa [11, 12, 23, 24]. The belief that "children are wealth" is a core tenet of hegemonic masculinity in this context, reinforcing traditional gender roles where male dominance dictates ultimate reproductive authority, severely limiting female autonomy [10, 19, 25]. This finding is critical because it reveals that the standard for being a man in Rubanda is directly linked to an anti-family planning stance, which directly restricts women's ability to negotiate family size [10, 26–28]. This highlights that simply promoting joint decision-making is insufficient; interventions must actively work to redefine hegemonic markers of masculinity to include responsible fatherhood and shared welfare, rather than just virility. Furthermore, the pervasive impact of alcohol abuse emerged as a central catalyst for men's abdication of responsibility. This behavior exacerbates household stress and diverts scarce resources [23, 24]. Critically, alcohol abuse accelerates the structural inequality of gender power by directly impairing the men's ability to perform the masculine role of provider. As men spend resources on alcohol, the resulting financial neglect forces women to become the sole financial planners, viewing LARC use as the only viable mechanism to limit family size to what they can realistically support. This establishes a clear, causal link between the men's failure to provide and the women's strategic, covert control of their fertility [29].

Consequently, the prevalence of covert contraceptive use, driven fundamentally by the fear of domestic violence [10, 19, 24,30], is not merely an act of defiance but a necessary survival strategy that highlights a severe imbalance of gender power. This secrecy is a direct response to male dominance, where a woman's exercise of reproductive agency is perceived as a challenge to patriarchal authority, often triggering the use of violence (GBV) as a mechanism of control [31]. While covert use demonstrates the women's resilience, this reality underscores the inadequacy of standard public health interventions. For example, while programs like 'Men as Partners' have shown success in other contexts by promoting male engagement [32], our findings suggest their effectiveness in Rubanda will be severely limited. These interventions often focus on addressing misinformation and

male literacy, yet they fail because they do not confront the core issue: the power dynamics that motivate men to willfully ignore health information to maintain reproductive control. Therefore, future programs must be explicitly designed to dismantle the foundational issues of male dominance and inequitable power relations in relationships, particularly those exacerbated by chronic alcohol abuse and financial neglect. The solutions recommended by this paper are consequently deeply contextualized by the specific, interlocking power barriers that must be confronted to achieve safe, collaborative family planning in this region.

Conclusion and recommendations

In Rubanda District, women's access to safe and planned motherhood is obstructed by a deeply entrenched system of male resistance fueled by misinformation, cultural pressures, and neglect. This reality forces women to bear a silent burden, often resorting to clandestine measures to exercise control over their own bodies and secure their families' futures. This situation is both unsustainable and unjust. To dismantle these barriers, a fundamental shift in public health strategy is required. Interventions must move beyond a singular focus on women and actively engage men.

To significantly increase male engagement in family planning and improve reproductive health outcomes, a multi-pronged approach is recommended. This involves developing male-centric health education by delivering family planning information directly in male-dominated spaces like markets and transportation hubs. Simultaneously, a key strategy is to reframe masculinity through community dialogue, collaborating with traditional and religious leaders on campaigns that redefine positive masculinity to include responsible fatherhood, shared decision-making, and family protection, thereby challenging restrictive traditional norms. Furthermore, it is essential to integrate health and social services by linking family planning with programs that address alcohol abuse, as excessive drinking by men often leads to neglect and opposition to contraception, forcing women to shoulder the full financial and childcare burden. Finally, programs must actively promote spousal dialogue by implementing and scaling up initiatives, such as couple's counseling, to establish safe and structured platforms for couples to communicate about their reproductive health and shared family goals.

In addressing the root causes of male resistance and championing a vision of masculinity grounded in partnership, it is possible to lift this silent burden from women and foster a future where every child is wanted and every family can thrive.

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Author contributions
Ronald Arineitwe Kibonire conceptualized the study, designed the study framework, led data collection and interpretation, prepared the manuscript, and reviewed the paper. He is the principal investigator. David Ditaba Mphuthi, as co-author, provided guidance throughout the study's conception, design, data collection, and analysis phases, reviewed the manuscript, and offered valuable feedback for refinement. He served as the co-investigator. Muzafaru Twinomujuni was part of the data collections and analysis and also helped in reviewing the abstract.

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Data availability
The primary study document, including the detailed information and dataset used and analyzed, is available upon reasonable request from the corresponding author.

Declarations

Ethics approval and consent to participate
This study was conducted in accordance with the Declaration of Helsinki and all applicable ethical guidelines for research involving human participants. Clearance to conduct this study was obtained from the Department of Health Studies at the University of South Africa, under registration number UNISA Rec-240816-052. Further ethical approval was granted by The AIDS Support Organisation Uganda (TASO) Ethics Committee, under registration number TASO-2021-56, and final clearance for data collection was obtained from the Uganda National Council for Science and Technology (UNCST), reference number HS2152ES. Informed consent was obtained from all participants prior to their involvement in the study.

Consent for publication
The researchers obtained written consent to use quotes from participants in publications.

Competing interests
The authors declare no competing interests.

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