Couple School Cohort, Uganda
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INSIGHTS SYNTHESIS MAVERICK NEXT UGANDA COUPLES' CONTRACEPTIVE COMMUNICATION PROJECT

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EXECUTIVE SUMMARY

The philanthropist-funded Maverick Next Uganda Couples' Contraceptive Communication project was implemented by PSI Uganda (PSIU) from May 2023 through June 2025 in Busukuma and Gombe sub-counties of Wakiso District, Uganda. PSIU leveraged a human-centered design (HCD) approach to develop targeted social behavior change (SBC) interventions that promote healthy, informed, and gender-equitable couples' communication regarding family planning (FP). In tandem with these SBC activities, Maverick designed and implemented quantitative and qualitative research activities for monitoring & evaluation (M&E) purposes. The research also aimed to fill evidence gaps pertaining to couples' FP decision-making dynamics and male partners' knowledge, attitudes, and behaviors concerning to FP, child spacing, and related gender norms. The project intentionally selected a small geographic area for all SBC and research activities to achieve a 'saturation' effect and maximize the likelihood of generating measurable change.

The Maverick research activities included a baseline and endline Household Survey with a sample size of ~500 men (ages 20-30) and ~200 women (ages 18-30); as well as qualitative In-Depth Interviews (IDIs) with 16 couples (of the same ages) who participated in the 'Bufumbo College' activity; a seven-session couples' communication course covering the topics of family goal setting, gender roles, communication, child spacing, family planning, and myths.

The project's learning agenda achieved the following objectives:

- Baseline findings were used to shape and adapt the project's SBC messaging and strategy
- The couples' IDIs offered rich insights into couples' SRH decision-making dynamics within the study area, which can inform future programming
- The quantitative household survey data and qualitative IDI data helped evaluate the project's impact, with some indicators suggesting that statistically significant shifts in desired knowledge, attitude, and behavioral outcomes were achieved.

The research findings also validated the Maverick program team's central hypotheses going into the project. Among these, it was confirmed that men's knowledge of FP methods is low and that myths about perceived health risks of using female contraceptive methods are very prevalent among male partners, which can present a major barrier to women's uptake and continuation of contraception. Furthermore, the vast majority of married women among the survey population stated that they preferred to make family planning decisions jointly with their partner rather than unilaterally. This suggests that covert use is seen as highly undesirable and that unilateral FP decisions are the exception rather than the norm among married / cohabiting couples within the study area. Lastly, both gender norms and concerns about sexual pleasure significantly factored into couples' FP decision-making dynamics. Among both women and men, concerns about reduced pleasure and/or failure to uphold societal expectations regarding gender roles were both cited as reasons for negative attitudes towards multiple types of contraception, including vasectomy, condoms, and female-controlled methods.

These learnings, which are presented in depth below, offer actionable insight for the global SRH community of practice for advocacy, policy, and program design purposes. As a key takeaway message, the authors of this brief recommend that the definition and framing of Informed Choice should be customized to suit the programmatic target audience. In particular, Informed Choice should be defined as either Individual-based or Couples-based depending on whether it is the individual client or the couple who is making FP decisions. In contexts like Wakiso where couples' joint decision-making is the norm rather than the exception (at least among married people), Couples' Informed Choice is a more appropriate framing than Individual Informed Choice. The distinction is important given that Couples' Informed Choice can be easily infringed by information-based and gender-based barriers even if the woman in the couple receives the highest quality information and counseling from trained FP providers.

BROADENING INFORMED CHOICE BEYOND THE INDIVIDUAL

INDIVIDUAL (WOMEN'S) INFORMED CHOICE

COUPLES INFORMED CHOICE

CLIENT PROFILE

INDIVIDUAL (WOMEN'S) INFORMED CHOICE	COUPLES INFORMED CHOICE
Covert users, unmarried or independent women. More common in individualistic societies.	Couples (often, married) who prefer to decide on FP jointly. Very common in more communitarian societies.

PARADIGM BENEFITS

INDIVIDUAL (WOMEN'S) INFORMED CHOICE	COUPLES INFORMED CHOICE
Prioritizes women's knowledge and emphasizes women's reproductive autonomy.	Acknowledges the reality that men are (very often) part of the FP decision-making equation.

CONTRACEPTIVE OPTIONS

INDIVIDUAL (WOMEN'S) INFORMED CHOICE	COUPLES INFORMED CHOICE
Limited to only female methods.	Maximum options. Female and male methods including vasectomy and condoms.

INFORMATION FLOW

INDIVIDUAL (WOMEN'S) INFORMED CHOICE	COUPLES INFORMED CHOICE
Health system communicates with women only.	Health system proactively shares FP information with male partners to prevent myths.

RISKS

INDIVIDUAL (WOMEN'S) INFORMED CHOICE	COUPLES INFORMED CHOICE
• Perpetuates the stereotype that men are not contraceptive users. • Couples are more susceptible to the influence of myths, undermining women's autonomy.	• Couples' Informed Choice cannot be achieved if men are under-informed. • Risk of coercion if men are not engaged in a gender transformative fashion.

NORMS

INDIVIDUAL (WOMEN'S) INFORMED CHOICE	COUPLES INFORMED CHOICE
Current default paradigm for FP programming. Engaging men is often perceived as 'risky'.	Evidence suggests couples' joint decision making is the norm in much of the Global South, yet Informed Choice models often neglect partner influence.

BACKGROUND LITERATURE REVIEW

The PSI Sexual and Reproductive Health (SRH) team has sought to be increasingly gender transformative with its approach to program design. To generate insights into effective male engagement strategies for SRH interventions, an extensive literature review was conducted which synthesized findings from more than 30 research papers pertaining to SRH male engagement interventions in sub-Saharan African geographies. The key takeaways that were generated from this review which were used to inform the Maverick project's approach included:

- Entrenched gender norms limit who is eligible to be considered as an SRH client, with the normative viewpoint being that only women should receive SRH services or information from trained FP providers[1].
- It is widely assumed that women will pass this SRH information to their partners, but in practice, male partners have more trust in information they receive from male peers or directly from health workers[2].
- Within the sub-Saharan African region, myths and misperceptions pertaining to contraception are rampant, and are more widely believed by men than women[3].
- Male-controlled contraceptive methods (condoms and vasectomy) are highly unpopular and stigmatized in this region, with concerns about diminished pleasure (with condoms) and undermined masculinity (with vasectomy) commonly cited as reasons for low uptake[4]. Injectables are the most popular category of contraceptives in the region[5].
- When implemented skillfully and in a gender transformative manner, SRH male engagement interventions have been proven to 'move the needle' in terms of positively influencing male partner knowledge, attitudes, and behaviors pertaining to SRH and adjacent health areas. Effective male engagement commonly 'breaks silos' by contributing to positive health outcomes across multiple health areas including FP, MNCH, HIV/AIDS, and GBV prevention[6].
- Selecting the right messengers and reaching men 'where they are' with a combination of accurate FP information and gender-transformative messaging are critical drivers of success for SRH male engagement interventions[7].

These learnings from the sub-Saharan Africa region were further supplemented with data specific to Uganda which confirmed many of the trends outlined above. Additionally, PMA survey data found that 62% of Ugandan women of reproductive age decide on contraception jointly with their partner; 7% defer to their partner to decide; and only 31% decide on their own[8]. Furthermore, Uganda had an estimated 22% unmet need for contraception as of 2022, as per Uganda Demographic Health Survey Data. To address these identified challenges and opportunities, PSI sought to design and implement an evidence-based, gender-transformative program that would innovate while also drawing upon proven best practices.

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DEFINING THE TARGET AUDIENCE, PROJECT GEOGRAPHIES, AND PERFORMANCE INDICATORS

PSIU's first order of business during project startup was to define 'success', select the target audience, and narrow down sub-counties where the project would be implemented. The project's two target audiences for SBC activities were defined as:

- Heterosexual male partners (in long-term relationships) ages 20-30 who are living with their wife/partner, have at least one child together, and fall in the lower two wealth quintiles
- Heterosexual couples in which the man is aged 20-30 and the woman is 18 or older, who have had at least one child together, and fall in the lower two wealth quintiles.

These parameters were selected based on the assumption that younger men and couples who were less economically advantaged and at an earlier stage of family planning would stand to benefit the most from support with FP decision-making—compared to wealthier couples or those who already had larger family sizes. Men were considered the main target audience of the project's intended SBC agenda, however, one of the project's workstreams specifically engaged couples.

Busukuma and Gombe sub-counties of Wakiso district were selected as Maverick's geographies based on the following factors:

- Health system factors: Availability of PSIU-supported healthcare facilities, including health centers and hospitals, in each sub-county that can service referrals.
- Population dynamics: Sub-counties with a high population of women aged 20-30 years were prioritized as they were considered to have greater demand for FP education and services.
- Economic factors: Sub-counties that have variable and vibrant economic activities beyond subsistence farming for men (such as boda-boda riding, brick making, sand mining, stoney quarries, and factories) were prioritized.
- Peri-urban sub-counties were prioritized in that there would be a clearer connection between family size, aspiration, and quality of life compared with more settled communities/population.

The following three Program Outputs were agreed upon, on the basis that they contribute to the Primary Outcome ("women have improved voice, choice, and agency to decide on contraception"):

1. Increased accurate knowledge and understanding of contraception among men.
2. Understand men's attitudes and behaviors towards modern contraception and child spacing
3. Healthy and balanced couples' communication on contraception.

THEORY OF CHANGE

VISION	Women exercise their power to improve and enjoy their SRH		
PRIMARY OUTCOME	Women have improved voice, choice and agency to decide on contraception		
TARGET AUDIENCE	Men; Couples		
INTERMEDIATE OUTCOMES	Men are more informed and involved in supporting women's reproductive autonomy	More equitable decision-making power on contraception use amongst couples	Contraception is perceived as men's and women's shared responsibility
OUTPUTS	Increased accurate knowledge and understanding of contraception amongst men	Men have more favourable attitudes towards the role of contraception in their lives	Healthy and balanced couple's communication on contraception

HUMAN-CENTERED DESIGN (HCD) PROCESS

A user-centric approach is fundamental to PSI Uganda's strategy for addressing any public health challenge. To generate promising intervention ideas, PSIU held HCD workshops (one per subcounty) bringing together 36 participants from the target audiences. By including both male and female participants in the workshops, PSIU was able to 'triangulate' and discern whether men's self-reported attitudes and behaviors differed from what was observed and reported by women.

The design workshops gathered insights around the following four questions:

- How might we normalize child spacing amongst men?
- How might we help men understand and trust the contraception options available?
- How might we motivate male support of women's contraceptive autonomy?
- How might we encourage men to have balanced conversations around child spacing with their partners?

As a result of the insights and ideation from these workshops, five intervention-prototypes were developed and selected as full-fledged SBC workstreams, namely:

1. **Workplace influencers** (WPIs) who are trained to reach men with accurate FP information and gender transformative messaging 'where they are' via a peer-to-peer approach; selected workplaces included boda boda (motorbike taxi) stages, markets, factories, stone quarries, and bricklaying sites.
2. Male **'safe spaces'** that equip men with health information and services from trained providers—held in convenient locations near workplaces on a 'pop up' basis suited for quick mobilization.
3. **Community dialogues** that bring together influential people to share information on relevant SRH and gender-related topics. These dialogues are instrumental for debunking FP myths and misconceptions and normalize men's involvement with SRHR.
4. **Radio drama skits** designed to appeal to the target audience and foster gender transformative discussions on FP and joint decision-making, with the aim of helping men to recognize that SRHR is not solely a woman's responsibility.
5. **Couple's communication 'college' (Bufumbo College).** Bufumbo is the Luganda (local dialect) word for 'marriage'. The Bufumbo College is a seven-session course specially designed to promote healthy, gender equitable, and well-informed couples' communication regarding family planning. Out of a total of 85 couples enrolled in Bufumbo College, a sample of 16 were selected to participate in qualitative In-Depth-Interviews (IDIs) for learning purposes.

Further information regarding PSIU's HCD approach can be found in the projects HCD Technical Brief.

Men review poster messages for clarity, appeal, and relevance
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RESEARCH METHODOLOGY

The two Research activities (Bufumbo College IDIs and quantitative household surveys) served a dual purpose as monitoring & evaluation (M&E) tools, and as a means of filling evidence gaps to support the SRHR community of practice. The Baseline household survey was conducted prior to activity rollout in early 2024, whereas the Endline survey and IDIs were both conducted in 2025. The Baseline survey findings also validated and influenced the project's SBC channel selection and messaging approach. Maverick submitted a protocol to Mildmay Uganda Research Ethics Committee (MUREC) which was approved in February 2024.

Two rounds of household level cross-sectional surveys (baseline and endline) were planned to be conducted in study areas to better understand the community-level impact of program activities on key indicators listed above. PSIU conducted these surveys among randomly selected men and women to enable us to assess changes across project performance indicators over time at the population level, as well as to measure the possibility of diffusion of ideas emanating from program activities. The surveys were conducted in the project sub counties (Busukuma and Gombe) in Wakiso district.

Questions were designed to directly correspond to the project's performance indicators, which align with the three Outputs listed above. Broadly, the survey questions ask about respondents' knowledge, attitudes, and behaviors pertaining to family planning, child spacing, and communication with their partner and peers pertaining to these SRH and associated gender-related topics. Specific questions were also influenced by relevant findings and common patterns identified from the background literature review. For example, questions about myths were informed by common myths that researchers had identified elsewhere in sub-Saharan Africa, such as the belief that injectables cause permanent infertility.

The target sample size for both the baseline and endline surveys is 497 men and 200 women. Eligible participants were those that fell within the project's target audience parameters in terms of age, (18+ for women and 20-30 for men) and parity (at least one child together with the partner they are currently living with), and relationship status (have been living with their partner for 1+ year).

PSI Uganda's Household Survey Data Collection
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The reason for the higher sample size for men is that the project's SBC objectives are geared towards facilitating male behavior change and knowledge acquisition. Female perspectives were mainly sought for comparison purposes as well as to 'triangulate' data on men's self-reported behavior change, i.e. to help discern whether there is a discrepancy between what men are saying about their behavior versus what is observed by the women in their communities. Couples were not recruited, i.e. the men and women were recruited independently of each other.

METHODOLOGICAL LIMITATIONS

PSIU designed the project's household surveys within the context of a constrained budget, and with the intent of maximizing the survey sample sizes to increase the generalizability of the findings. The project's hypothesis was that by focusing 100% of SBC activities within the relatively confined area of two sub counties, we would likely see statistically significant shifts in the general population's knowledge, attitudes, and behaviors by surveying randomly selected members of the target audiences. However, numerous limitations to the survey methodology should temper any interpretation of the survey findings as an assessment of programmatic impact. Most notably, these limitations include:

NON-OVERLAPPING SAMPLES

Baseline and endline surveys were conducted in different villages, introducing potential confounding from unobserved community- and individual-level differences unrelated to the intervention; observed differences may reflect pre-existing differences in outcome levels rather than intervention impacts. For example, the set of villages selected for the endline study might have in fact seen major improvements in men's knowledge of contraception since the start of the project, but this cannot be known given that baseline data was not conducted there.

EXTERNAL FACTORS AND SECULAR TRENDS

Without a contemporaneous control area, it is difficult to rule out external influences or secular trends as alternative explanations for observed changes.

VARIABLE PROGRAM EXPOSURE AMONG ENDLINE RESPONDENTS

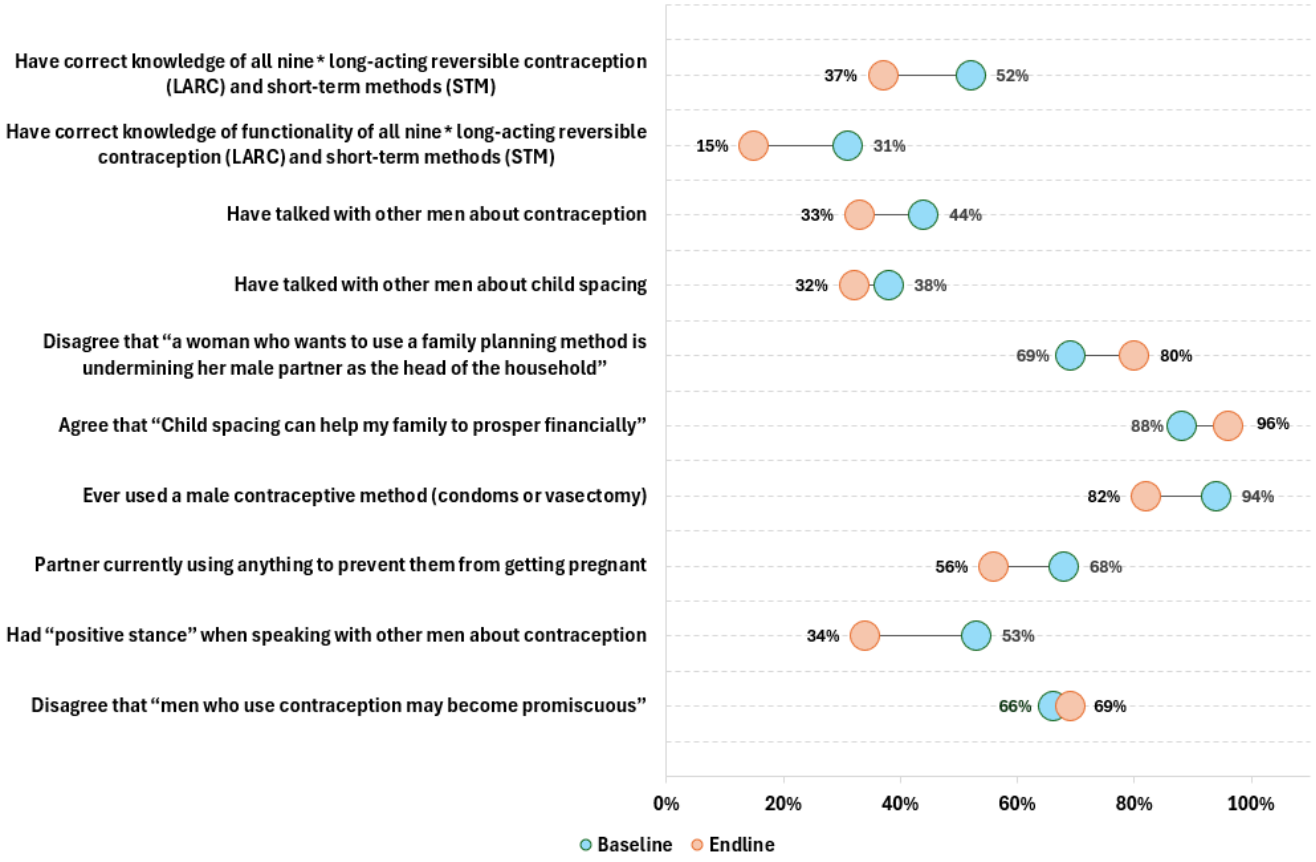
Lack of information on whether or how much endline participants were exposed to the intervention undermines the ability to attribute any observed differences to the intervention itself.

NON-RANDOM SELECTION OF ENDLINE VILLAGES

Endline villages were selected based on where implementation actually occurred, which may bias the sample toward more accessible communities. These findings may not generalize to all villages in the intended intervention area or to other areas of Uganda.

RESEARCH FINDINGS

Household surveys were conducted in April 2024 (baseline) and May 2025 (endline), pre- and post-implementation of SBC interventions. The sample sizes were 498 men and 201 women at baseline and 463 men and 210 women at endline. The PSI research team assessed the statistical significance of baseline to endline shifts using generalized linear models (GLM) which controlled for age, education and interviewer gender[9]. Detailed results (organized by indicator) are presented below, in order of the three outputs / objectives. Statistically significant findings are shown in in the chart below.



For agree / disagree questions, positively worded questions/indicators coded as: agree (1) or neutral/disagree (0). E.g., % agree that Child spacing can help my family to prosper financially. Negatively worded questions/indicators coded as: disagree (1) or neutral/agree (0). E.g., % disagree that a woman who wants to use a family planning method is undermining her male partner as the head of the household

THEMATIC FINDINGS BASED ON DETAILED SURVEY RESPONSES

Whereas the data above show trends based on project performance indicators, an examination of responses to specific survey questions sheds further light on important gender norms and reproductive health equity issues among the target population. Key highlights are summarized below according to thematic area.

FEAR OF DANGEROUS SIDE EFFECTS

As shown in the table below, the survey confirmed the project's hypothesis that men are more prone to believing negative myths about health risks associated with contraceptives, compared to women. This finding is unsurprising given the disproportionate flow of FP information from the health system to female clients relative to male partners. The specific survey questions that were asked were based on common myths from other sub-Saharan African settings, as well as input from PSI Uganda regarding myths they had learned about from word of mouth.

The most prevalent fears were that:

- Hormonal methods cause life-threatening changes to menstrual bleeding (believed by 75-80% of men and 36-40% of women)
- Injectables cause permanent infertility (believed by ~50-60% of men and 21-48% of women)
- Contraceptives cause cancer (believed by 46-56% of men and 10-24% of women)

The prevalent belief among even women that hormonal contraceptives' effects on bleeding are 'dangerous and life-threatening' is worth underscoring as a potentially significant barrier to women's use of such methods, emphasizing the need for FP programs to improve educational outreach efforts. In retrospect, men's beliefs in myths declined significantly from baseline to endline, indicating a positive outcome. In response to the baseline findings on this theme, the project prioritized outreach and messaging designed to debunk these myths and allay men's and couples' fears.

Question	Response	Men		Women	
		Baseline	Endline	Baseline	Endline
		%	%	%	%
Some contraceptives cause cancer	Agree	55.9	45.9	10.5	24.1
	Neutral	16.1	18.6	0.0	0.0
	Disagree	28.0	35.6	89.5	75.9
Injectable contraceptives cause permanent infertility	Agree	62.4	49.9	21.1	48.3
	Neutral	10.3	13.3	0.0	0.0
	Disagree	27.3	36.8	78.9	51.7
Injectable contraceptives cause diabetes	Agree	20.9	11.5	N/A question not asked to women	
	Neutral	20.4	24.8		
	Disagree	58.7	63.6		
Hormonal contraceptives affect women's menstrual bleeding in a way that is generally dangerous and life-threatening	Agree	80.7	75.9	45.6	36.2
	Neutral	8.5	8.3	0.0	0.0
	Disagree	10.8	15.8	54.4	63.8
Women's periods go back to normal when they stop using hormonal contraception, but they may take a little while i.e., the changes are not permanent	Agree	76.9	76.8	N/A question not asked to women	
	Neutral	11.9	12.5		
	Disagree	11.3	10.7		
Coils disappear in the body	No	N/A question not asked to men		100.0	93.1
	Yes			0.0	6.9
Coil swing through your blood stream and to the heart causing death	No			98.2	98.3
	Yes			1.8	1.7

NORMATIVE VIEWS OF MASCULINITY

Based on a depth of literature suggesting that conceptualizations of masculinity can influence men's family planning attitudes and behaviors, the project sought further clarity regarding commonly reported perspectives such the stigmatization of vasectomy use, conflation of masculinity with reproduction, and men's role as the 'breadwinner'. The survey found higher endline endorsement of the view (among men) that child spacing promotes financial health at home – with very strong endorsement of this sentiment overall (88% baseline, 96% endline). There was a significant drop in the men's conflation of male 'strength' with fathering many children, with baseline at 36.4% and endline at 17.8%. Interestingly, female respondents conflated male strength with reproduction to a far greater extent than men—at 90.8%(baseline) and 87.6% (endline). As for vasectomy stigma, there were significant reductions in the percentage of both men and women who agreed that "a man who undergoes vasectomy is a weak male" (40.8% baseline and 28.2% endline for men, and 31.3% baseline and 25.6% endline for women). The latter statistic underscores that cultural views on masculinity held by men and women alike can feed into the larger stereotype that men are not contraceptive users.

PERSPECTIVES ON HEALTHY AND BALANCED COUPLES COMMUNICATION ON CONTRACEPTION

Men were directly asked about their beliefs and practices pertaining to communication with their partner regarding contraception. Key findings include:

- Approximately ¼ of the male survey participants (all of whom were married / co-habiting) had not communicated with their partner on contraception, suggesting barriers to couples' communication persist
- Approximately 20-25% of men conflated contraception use with cheating and/or promiscuity, suggesting FP use is still significantly stigmatized.

Women were also asked whether men should be involved in contraceptive decision making. The survey found that 85% of women felt it is 'crucial' for men to take an active role in contraception decision-making demonstrates that married women rarely desire to use contraception covertly and that there is strong support for interventions that seek to encourage men's positive involvement in gender equitable FP decision-making.

PROGRAMMATIC IMPLICATIONS OF HOUSEHOLD SURVEY FINDINGS

Looking across all indicators, approximately half the indicators (10 out of 21) showed statistically significant changes, while for the other 11, the differences between baseline and endline were insignificant. Among the ten statistically significant findings, most showed 'worse' performance at endline compared to baseline, whereas only three showed 'better' performance at endline compared to baseline, namely the following:

Objective	Indicator	Baseline		Endline		aRR*	p-value
		n	(%)	n	(%)		
2	% disagree that "a woman who wants to use a family planning method is undermining her male partner as the head of the household" (Q3.1.2)	341	(69%)	368	(80%)	1.164	0.001
2	% agree that "Child spacing can help my family to prosper financially" (Q3.5.1)	434	(88%)	432	(96%)	1.055	0.002
3	% of men who disagree that "men who use contraception may become promiscuous"	325	(66%)	312	(69%)	1.175	0.001

The two contraceptive uptake questions (ever used a male method and partner currently using a method to prevent pregnancy) showed lower rates of uptake at endline compared to baseline.

Taken together, the complete results paint a picture of a survey methodology that was not adequately designed to assess program impact, given the limitations noted above. Notwithstanding this significant design flaw, the survey responses nonetheless yielded a rich set of insights that are invaluable for practical program design purposes in Uganda and beyond.

BUFUMBO COLLEGE IN-DEPTH INTERVIEW (IDI) RESULTS

In addition to the household survey, the Maverick project's other main research activity was a series of IDIs with couples who participated in the Bufumbo College (couples' communication course).

Alongside synergistic educational and SBC activities, PSIU engaged couples via a couples' communication 'college' (termed 'Bufumbo', in Luganda – local dialect for 'marriage'). Eligibility requirements in terms of age, parity, location, and relationship status were the same

as those for the household survey, except that couples were enrolled rather than individuals. Eighty-five (85) couples participated in the seven-session 'college,' which covered topics such as family goal setting, gender roles, communication, child spacing, family planning, and related myths. For the Bufumbo component, PSI applied a longitudinal design and successfully followed 9 couples who participated in in-depth interviews at baseline and endline to gather insights on family planning knowledge, gender norms, communication, and decision-making.

Couple writes out their family planning knowledge, goals and next steps in decision-making as a unit © PSI Uganda

CALL TO ACTION

The findings outlined in this brief provide critical and actionable insights for the global SRH community, with direct implications for advocacy, policy formulation and program design. To effectively advance FP initiatives, it is essential that Informed Choice be framed with nuance and adaptability. Programs should carefully consider whether decision-making is primarily exercised at the individual or couple level and tailor their definition of Informed Choice accordingly. By adopting this context-sensitive approach, practitioners and policy makers will be better positioned to design interventions that resonate with their intended audiences, enhance client autonomy and ultimately strengthen the relevance, effectiveness and sustainability of SRH programming across diverse settings.

Change in attitude towards child spacing and FP

> I shifted from wanting 10 children to planning for 4 children and actively using FP after training. Recognized my previous negligence... I changed and decided to stop at that last baby... I was a bit negligent as a husband. I decided to let such a thing not happen again.
> – Male respondent endline

Shift in gender norms

> ...Now when am tired, he helps me peel matooke! Before training, we fought over everything, we fought over child rejection claims...
> – Female respondent endline

> The training strengthened our relationship... we now plan together.
> – Male respondent endline

Improved FP knowledge

> Now like me I thought that when you use family planning, you don't produce but when they trained us, they told us that you can produce, but there is a way the drug delays in the body especially the one of an inject plan. So, it may take you some time to conceive after stopping it. So, there is a way it remains in the body and delays you. But I learnt that later you conceive.
> – Female respondent