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"I was obligated to accept": A qualitative exploration of contraceptive coercion

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ABSTRACT

Despite narratives about empowering women through contraception, global family planning programs are evaluated primarily by their ability to increase contraceptive uptake and reduce fertility in the developing world. Some scholars have raised concerns that this emphasis on fertility reduction and contraceptive uptake may contribute to situations where women are coerced into adopting contraceptive services they do not fully understand or want. Yet surprisingly little data have been collected to investigate whether such coercion exists or how it might manifest. In-depth interviews with 49 women of reproductive age in a sub-Saharan African country begin to fill this knowledge gap. Respondents reported a range of non-autonomous experiences including biased or directive counseling, dramatically limited contraceptive method mix, scare tactics, provision of false medical information, refusal to remove provider-dependent methods, and the non-consented provision of long-acting methods. The results show that, rather than a binary outcome, coercion sits on a spectrum and need not involve overt force or violence, but can also result from more quotidian limits to free, full, and informed choice. The study finds that global family planning policies and discourses do appear to incentivize coercive practices. It also calls into question the central role of intentionality, by demonstrating how coercion can arise from structural causes as well as interpersonal ones. By showing how contraceptive autonomy may be limited even by providers working in good faith, these results argue for an end to the instrumentalization of women's bodies, and for a radical reconceptualization of family planning goals and measurements to focus exclusively on reproductive health, rights and justice.

1. Introduction and background

Global family planning programs have many supporters, but the rationales for their support can vary greatly. Feminists promote safe, affordable contraception because women's ability to control their own bodies is central to the pursuit of gender equity (Reichenbach and Roseman, 2011). Environmentalists promote family planning to mitigate climate change (Guillebaud and Hayes, 2008). Public health advocates promote family planning to reduce maternal mortality (Ahmed et al., 2012). And development scholars promote family planning to achieve a range of micro- and macro-economic goals (Becker and Lewis, 1974; Bloom et al., 2007). Despite disparate motivations, these constituencies regularly work together to expand access to contraceptives throughout the world. There remain tensions, however, between these "strange bedmates," (Hodgson and Watkins, 1996), some of whom seek to advance women's reproductive autonomy for its own sake and others who seek to reduce fertility as a means to achieve other development goals. As development organizations increasingly motivate investment in family planning with numerical targets for contraceptive uptake, scholars have worried that such target-driven contraceptive programs may incentivize coercive practices (Bendix et al., 2019; Hendrixson, 2018). And yet, these concerns have been the subject of scant empirical research.

This paper uses 49 in-depth interviews conducted at two sites in an anonymized sub-Saharan African country to explore the extent to which contraceptive coercion exists and what forms it might take. As the first study to document coercive practices among programs chasing global contraceptive uptake goals in the post-ICPD era, these findings build a theoretical foundation that should facilitate future investigations into the breadth and depth of coercion in family planning programs. Finding evidence of a spectrum of both structural and interpersonal coercion, I conclude that global family planning programs pursuing contraceptive uptake to achieve other development goals can end up instrumentalizing women's bodies in this pursuit. While access to high-quality contraception is essential, this study shows that using women's bodies as a means to an end can result in threats to autonomy rather

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than the empowerment that family planning programs often promise.

1.1. – Coercion and family planning

In the 1950s–60s, a range of governmental, multi-lateral and non-governmental organizations emerged with the aim of slowing population growth, from the Population Council, to the United Nations Fund for Population Activities, to the Office of Population within the United States Agency for International Development (USAID). During this "Population Era," some organizations advocated for coercive tactics to limit births when they thought that voluntary family planning would not be adopted at sufficient rates (Christiansen, 1977; Hartmann, 1997). Population Council President Bernard Berelson, for example, promoted what he called a "step-ladder" approach, in which he justified a range of progressively more coercive tactics, writing that "there are undoubtedly cases of justified coercion" in family planning but cautions that "overt violence or other potentially injurious coercion is not to be used before noninjurious coercion has been exhausted" (Berelson and Lieberson, 1979). Many countries in the Global South adopted population policies that employed coercive mechanisms including economic penalties for high fertility (e.g. Singapore), quotas for providers (e.g. India), and compulsory sterilization (e.g. China) (Connelly, 2008; Isaacs, 1995).

In 1994, the International Conference on Population and Development (ICPD) was held in Cairo, signaling the end of the Population Era. In its place, the 179 signatories to the ICPD Programme of Action affirmed reproductive health and rights as guiding principles and declared that "any form of coercion has no part to play" in family planning, disavowing the use of coercion no fewer than 13 times (UNFPA, 1994). In the wake of ICPD, the global family planning community went to great lengths to affirm its commitment to rights and voluntarism. The 1998 Tiahrt Amendment specified that any USAID-funded family planning must not use "incentives, bribes, gratuities, or financial reward for family planning program personnel for achieving targets or quotas, or for individuals in exchange for becoming a family planning acceptor" (USAID, 2013). Other family planning programs have adopted similar policies and rhetoric, emphasizing the primacy of voluntarism in the provision of contraceptive services (Brown et al., 2014, for example).

1.2. – Contemporary family planning in the Global South

In 2012, the London Family Planning Summit sought to "launch a global movement" for family planning, marshalling new resources for programs, and setting a goal of 120,000,000 additional users of modern contraception worldwide by 2020. This "120 by 20" goal became the centerpiece of a new global family planning initiative called Family Planning, 2020 (FP2020). As part of the FP2020 process, 69 poor countries were selected for programming, many of which have, in turn, worked to set their own contraceptive uptake or fertility targets at the regional and national levels. Examples of some of the quantitative targets set by countries and initiatives are summarized in Table 1 (Sources: "Family Planning, 2020- Commitment Makers," n.d.; Partenariat de Ouagadougou, 2016).

Many of the 69 FP2020 focus countries have elaborated national strategic planning documents to support and guide their pursuit of these goals, often dividing the national-level goals into province or district-level sub-goals. The FP2020 initiative has affirmed the voluntary nature of these goals and all family planning services that are provided within them (Brown et al., 2014),setting up a Rights and Empowerment Working Group (operational between 2013 and 2015) that enumerated a set of principles to guide pursuit of the quantitative targets. The "Track 20" core indicators for FP2020 also include some metrics intended to "provide a glimpse into issues of agency and autonomy, quality, availability, and informed choice" although these indicators are measured only in a subset of the 69 focus countries. ("Track20 - FP2020 Core Indicators," n.d.).

Family planning is not alone in its increasing reliance on quantitative targets and indicators. Throughout the eras of the Millennium Development Goals and the subsequent Sustainable Development Goals, many subfields within global health and development have shared this increasing reliance on quantitative indicators to track progress. Social scientists caution, however, that the growing influence of indicators can serve as a new form of global governance that reinscribes existing power differentials and masks indicators' underlying ideologies under a veneer of technical rationality and objective truth (Merry, 2016; Suh, 2014; Wendland, 2016). Critics also warn that relying heavily on a selected few indicators can lead to a sort of tunnel vision, where that which is specifically measured becomes narrowly prioritized to the exclusion of related and broader health issues (Suh, 2019; Yamin and Boulanger, 2013). In the case of family planning, there is concern that FP2020's overarching goal of adding 120,000,000 new contraceptive users (and the country-level targets it begat) creates perverse incentives for providers and programs to meet these contraceptive uptake targets at the expense of rights-based care (Bendix et al., 2019; Hendrixson, 2018).

1.3. Theorizing coercion

Despite its centrality to discussions of family planning and voluntarism, the term "coercion" was not defined in the ICPD Programme of Action, and has remained somewhat contested in the years since. In their systematic review of reproductive coercion, Grace and Anderson define the term as any "behavior that interferes with the autonomous decision-making of a woman, with regards to reproductive health" (Grace and Anderson, 2016). Discussions surrounding the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) at the United Nations have sought to flesh out the definition to emphasize that coercion need "not necessarily include[e] physical force," and include the use of fraud and deception as coercive tactics (United Nations, 2005). Concerned that "Defining coercion or coercive actions too broadly could incriminate all family planning programs," however, Hardee et al. argue for a definition that limits coercion to the presence of "force, violence, intimidation or manipulation" (Hardee et al., 2014).

Perhaps it is this debate around the meaning of the term that has contributed to the critical lack of research on contraceptive coercion. Indeed, the body of research on coercion in family planning programs is almost vanishingly thin, with existing works falling short in three main ways. First, there is a notable gap between the attention paid to

Table 1
Examples of global family planning targets.

Body	Target	Timeframe	Location
FP 2020	120 million additional users of modern contraceptives	2012–2020	69 focus countries in the Global South
The Ouagadougou Partnership	2.2 million additional women using modern contraceptive methods	2011–2020	9 francophone West African countries
Ghana	Reduce the total fertility rate from 5.5 to 3.0	1990–2020	Ghana
Rwanda	Achieve an mCPR of 70%	2012–2020	Rwanda
Tanzania	Achieve a national contraceptive prevalence rate of 60%	2012–2015	Tanzania
Benin	Benin aimed to Increase mCPR to 20%	2013–2018	Benin

deploring and disavowing coercion on the one hand, and the remarkable disinterest in assessing or documenting coercion on the other hand. What scant research there is on contraceptive coercion tends to come from within the United States, where reproductive, racial and disability justice movements have called attention to the ways that institutionalized discrimination affects how family planning is provided to marginalized groups (Kramer et al., 2018; Yee and Simon, 2011; Zeal et al., 2018, for example). When family planning researchers explore issues of autonomy in contexts outside of the United States, the analyses tend to be historical (Barot, 2012; Hardee et al., 2014, for example) or couched in the language of "quality," with threats to autonomy framed as a form of low-quality care rather than explicitly as coercion (Diamond-Smith et al., 2018; Sudhinaraset et al., 2018, for example).

Second, existing approaches tend to define coercion as an action that one individual takes against another, rather than conceptualizing coercion as something that can happen through structural processes. Many works on reproductive autonomy focus specifically on the intimate partnership dyad, rather than the health system or other state actors. A recently validated scale to measure reproductive autonomy, for example, does not include items intended to assess coercion coming from outside the intimate partnership (Upadhyay et al., 2014). Grace and Anderson likewise write that "Perpetrators of reproductive coercion may be an intimate partner, a family member, or a family member of the partner" (Grace and Anderson, 2016). The lack of attention to the role of structural coercion is surprising, given the myriad analyses in related fields demonstrating how structural factors affect individual-level power. Critical development literature, for example, has explored the multiple ways that scientific racism, sexism, and Western hegemony have systematically suffused the development project from its inception (Corrêa, 1994; Escobar, 2011; Ferguson, 1990). Likewise, the systemic gendered and racialized logics of global family planning programs have been well-documented in studies showing how intersecting systems of oppression (racism, sexism, poverty, colonization, etc.) have constructed poor women of color living in poor countries as the target of contraceptive interventions and fertility reduction regimes (Kuumba, 1999; McCann, 2017; Takeshita, 2012). There is also a rich body of ethnographic literature that explores the complex ways that women's reproductive autonomy can be mediated or constrained by larger structural factors, and the microprocesses that translate these wider societal phenomena into women's embodied experiences (Brunson, 2019; Foley, 2007; Greenhalgh, 1990; Maternowska, 2006).

These explorations are related to a movement for reproductive justice in the United States, in which Black American women aimed to shift the focus from a narrow view of individual choice to a broader analysis of racial, economic, and structural constraints on power (Ross et al., 2017). Though the reproductive justice framework has heretofore been primarily applied within the United States, its intersectional analytic approach is of enormous value to the global context, where issues of structural racism and patriarchy take different forms but are no less salient. Drawing on this diverse body of literature, I argue that any theory of coercion in family planning must allow for the possibility that contraceptive coercion manifests through *structural* forces (even in the absence of intent or ill will), as well as through *individual* actions.

Third, contraceptive coercion, to the extent that it has been theorized at all, is historically conceived as a unidirectional phenomenon in which women are forced to adopt a method they do not want—what I call "upward coercion." Forced sterilization in Peru, China's One Child Policy, or other efforts to compel women to limit fertility in ways that they do not want would all constitute examples of upward coercion. Yet, contraceptive coercion can also travel in the other direction: women can be prevented from accessing or using a method of contraception that they desire, which I refer to as "downward coercion." Fig. 1 illustrates how, even when the directionality of the coercion differs, the fundamental discordance between contraceptive desire and contraceptive reality is the same in both cases. Both directions of coercion present equally substantial threats to contraceptive autonomy.

		Has FP method	
		No	Yes
Wants FP method	No	[No coercion]	Upward coercion
	Yes	Downward coercion	[No coercion]

Fig. 1. Bidirectional conceptions of coercion.

There are some overt examples of downward coercion from Romania and elsewhere, where governments intentionally limited access to contraception in the pursuit of pronatalist policies (Barot, 2012). But more common are the myriad types of downward coercion documented in the form of "barriers to access." Using terms like "medical barriers" and "limited method choice," scholars have identified a range of factors that routinely keep women from using a wanted method (Campbell et al., 2006). Of particular recent interest to researchers has been "provider bias," including the denial of contraception to young and/or unmarried women for whom sexual activity is often stigmatized (Choi et al., 2016; Williamson et al., 2009). Though a topic of frequent global family research, barriers to access have generally not been framed as a form of coercion.

The comprehensive theory elaborated here rests on the contention that all obstructions to women's contraceptive autonomy should be understood and analyzed as various iterations of the same process: coercion. Bringing together notions of downward coercion (i.e., women cannot have contraceptive autonomy unless family planning programs provide her with the accessible and affordable contraception of her choice), and upward coercion (i.e., women cannot have contraceptive autonomy unless family planning programs also respect her decision to not use contraception) in one cohesive theoretical approach is necessary if scholars are to map the multiple, intersecting constraints to reproductive justice. This theoretical approach encourages scholars to give equal weight to both upward and downward coercion in their analyses, in contrast to present approaches that disavow upward coercion but fail to investigate whether or how it manifests. And finally, this comprehensive theory of contraceptive coercion impels scholars to interrogate structural as well as individual sources of coercion, eschewing a focus on ill intent in favor of a more nuanced understanding of the everyday ways that women see their contraceptive autonomy limited, even by providers working in good faith. Using this broader understanding of contraceptive coercion, this paper interrogates whether and how this might be manifested and experienced by women in the current family planning moment.

2. Methods

This study takes place in a low-income country in sub-Saharan Africa that is engaged in global, regional and domestic family planning initiatives that employ quantitative contraceptive uptake targets in the pursuit of fertility reduction. This country is a theoretically useful case because it is firmly in the mainstream of the contemporary family planning movement, and has been commended as a model of exemplary family planning programming by the international family planning community. The family planning work in this country is funded by prominent donors, supported by well-known NGOs, guided by mainstream policies and goals, and uses internationally determined best practices. As such, if coercion is found in this highly visible, award-winning program, it is logical to hypothesize that the coercion may be a problem throughout similarly conceived global family planning programs. Given the politicized nature of the findings presented here, the decision was made to anonymize the site of this research to protect the country and its family planning program from being singled out for punitive measures or defunding.

2.1. Ethics approval

All relevant ethics boards reviewed and approved this study. These include the Institutional Review Board of the Office of Human Research Administration at the Harvard T. H. Chan School of Public Health in Boston, USA, the national ethics committee of the country where the study took place, and the local ethics committee at one research site. Written informed consent was obtained from all adult participants (ages 20 and above). For minors (ages 15–19), written parental informed consent was obtained in addition to written assent from the minor. Pseudonyms were assigned, and no identifying respondent information was retained.

2.2. Data and analysis

The data for this study are 49 in-depth interviews with women of reproductive age (ages 15–49) in a country in the Global South that participates in the FP2020 Initiative. Fieldwork was conducted at two sites (one rural, one urban) in 2017. Detailed information about the interview guide, interviewer training, respondent selection, and interview processes can be found in the methodological appendix.

Data collectors were recruited and trained to carry out interviews in three local languages. Respondents were prompted to guide the discussions toward their concerns and interests within the broader umbrella of autonomy and quality in family planning. Questions included standard sociodemographic background information in addition to probes on previous use of contraception, past experiences with family planning service providers, reproductive desires, fertility intentions, gender roles in decision-making, and cultural views on childbearing. All interviews were audio-recorded and transcribed verbatim with personal identifiers removed.

Key informants were used to propel a purposive sampling strategy designed to obtain a diversity of opinions and experiences among respondents. Dimensions along which diversity was sought include age, ethnic group, religion, marital status, educational attainment, parity, and contraceptive use. Women were eligible for inclusion if they lived in one of the research sites, were between 15 and 49 years old, and were able to provide informed consent in one of the three study languages. The characteristics of the respondents are shown in Table 2.

Additionally, we interviewed three key informants who occupy positions within the regional health administration to obtain supplementary perspectives on contraceptive uptake targets in service provision. Transcripts were coded manually to generate a codebook and main themes.

Table 2
Characteristics of Respondents, by study site.

	Urban site	Rural site	Total
Total Interviews	25	24	49
Marital Status			
Married	17	17	34
Unmarried	8	7	15
Age Group			
15–19	6	8	14
20–24	10	5	15
25–39	1	3	4
30–34	1	2	3
35–39	2	3	5
40–44	1	2	3
45–49	4	1	5
Religion			
Muslim	12	12	24
Christian	13	12	25
Ethnicity			
Predominant ethnicity	22	2	24
Ethnic minority 1	1	3	4
Ethnic minority 2	0	4	4
Ethnic minority 3	0	12	12
Ethnic minority 4	2	0	2
Ethnic minority 5	0	1	1
Ethnic minority 6	0	2	2
Education			
Primary or lower	9	15	24
Secondary or higher	16	9	25
Number of children			
0	7	6	13
1	9	7	16
2	2	3	5
3	1	2	3
4	2	3	5
5+	3	3	6
Student status			
Current student	8	6	14
Not student	13	18	31
Current contraceptive use			
Current user	15	14	29
Former user	6	3	9
Never user	4	7	11

3. Results

3.1. "There is a certain quota": How structures can promote coercion

The key informants discussed some of the ways that the health system incentivized a proactive approach to fertility reduction. Targets for modern contraceptive prevalence rates (mCPR) set by the government in strategic planning documents are translated from regional and national targets into district and then finally clinic-level targets. Seeking to understand how these targets are pursued, we had the following exchange with a district-level supervisor:

> **Interviewer:** How do you define success or failure during supervision, like a [health center] that succeeds at family planning, or a [health center] that fails at family planning?
>
> **Administrator 1:** For example, if we arrive on the ground, we try to see what's really working. If you go out and you see, for example, the women giving birth, that the births are spaced together, we can see it's not working. Or, we look at the prevalence rate. For example, at the beginning of the year, there is a certain quota. We say that each [health center] has to have a certain percentage for family planning, and so we try to evaluate, for example, in the [health center], looking at the total population, we have to know how many women need to come for FP [family planning]. So, if we calculate it, and we see that it's low, we say, "No, you didn't really get there."

This supervisor said he does not take punitive measures against providers for failing to meet their targets, but that these numbers are used as a principle way to evaluate health centers and that there are even informal competitions at the district and provincial level to see who can get the best numbers. He also mentioned that, in addition to bragging rights for providers and health centers that meet their quotas, there are also small prizes (such as free t-shirts) to help motivate providers. Another health administrator explained that:

> At the district level, we also give goals to each [health center] so that they can attain the targets, those that concern all the methods mixed together but above all the long-acting methods that we're really emphasizing.

This institutional focus on meeting mCPR targets and targets for long-acting methods is further reinforced by the record-keeping system used to evaluate providers' and clinics' success. Key informants shared that in some versions of family planning registries, there was no place for a provider to record counseling a woman who then declined to adopt a method. Thus, the only way for a provider to get 'credit' for family planning counseling was to record the method (along with detailed information about dosage, etc.) that the client ultimately

accepted.

Another way that health system structures can constrain women's choices is through the range of contraceptive methods offered. In our sample, the three methods that most women were offered were oral contraceptive pills, injectables, and implants. In the case of Jennifer, a 36-year-old married woman from the rural area, no other methods were presented to her, even when it became clear to the provider that another method might be needed:

> When I arrived, I told the nurse that I wanted to use the implant, but that previously when I had used the implant, I lost an enormous amount of blood, especially during my period. The nurse said that that now, it [the implant] is not the same as what it was before, so she asked me if I want to use the implant again, before telling me I could use another method: the pill or the injectable. I'm really scared of injections, so I told her I would take the pills and I went back home.
>
> I used the pills for a month, and then the second month, I started to forget… So, I went back to see her [the nurse] and explain to her that I very often forget the pills. That's when she said 'Hey, you have to take the pills every day, without the possibility of skipping days.' … That's when she told me to use the injectable method.

Despite her fear of injections, and a multitude of other methods registered in the country that might suit Jennifer's needs, only the injectable was proposed to her at this time. This was a story echoed by many respondents. Christina, for example, is a 23-year-old married woman from a small rural town. She reported that:

> If you come [to the clinic], they tell you to choose the method that you want, if it's the implant, the injectable, or the pills that you want. They give you what you choose to use.

Though she uses the language of choice to describe these encounters, Christina's choice is constrained to a small range of exclusively hormonal contraceptives. Very few women in either the urban or rural areas reported being offered or even told about barrier methods, fertility-awareness based methods, IUDs, or other non-hormonal options. This remained true even when women reported discomfort or side-effects from previous experiences with hormonal contraception.

3.2. "They give it to everyone without exception": Downward coercion among the young and unmarried may not be as salient as previously thought in this setting

Despite the conventional wisdom that youth have restricted access to contraception and that judgmental providers are reluctant to provide contraception to younger and unmarried women (Brittain et al., 2018; Williamson et al., 2009, for example), respondents reported that downward coercion is scarce in their communities. Even with an interview guide that specifically probed on potential barriers to access for young and unmarried people, respondents replied overwhelmingly that providers are happy to give contraception to young, unmarried, and nulliparous women. Mary, a 16-year-old unmarried woman from the urban area, evoked a common heath rationale:

> Some young women are very small when they get pregnant, and … aren't more than 14 or 15 when you see them with a pregnancy. Some of them die and some of them can't deliver except via operation. That's why they [health providers] tell even young women to go use a method. Then, after, if God sends them a husband, they can get married.

By emphasizing that a woman can get married after using contraception, Mary seems to be refuting older attitudes regarding the diminished marriage prospects of sexually active unmarried women in the urban area. That there has been significant change in attitudes towards young women using contraception in recent years was echoed by Elizabeth, a 24-year-old married woman from the urban area.

> **Elizabeth**: These days, I don't think that a health worker would refuse to give a method to a woman. Even if you're a young unmarried woman, they give it to you, they give it to everyone.
>
> **Interviewer**: Even young unmarried women?
>
> **Elizabeth:** Before, they didn't use to give methods to young unmarried women, but these days, with how life has become, they give it to everyone without exception.

Elizabeth, Mary, and other respondents pointed to changing views on the health, social and economic benefits of practicing contraception for young people as reasons that downward coercion now seems so rare. Rare, of course, does not mean non-existent. Sarah, a 40-year-old married woman with two children living in small rural town, does not fit the profile of a young, unmarried woman. And yet, after her first child was born, Sarah shared:

> I told myself that I was going to use contraception to avoid closely spaced births because if the births are too closely spaced, it's very difficult. Imagine a little bit if you get pregnant and you are carrying another child on your back when you go out to the field [to do farm work], and there is no one to take care of you? So, this is why I went to say I want to use a contraceptive method, and she [the provider] told me to come back later. I insisted on it, but she stayed firm on her position because I didn't have enough children.

In this case, a provider's belief that women must have multiple children before using contraception led to downward coercion for Sarah. Sarah told us that she would have liked to use the implant, and to wait up to five years before having another child. Because of Sarah's rural environment, where both health centers and providers are sparse, Sarah was unable to seek family planning services from a more amenable provider elsewhere. Sarah's story is notable both because it illustrates the enormous power over a woman's reproduction that a single provider can wield, as well as because it was the sole instance of downward coercion from a provider that was shared among the 49 women we interviewed.

3.3. From flattery to force: Coercion as a spectrum

While reports of downward coercion were rare, many respondents shared stories of upward coercion that varied in both type and severity, ranging from things that subtlely constrain autonomy, to more overt action. Fig. 2 illustrates a spectrum of coercive phenomena reported by women in this sample.

3.3.1. "But what they think is best, it's only the 'five years.'" - Subtler forms of coercion

One of the most common, if subtle, forms of coercion reported was counseling geared toward ensuring that a woman adopted a long-acting method of contraception regardless of the woman's specific needs and desires. For example, Maria is a 21-year-old married woman who told us that providers use directive counseling to promote implants.

> **Interviewer:** Before you went to get the implant, was it a health worker who told you to get this method, or was there someone else who was a part of your decision?
>
> **Maria:** Well! The health workers normally counsel you that if you want to choose, you have to choose the "five years" [the implant]. Now, if that method isn't suitable for you, you can take it out and get the "three months" [injectables], but if you don't like that, you can't take it out. You have to wait for the three months to be over, otherwise you can't remove it.
>
> **Interviewer:** So, it's the providers who told you?

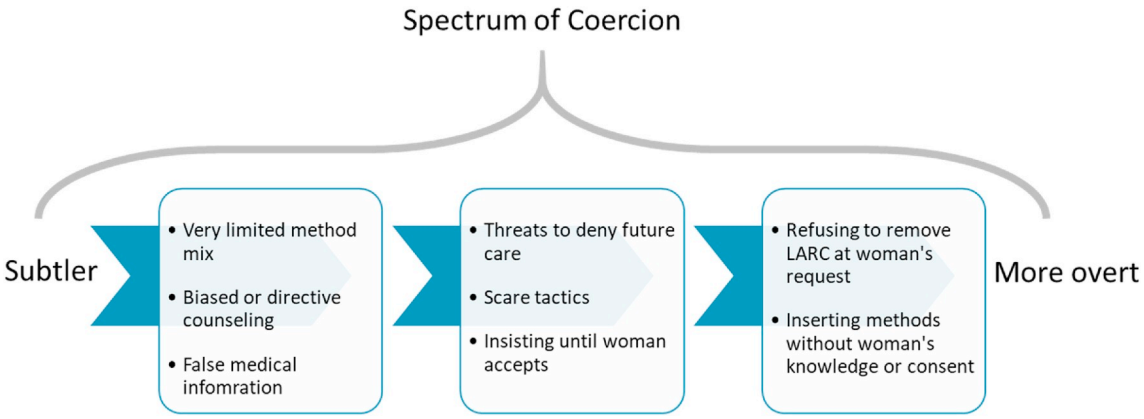

Fig. 2. Spectrum of coercion.

Maria: It's true that there's counseling and they tell you to choose what you like, but what they think is best, it's only the "five years" [the implant].

Some providers may also bias their counseling by sharing only the advantages of family planning with women, failing to disclose information about side-effects or other risks of use. We asked Christina about the advice she received after she delivered her child:

Christina: They give you advice about the baby, and about you yourself.

Interviewer: Did the health worker give you information about the good things and the bad things about using the injectable?

Christina: [They tell us] all about birth spacing, if we avoid having a lot of kids, and closely spaced pregnancies. When you use the injectable, you can go 4 or 5 years without having another child, unless you stop using it…

Interviewer: What are the negative aspects of contraceptive methods?

Christina: If the child gets sick all the time, the care can cause financial difficulties.

Interviewer: I want to ask about the harmful effects of contraceptive methods.

Christina: [Pause] It doesn't have any harmful effects.

Here, even after repeated probing, Christina continued to share the advantages she had been told about family planning, almost as if reciting from a script. She shares information about her counseling and seems to have retained a good deal of detail about the benefits of contraception. And yet, probed to share a disadvantage of any contraception method, she is unable to do so.

In addition to only sharing the advantages of family planning, some women reported receiving medical information from providers that differs substantially from accepted international medical consensus. Here is an exchange with Carol, a 27-year-old married woman:

Interviewer: How did you get to the decision to use the injectable?

Carol: Because the health workers said that if you give birth via C-section, you must use the injectable and wait five or four years before your next child

Interviewer: The health workers said that if you give birth via C-section, you have to use the injectable?

Carol: Yes …

Interviewer: If the health workers hadn't told you to use contraception, would you use it?

Carol: No… I don't like the injectable

The World Health Organization currently recommends a minimum interpregnancy interval of two years for women who deliver by C-section and has no method-specific contraceptive recommendations for these women, nor are there credible guidelines or rigorous research of any kind to support the provider's recommendations (Shelley, 2014). The provider appears to be exaggerating or falsifying medical advice in an effort to get Carol to adopt the provider's preferred method contraception.

3.3.2. "When they spoke like that, in all honesty, it made me scared" - Moderate forms of coercion

A step up from biased counseling and false medical information is threats to women about what will happen to them if they decline the provider's offer of a method, or attempt to discontinue a method. One story like this comes from Cindy, a married woman from the urban setting who had recently had a baby and then returned for a post-natal check up on the 45th-day after delivery.

When I brought my child into the world, I went back for the 45th-day checkup and they [the nurses] asked me to see if I was going to use a contraceptive method to space my births and I said no. They told me that if I decided to not use [family planning] and then later I have problems and start to run panicked in the midday sun to say that people should help me, it's complicated. When they spoke like that, in all honesty, it made me scared.

Cindy felt scared because she thought the nurse was implying that if she ever got sick or got pregnant again and came back to the clinic for care, she might not receive the medical attention she needed. Cindy's story, like many others, describes the 45-day postpartum checkup as a particularly salient time for contraceptive coercion.

Other threats revolve not around medical consequences, but the social or familial consequences of non-use. Elizabeth told us that:

Elizabeth: One day I went to see the midwife to tell her that I had decided to stop the injectable, but that I had also asked my husband's opinion and he said he didn't know. And the midwife asked me why I wanted to stop, [and said] that I should continue, that I shouldn't even dare to stop using it. What do I know about why my husband says he doesn't really know, that men can be bizarre, and often they might not say anything, but once you get pregnant, they might ask you why you didn't take any precautions, that he didn't want the child and for that he can kick you out of the house with your child. When that happens, what will you do with your child? When she said that, I didn't have the courage to stop, so instead I continued to get the injectable.

Interviewer: So, in your opinion, did the health worker force you to continue or not?

Elizabeth: In my opinion, she forced me to continue to use the injectable…

Interviewer: But why had you decided to stop the injectable?

Elizabeth: Because I was starting to ask myself the question, saying that I had spent three years, only using the injectable, and maybe I should stop and start looking to have a child.

Interviewer: So, you wanted a child?

Elizabeth: Yes, I wanted to have a child…

In this case, Elizabeth reports that the provider made her feel that her husband might abandon her and her child if she went through with her decision to discontinue use of the injectable. In another case, Laura, a married woman from the urban area with a very high level of education reported that when she refused to be swayed by a provider's pressure to use the implant, the provider (whom she also knew socially) showed up at her home several times to discuss the method and even offered to bring the implant and insert it then and there in the home.

In addition to these types of scare tactics and insistence, some women reported being compelled to use a contraception against their will due to the perception of high parity. Jessica, a 47-year-old married woman from a rural town shared the following exchange with us:

Interviewer: You said that you currently use the implant. Can you tell us how you managed to get this method?

Jessica: When I got pregnant with my 10th [child]... the midwife told me that I have a lot of children and that I would have a difficult delivery. It's there that she told me that I need to go to [a nearby town] at the start of my 9th month. So, when my 9th month came, I did go to [a nearby town], and I delivered there. So, the health workers in [a nearby town] said that I needed to get the implant by force.

Interviewer: They obligated you to get the implant?

Jessica: Yes, I was obligated to accept, and they gave me the implant. The nurse told me that it would be five years, and even before the date of the fifth year, I started to feel illnesses due to the implant…

Jessica went on to share how she was eventually able to get her implant removed, got pregnant again, and was again compelled to use contraception, with providers telling her that she "should not have any more children." Jessica used the injectable for a while and then stopped, getting pregnant and successfully delivering her 12th child by C-section.

3.3.3. "He refused, he said that it hasn't yet been five years" - overt forms of coercion

Along this trajectory, however, Jessica encounters difficulty getting her implant removed, even though she strongly dislikes the side-effects she feels it causes. She reports that:

I went to the tell the hospital [that I got headaches from the implant], and it's there that the health worker told me that the date to remove it hasn't yet arrived, so he can't remove it… He refused, he said that it hasn't yet been five years, and there are two months that still remain.

Jessica's difficulty getting her implant removed was far from rare among our respondents, many of whom shared similar stories of providers inappropriately treating the five-year efficacy of the method as the minimum duration of use. Several women reported being told to come back when their five-year period was up, even when experiencing side-effects or expressing the desire to get pregnant. In this way, methods that require a provider for discontinuation allow for contraceptive coercion to be a protracted process along multiple time-points, rather than a single event at the time of method adoption.

We also heard stories of women being provided long-acting methods without their consent or somtimes even their knowledge. An 18-year-old rural woman named Nancy told us about her sister-in-law:

Nancy: [My sister-in-law has] AIDS… when she gave birth to her child, they told her to come quickly to the hospital with the baby, they want to look at the baby, and then when they were there, they gave the implant to the woman. Then, they came to explain the situation to my father. They told him that she shouldn't have any more children. That she doesn't have the strength to tolerate another pregnancy, and that if she gets pregnant again, she can die.

Interviewer: So, it's because of AIDS they put the implant in her?

Nancy: Yes…they came to inform my father-in-law but even today the woman doesn't know about any of this.

Interviewer: So, the woman doesn't know that they had placed an implant inside her?

Nancy: No, she doesn't know. There was a medical officer, and it was he who came to tell my father-in-law.

Interviewer: So, the husband doesn't know that the woman has an implant?

Nancy: No, the husband knows about it, because my father-in-law told him. It's the woman who doesn't know.

Nancy's story is notable for a number of reasons. The health officer seems to have decided that having HIV/AIDS means that the woman should no longer have children, inserted an implant into the woman without her knowledge, and then chose to share this medical information with the woman's father-in-law, as he is head-of-household for that family compound. The father-in-law then chose to share this information with his son (the woman's husband) and others, so that it appears that everyone living in the compound is aware that the woman's fertility has been restricted except for the woman herself.

3.4. Perceptions of and responses to coercion

There was diversity of perspectives about the pressure to adopt a contraceptive method, with respondents expressing a range of sometimes contradictory opinions on whether the coercion is justified.

3.4.1. "For me, it's good that they did that" – faith in health workers

Many respondents expressed an underlying faith in both the motives and tactics of providers. Respondents tended to respect providers' learnedness, and infer that actions taken by the providers were done in women's best interest. Laura, a 25-year-old married student shared:

Laura: Once, I went to get [my implant] removed, and they told me not to take it out. At that time, it was giving me a lot of pain around my kidneys, so I went to the health center to say that, if it's going to be like this, I want to take it out. They told me no, not to take it out. …They asked me if they were to take the implant out, would I take the pill, and I said no, so they told me to leave the implant...

Interviewer: But when you went to get it taken out and they refused, how did you take that?

Laura: For me, it's good that they did that… The health workers know better than we do.

Despite this incident that seems like a fairly clear-cut case of coercion, Laura expressed gratitude to the provider, and assumed that this decision was made in the best interest of her health and well-being.

3.4.2. "It's like they buttered you up, like they lied to you– frustration at the health system

Though many women shared Laura's belief that whatever the

providers did was ultimately in women's best interest, many others expressed anger, confusion and frustration about what they considered to be heavy-handed approaches to family planning counseling and provision. We shared the following exchange with Regina, a married 34-year-old from the urban setting:

> **Interviewer:** What do you think about the fact that at the 45th-day checkup, the health workers start to talk to women about family planning?..
>
> **Regina:** I think that if she [a woman] is really interested… she can make the decision to go get family planning if she wants to, but the health workers don't need to force all women systematically to go into the family planning room so that they'll use family planning. Sometimes at 45 days, the wound isn't even totally healed…
>
> I've even come across a woman who told me that she won't go to the 45th-day checkup because if you get there, it's not just a checkup that you'll get, but that they'll force you to use family planning. They [the providers] say that it's to help women, meanwhile the women say that it's like a sort of pressure they put on us to use contraceptive methods.

Regina later shares that her own sister, among other friends and acquaintances, has skipped the 45th-day checkup on order to avoid exposure to contraceptive coercion. Barbara, 35-year-old woman uses stronger language to describe the situation, sharing the story of her neighbor:

> The woman had just given birth to her third child, and so she went to get it [the implant]. Less than two months later, her baby died, and so she went back so they would take it out. She did everything she could think of to get them to take it out, she even came and started crying in front of our house… It's like they buttered you up, like they lied to you. They tell you to put in the method, that you can take it out whenever you like. Then you arrive at the health center, and they refuse to take it out.

Despite this strong language about her neighbor's case and some other examples of coercion that she has witnessed, Barbara still expressed faith in health workers and their motivations, saying

> It's us that they want to help. Having a lot of children sets us back. You can't save because everything goes toward your expenses… That's why the health workers want to help women blossom."

Barbara's seemingly contradictory views of health providers as simultaneously deceitful and kindhearted shows the complexity (and cognitive dissonance) of women's perceptions of contraceptive coercion.

4. Discussion

These findings reveal that even in a model global family planning program, a range of coercive practices can impede women's ability to practice contraceptive autonomy. This inquiry has allowed for the development of three theoretical advancements when studying contraceptive coercion: 1) coercion as bidirectional (both upward and downward); 2) coercion as a spectrum (from subtle to overt), rather than a dichotomous outcome; and 3) coercion as structural phenomenon, rather than simply an interpersonal one. Results also show that coercion can happen along multiple timepoints (not just at the time of method provision) and that the postpartum period may be a particularly salient time for contraceptive coercion. Documented here are a variety of coercive practices, ranging from biased counseling to severely limited method mix to scare tactics to outright refusal to remove implants. In contrast to the bulk of the published literature, the practices reported here leaned overwhelmingly toward upward coercion rather than downward coercion/barriers to access. Indeed, situations of downward coercion in which women were denied access to contraception based on their age or marital status was virtually unheard of in our sample, suggesting great progress in expanding access for young, unmarried women in these settings. Women's responses to coercion are varied and include frustration at health workers actions as well as faith in their motives.

Much of the coercion reported has roots in structural causes rather than any apparent malice on the part of individual providers. Health centers are incentivized to meet specific contraceptive uptake targets, with financial benefits to increasing uptake and providers accountable to their supervisors if targets are not met. With the presence of performance-based financing schemes in many countries of the Global South, these types of routine monitoring indicators can go beyond perceptions of success, and actually affect the type of remuneration that providers and administrators can expect for their clinics. The World Bank, for example, provides financial incentives for providers and health centers to increase the number of users of both short-acting and long-acting methods (World Bank, 2018). This can (and indeed, is expressly intended to) create structural incentives for providers to maximize the provision of modern methods, without any attempt to address the ways that this might incentivize coercion too. The absence in some clinic registries of a space to record women who had received counseling but chose not to adopt a method exemplifies these structures.

The creation of new registries, approaches to supervision, remuneration schemes, and global targets that give as much credit for a counseled patient who declines contraception as one who accepts would be important steps toward reducing structural causes of coercion. Though virtually all family planning programs affirm a strong commitment to voluntarism and reproductive rights in their rhetoric, the regimes of measurement they employ to track progress are dominated by indicators of contraceptive uptake and fertility reduction. New systems of measurement, evaluation and oversight are needed that make autonomy and respect for rights the primary outcomes of interest (Senderowicz, 2018). Expanding contraceptive method mix and emphasizing a wide range of methods with various attributes (Festin et al., 2016) rather than a select few hormonal methods can help ensure that women who wish to contracept have a meaningful choice. The widespread adoption of the shared decision-making framework for contraceptive counseling can help address both subtle and overt types of interpersonal coercion, emphasizing both provider's and patient's realms of expertise (Dehlendorf et al., 2017).

These research methods do not allow us to know whether providers are deliberately misleading women to encourage uptake or whether providers are themselves misinformed. In either case, the lack of access to accurate medical information infringes on women's ability to make informed decisions about their reproductive health. From the perspective of women who want to remove their implants, for example, it makes little difference whether providers refuse to remove them because they want to meet contraceptive prevalence targets or because they were not trained on removal techniques. The result for women is the same: they are compelled to continue a method they wish to discontinue. Thus, the absence of individual intent to coerce does not necessarily mean the absence of coercion. Importantly, however, while structural and interpersonal coercion have the same impact on women, their causes are distinct, and they will require different programmatic solutions.

5. Conclusion

Although voluntarism is ever the watchword in global family planning programs, to my knowledge this study is among the first to explicitly explore contraceptive coercion in sub-Saharan Africa post-ICPD. By understanding what women's experiences with contraceptive service provision are actually like, we can better assess the extent to which family planning programs are adhering to the principles of voluntarism that they proclaim. These results argue strongly for an end to family planning approaches that instrumentalize women's reproductive

capacity in the pursuit of external social goals and to target-driven contraceptive programs that create perverse incentives for providers to prioritize contraceptive uptake above all else. Broadening our understanding of coercion to include more subtle threats to autonomy can help combat the more insidious ways that fertility reduction is imbued in contemporary approaches to family planning.

These results in no way argue for a reduced access to family planning services or a scale-back of efforts to advance family planning programs. Access to high-quality contraceptive care is a transformative force for good in people's lives and should continue to be expanded and promoted throughout the world. Rather, these results argue for a greater emphasis on women-centered, rights-based care in family planning that allows for the full exercise of contraceptive autonomy.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2019.112531.

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