"He used to tell me that if I continue with the pills, then he would break my leg": A Qualitative Exploration of Reproductive Coercion in Bangladesh

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Abstract

Reproductive coercion (RC) includes behaviors that undermine women's autonomous decision-making in reproductive health and is known to negatively impact women's well-being and reproductive health. This qualitative study explored RC in Bangladesh using in-depth interviews (IDIs) and focus group discussions (FGDs) with women seeking violence support or abortion services and with abortion providers. All IDIs and FGDs were audio recorded, transcribed verbatim, and translated from Bangla to English for thematic analysis. We find that RC is perpetrated primarily by husbands and in-laws, and ranges from telling a woman not to use contraception to severe violence. RC occurs for a variety of reasons and is bidirectional, with women experiencing coercion to become pregnant or keep a pregnancy against their will, and coercion to avoid pregnancy or to abort a pregnancy against their will. Coping strategies included private use of contraception and abortion as well as strategies to avoid forced abortion.

Background

Reproductive coercion (RC) and intimate partner violence (IPV) negatively impact women's health and well-being and are strongly associated with poor reproductive health and unintended pregnancy (WHO et al., 2013; Silverman & Raj, 2014; Miller et al., 2010). RC includes male partner behaviors that directly interfere with women's attempts to control their fertility, typically through coercion to become pregnant against her wishes or interference with her use of contraception. Consensus regarding the critical and mechanistic role of RC in unintended pregnancy is mounting, with recent guidelines published by WHO (2013) identifying RC as a key aspect of violence to be assessed and considered by health care personnel globally, particularly in family planning settings.

Emerging evidence suggests RC is more prevalent in South Asia than in the U.S., affecting 12% of reproductive age women in Uttar Pradesh, India (GEH, unpublished), compared to only 5.1% in the U.S. context (Miller et al., 2016). RC is associated with non-use of contraception as well as history of unintended pregnancy in rural India (GEH, unpublished) as in the U.S. (Miller et al., 2010), suggesting that the mechanisms linking RC to poor reproductive health cross cultural and socio-economic lines. In Bangladesh, RC has not been measured, but IPV is prevalent with an estimated 50-60% of women having experienced physical and/or sexual IPV in their lifetimes and 30% having experienced such violence in the past year (Garcia-Moreno et al., 2006). IPV experience is associated with a 50-60% increase in unwanted pregnancy and over two times higher odds of abortion (AOR=2.60) in Bangladesh (Silverman et al., 2007; Pallitto et al., 2013). A recent study in Bangladesh identified IPV and discordance in fertility intentions regarding the terminated pregnancy between a woman and her husband as correlates of delayed post-abortion contraceptive initiation, particularly with spousal accompaniment for abortion (Pearson et al., 2017a). This study also found that abortion clients experiencing IPV were more likely to report that contraception was too difficult to obtain and inconvenient to use, that their husband and in-laws wanted the terminated pregnancy more than they did, and that their in-laws oppose their use of contraception (Pearson et al., 2017b). Though RC was not measured directly in these studies, findings suggest RC contributes to unintended pregnancy and acts as a barrier to uptake and use of abortion and post-abortion contraception. The present study seeks to understand RC in the Bangladesh context, including types, perpetrators, and reasons for RC as well as coping strategies women use in response to RC.

Methods

In-depth interviews (IDIs) and focus group discussions (FGDs) were conducted with menstrual regulation[1] (MR) and postabortion care (PAC) providers and counselors, and women age 18-49 who were either violence support service clients or MR/PAC clients recruited from three Medical College Hospitals in Bangladesh (Dhaka, Faridpur, and Rajshahi) from April to June 2018. Data were collected to inform the design of an intervention to mitigate the impact of RC on women's reproductive health, which will be implemented in Reproductive Health Services Training and Education Program (RHSTEP) Clinics within these three Medical College Hospitals. Women were eligible to complete an IDI if they were ever-married and former clients of a One-stop Crisis Center (OCC) located within one of the selected Medical College Hospitals. Violence support service clients were recruited after the monthly meeting held for former OCC clients with support from OCC staff. Women were eligible to participate in a FGD if they received MR or PAC services in a RHSTEP Clinic in one of the selected Medical College Hospitals. MR/PAC clients were recruited on the day of their uterine evacuation procedure or on the day of their follow-up appointment and invited to participate in a scheduled FGD. One MR/PAC provider and one MR/PAC counselor working in each RHSTEP Clinic completed an IDI. A total of seven IDIs were conducted with OCC clients, nine FGDs were conducted with RHSTEP clients, and six IDIs were conducted with MR/PAC providers and counselors.

Participants completed informed consent procedures in a private space with a trained female research assistant. IDIs and FGDs lasted 24-81 minutes (most were 45-60 minutes) and were conducted using a semi-structured guide, which explored experiences of RC (personal or others' experiences), including ways RC manifests, reasons for RC, and coping strategies women use. The goal was to understand RC in the Bangladesh context, and broad questions were asked to capture the full range of behaviors related to RC. Participants were asked about ways husbands, family members or others "pressured or forced women to get pregnant" and ways that they made it difficult for women to either access or use contraceptive methods. All IDIs and FGDs were audio recorded with participants' permission, transcribed verbatim, and translated from Bangla to English for analysis. All study procedures were reviewed and approved by the Bangladesh Medical Research Council

[1] Though induced abortion is only allowed to save the life of the woman in Bangladesh, menstrual regulation (MR) is widely available and allowed to "establish non-pregnancy" up to 12 weeks from the last menstrual period. In this study, MR will be considered equivalent to induced abortion.

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Data were analyzed thematically using a hybrid approach, which utilized deductive codes established *a priori* and inductive codes that emerged from the data (Fereday & Muir-Cochrane, 2006). This approach allowed us to explore facets of RC identified in other settings while enabling us to identify new themes emerging from the data in the Bangladesh context. Two members of the research team read the transcripts and created a first draft of the codebook, which was structured into themes based on topics covered in the guides and incorporated new themes that emerged from the initial read of the transcripts. Four members of the research team participated in coding, and all four members initially coded two interviews independently, one woman's interview and one provider's interview. Coding was then compared and reconciled between coders, and coders discussed recommended updates to the codebook as a team. The remaining English transcripts were coded independently by two members of the research team, and coders met approximately two times per week to compare and reconcile coding, discussing and resolving any inconsistencies in application of codes and the need for new codes. All four coders met weekly throughout the analysis stage to discuss themes emerging from the data and updates needed to the codebook. In this way, the codebook was iteratively revised to fit the data, and previously coded transcripts were re-coded as needed. Analysis was conducted using Atlas.ti version 7 (Scientific Software Development, GmbH, Berlin, Germany). Quotes are presented only by participant type due to privacy concerns. Socio-demographic characteristics of in-depth interview participants were recorded through a brief survey after the interview and are reported herein. These data were not collected for FGD participants.

Results

OCC clients participating in IDIs ranged from age 18-40. Only three of the seven women were currently living with their husband (one with her husband and children), three were living with their parents, and one was living only with her children. Five of the seven women had children (1-2 children), and two of the five had given birth to a child who later died. Six completed secondary or higher education, and one completed primary school education. All were Muslim, and three of the seven were currently working. Five had ever used contraception, and only one was currently using contraception.

Providers and counselors participating in IDIs were female and aged 31-55. They had been working in RHSTEP clinics 6-25 years.

Complexities of RC

RC was wide-ranging, including pressure or force to be pregnant and pressure or force not to be pregnant against the woman's wishes. A variety of actors were involved, including husbands, in-laws, and other family members. As one RHSTEP staff member articulated, families rather than women make decisions about reproduction:

> *When a girl comes here, she comes with a husband or other family members ok. She decides to come when her family members or others agree that she should get MR, but she does not agree with them. But this is not a headache. They convince her to get MR. On the other hand, the girl does not want to keep the baby, but the family wants. Ultimately the girl has to go with the family's decision because it is Bangladesh. Here, the girl has to obey the family's decision.* RHSTEP Provider/Counselor

Despite this lack of decision-making authority, participants suggested that women are responsible for controlling reproduction. Even if they are not allowed to use contraception, they are blamed for an unwanted pregnancy. One FGD participant talked about a young, newly married woman who was not allowed to use contraception because her family feared it would cause infertility in the future:

> *When she conceived, her husband did not want any baby. When she informed her husband about her pregnancy, it was too late for MR. It created a great problem in the family. Her family did not want to understand the problem. The husband has no fault, the wife needed to be careful. Is it possible for a man to be careful all the time? The wife must be careful.* RHSTEP client

Participants also reported complex situations where women were pressured to conceive by some family members, pressured not to conceive by others, and not allowed to use contraception. One FGD participant explained:

> *The mother-in-law wants the baby to be born much against the will of the woman. The husband does not want the baby to be born. He beat his wife for keeping the baby. The mother-in-law, on the other hand, beat her too as she [the woman]*

> *wanted to damage [abort] the child. The mother-in-law warned her sternly against any abortion. After the woman got beaten, her parents came to her house. After a quarrel with her in-laws, the parents took her to her own house. The in-laws of the woman told that if a baby boy is born, then she will be allowed in their house or else not. By the grace of Allah, a boy was born and she was eventually taken to her in-laws' house... She desired [to use contraception] alright, but her husband was against it as he didn't like it…He used to warn her repeatedly telling that 'if you do it, I shall kill you'.* RHSTEP Client

Types of RC

Pressure to Conceive and Obstruction of Contraceptive Use

Most women and providers reported knowing someone who was pressured or forced to become pregnant against her will. Most pressure came from the husband, but in-laws and other family members were also involved, especially for young, newly married women. In most cases, the pressure was verbal, but some participants described physical force. One FGD participant described her involvement in forcing a young woman to become pregnant:

> *My sister's son…He brought out a girl from her home. The girl is too young [to legally marry] according to her school's register. I got them married by keeping them at my home. As the girl was young so the boy had to go to prison for 9 months…So, I forced her to do this [have intercourse]…so that if she conceives then the boy [her husband] would suffer less. For this reason, we forced her. His father called him and tells him to make his wife pregnant shortly, and then he would be saved…She didn't want to have a baby at that time.* RHSTEP Client

Participants also reported that women experience pressure to keep a pregnancy against their will. One woman described how husbands can see a woman's desire for MR as a threat to their ability to provide for their family. An RHSTEP staff member reported that women are sometimes delayed seeking MR due to their husband's insistence that they keep the pregnancy.

Obstructing women's access to contraception was another commonly reported phenomenon. In most cases, the husband or family member simply told the woman not to use contraception or stopped purchasing the woman's contraceptive method. One woman articulated how someone she knew became pregnant due to her inability to access contraception:

> *With her husband, both of them together used [a contraceptive] method for two years. The year after that her husband wanted to take children. Again in-laws also desired to have grandchildren. And the girl was saying, "My exam is near. I will take baby after my examination. Otherwise there will be problem". She said like that…She then took baby. Her husband did not allow her to adopt any method. She had tried [to access a method]. She cannot go out. As this is a town, she cannot go out alone. She said, she said in front of her mother that –"Mother, I cannot go out. They keep all the gates locked. And there is problem if I go out as people all around know me. I could not go out, for that reason this baby"…Previously her husband used to bring [the pills]. Later on he stopped bringing anymore. And how will she go? She is a housewife, she does not know that much. And if she goes out then someone may say that, "Look, XXXX's daughter-in-law has gone out to buy things" -- this will create a bad impression. After that she conceived, this girl of ours is very young at age.* OCC Client

In more severe cases, women reported that food and other resources were withheld as well as threats and violence if they tried to use contraceptive methods.

> *As I used to take medicines [oral contraceptive pills], I could not breast feed my little child. He used to tell me that if I continue with the medicines [pills], then he would break my leg.* OCC Client

> *He does not let her come [to get contraceptive methods]. If she wants to come, she is beaten.* RHSTEP Client

Contraceptive sabotage was mentioned by some women who were able to access contraceptive methods. A few women described the husband demanding that an IUD be removed, and several reported that their husbands threw their oral contraceptive pills away.

> *She didn't want to take a baby…She wanted to take the pill. Her husband told "no, no need to take the pill, if you take the pill at the beginning, then there would be no baby"…She took one file [packet] of the pill but after that, she couldn't take. They threw it away by snatching it from her, told that "what's the need of taking the pill, we need the baby for our family, as we have few people in our family."* RHSTEP Client

Pressure Not to Conceive or to Abort

Some women and providers discussed pressure not to conceive despite the woman's desire to have a child. For some women, pressure not to conceive resulted in pressure or force to have an MR against her wishes. This type of pressure was primarily due to a husband or family's desire to discontinue the marital relationship. An RHSTEP staff member described a situation of forced MR, after which the husband planned to divorce her:

> *Some days ago, there was a case like this that: Her husband and in-laws all came and took the MR service. The woman did not want to do it. She wanted to take the child. But they told her to do it [have MR]. After doing it, the husband sent her to her mother's house. Then he denies her. He will divorce her.* RHSTEP Provider/Counselor

Two women also reported pressure to abort due to their husbands' concerns about infidelity. One OCC client described her situation:

> *No, I haven't been obstructed for using family planning method, but my problem is that my husband beats me up and he is telling me to abort my baby because he thinks this is not his. This is the reason for all my misery…We never used to use any contraceptive, not even a condom. What he used to do was, he used to withdraw outside. I don't know what God's wish is, but miraculously I became pregnant. Now he thinks he is not the father. He wants me to abort; he says he has financial problems.* OCC Client

Two examples were given of extreme physical violence against a pregnant woman because the husband did not want the child. One resulting in the death of the fetus, and one resulting in the death of the woman as well.

> *My husband? My husband did not want to have a child. What do you mean by an obstacle? He killed; he killed my child in the womb by beating me.* OCC Client

> *The girl wants a child but the husband doesn't want…They burnt the girl with hot water, and the girl died…The baby was in her womb but he doesn't want to have the child. Anger…very solid anger. Rice was boiling in the pot, that time he throws the hot water.* OCC Client

Reasons for RC

Lack of Information and Method-related Reasons

Many participants discussed how women were now "aware", meaning that they knew about contraception and felt it was important to use, but some husbands were "not very much aware." Despite this lack of awareness, both women and providers described husbands as key decision-makers for contraceptive use. One woman described her wishes to use contraception despite her husband's opposition, which stemmed from his lack of awareness:

> *When my youngest daughter was in my womb I became mad to think that how could I look after all of my children? How can I feed them! This thinking made me near frustrated. After that those sisters [family planning officers] who visits village [to] give pills… I told one of them that I want to take contraception. But she said 'you need permission from your husband'. I told her that whether my husband gives me permission or not I want this. Otherwise, I cannot continue more. How can I take the responsibilities of this large family! My husband is not so bad. But he does not have any idea about these matters. Then how can I manage everything?* RHSTEP Client

Misconceptions and misinformation about side effects were discussed by many participants as reasons for not being allowed to use contraception despite their desire to do so. The most commonly cited misconception was that nulliparous women should not use contraception because it will cause future infertility. Women reported that they wanted to use contraception anyway, but some expressed uncertainty, saying that for some women infertility may result from contraceptive use.

> *We can see that now, many newly-married couples are thinking to have a baby in late – they want to settle first and then to have a baby. They want to understand each other – but the family puts pressure – I am also facing this problem. At the primary stage [before having children], the seniors won't allow us to have any methods, it's not possible, and they advise us not to take any methods. "In future, you will not be able to take the baby" – they say like that. I think this is a wrong idea. But, some people say it – sometimes it may truly happen, taking contraceptives at the primary stage makes hard to conceive afterward.* RHSTEP Client

Husbands and in-laws were primarily concerned about future infertility associated with contraceptive use, but a variety of other misconceptions about contraceptive methods were also shared, including a commonly held concern that contraceptive methods could cause cancer or that methods would make a woman fat or ugly. A few women reported other ill health effects like pills

causing a stone in the stomach, IUDs traveling around the body, and sterilization making a woman weak and unable to do her daily work. One woman described that her husband did not allow her to use contraceptive methods due to a variety of misconceptions, and blamed any illness on her previous contraceptive use:

> *These [contraceptive methods] cannot be taken. This kind of problems. [My husband says] this will fatten me. I would not be able to conceive anymore. Also there is the likelihood of suffering from cancer. He would become angry [when he found out I was using pills]. He would tell that I take the medicines and then complain about headache. He does not allow me to consult a doctor…because I have caused the sickness whatever by taking the medicines. I used to take medicines. So for any sickness, the blame fell on my taking the medicines.* OCC Client

Women expressed that when they experienced side effects of taking contraception, husbands pressured them to discontinue rather than switching methods, saying that contraception is "not necessary". One RHSTEP staff member described this common problem that was expressed by several providers and counselors:

> *For example, the wife has some problem in case of taking pills. So, the husband needs to use condoms. But he doesn't want to understand his wife's physical problem. He only says, "Don't take it, as you are feeling dizziness". But then they need to take at least another method, but the husband doesn't want to understand it. They discontinue the method.* RHSTEP Provider/Counselor

Some women were allowed to use a contraceptive method, but not the method they wanted to use. This was particularly common for women who wanted to use an IUD or have a tubal ligation.

> *Husbands don't support the ligation at all. They are in confusion…I am using the pill, and my husband has no concern/interest in it. I have two kids, and I wanted to have ligation from the beginning and I have no intention to have more children. But he objected that "No, it is impossible, you can't get ligation". I have been using the pill for a long 13 years. I am taking the pill. I had an accident [unwanted pregnancy] a few days back.* RHSTEP Client

Religious Reasons

Women reported religion as a reason that they were pressured to have more children against their wishes. Several women said that both husbands and in-laws felt that God would provide for however many children they had. One woman expressed the difference between her husband's religious perspective on childbearing and her more pragmatic perspective:

> *I said [to my husband], "Since you will not let me take a [contraceptive] method then carefully abstain [from sex]. I also have trouble bringing up another one and two others are being brought up; that is it, financial constraints, this and that." I tried to convince him in many ways. Bringing them up, educating them, you have to consider it in all aspects. Then he said Allah provides sustenance, you shouldn't think like that. "Allah is the Lord of sustenance, whom He will, He will ensure his sustenance, and you need not feel tense regarding these matters."* OCC Client

Religion was also cited as a reason for some women not being allowed to use contraception despite their desire to do so. Several women and providers reported that regular use of contraceptive methods was a sin, but MR was more acceptable.

> *There is the influence of religion. Those who are Hujurs [a religious person] obstruct the use of FP method. The Hujurs are educated persons. But then they create obstacles. They do not allow their wives to take any method. But they are not against their wives for undertaking MR. They are just against the use of any method. They tell that it is a sin.* RHSTEP Provider/Counselor

Maintaining Power or Control over the Woman

Women also reported a variety of reasons related to maintaining control over a woman. Some were overt efforts to make a woman pregnant to control or dominate her. As one woman described:

> *Her husband used to have regular coitus without any precaution. They gave birth to many children. The birth of children makes a woman weak. It seems a woman becomes valueless after the birth of children. In such an instance, the husband wants still more children so that his wife remains under his domination…That woman used a [contraceptive] method for some time and then gave it up on demand from her husband. The husband wanted a child whereas the woman did not. The husband remained same at his decision that he needs as much as children as he likes. It could be one, two or three. There are the husbands like this.* RHSTEP Client

Participants also described more indirect ways of using pregnancy to maintain control over a woman such as making a woman pregnant to keep her in the family or to force her to discontinue her studies.

> *There is a social angle to this, they think having a baby with the woman closes her way of availability to other men…The problem occurs when early aged people get married to 14/15 years old girls…They restrict the woman continuing education by making her pregnant, which is the reason in most cases…It is happening everywhere, where women are tortured to take babies, men don't care what their age is or what their physical condition is. This is pure pressurization.* RHSTEP Provider/Counselor

Women Not Valued

Some participants discussed RC, not specifically to control women, but because women were seen as childbearing vessels and not valued beyond their sexual and reproductive capacity. One FGD participant described how she tried to help a neighbor access contraceptive pills because the neighbor's husband did not value her enough to facilitate her access to contraception:

> *Her husband is selfish and crazy. If there is anything from which he will gain something, then he will work. Otherwise, he will not work…[She called and asked] "Would you bring one medicine for me?" I asked her, "Which medicine?" She said, "If I do not take that medicine, then menstruation will start"...I brought the medicine [pills] and gave that to her. Her husband's behavior is not good…[She has] two children. She has one child with a disability. Another child is abnormal. The child is not able to walk and move around… [Her husband] is a scoundrel, evil, evil…He is mad to have sexual intercourse with his wife but does not care for her. This is what I have seen…It is not that he does not allow her to use [a contraceptive method]. I mean, the fact is he does not care about her.* RHSTEP Client

Another common situation was RC resulting from son preference, whereby husbands and in-laws valued the woman only for her ability to produce sons. One woman described being pressured to use contraception and threatened with divorce because she had a daughter rather than a son:

> *[My husband and in-laws] always said that if my children were boys then they could consider [keeping me in the family]. Otherwise, it is not possible for them to continue with me. There was a lot of conversation about this matter…Situation was going to divorce. They said they would not keep me in their family anymore. Send me away to*

> *my parents' house. I could not bear a boy, I had a girl. I am still suffering…Now they are planning how they can exclude my daughter from their property. [My husband and in-laws] do not create barriers to using a contraceptive method, rather they tell me to take a method, but I need children. I need at least two children whether daughter or son.* RHSTEP Client

Strategies for Coping with RC

Convincing Family Members

RHSTEP staff members and some women discussed convincing husbands and family members to allow a woman to use contraception. One woman convinced her husband to allow her to use contraception by arguing that it would be better for her health:

> *It happened in my case [not being allowed to use contraception]. But he is now very conscious…I made him understand. Frequent D&Cs affect health. Everything has its own end…He understands it. The fact is that he married me at a very early age.* RHSTEP Client

One staff member described a success story of a woman who became more independent through an economic livelihoods program and was able to insist on contraceptive use:

> *She was dependent on her husband 150%. She was taking the pill for a long time and she was suffering for this. But her husband wouldn't use the condom in any way. As she was dependent on her husband so she had to listen to her husband. But basically, she couldn't take it anymore. Then she came to our community program. Then we made the village women understand. We told her that "you can plant fruit trees at your home or do farming of hens, then you can earn". When we visited for the third time we found that she was doing accordingly. Then she told her husband that "if you don't use the condom then you can't live with me this month". Then it was seen that her voice was raised a little.* RHSTEP Provider/Counselor

Private Contraceptive and MR Use

Many women and providers discussed private use of contraception as a successful strategy for coping with pressure to become pregnant against her wishes and/or coping with the husband or family's opposition to her contraceptive use. Some providers preferred trying to

convince the family members over private use of contraception, but many were supportive of their clients' private use. One RHSTEP staff member discussed advising clients that contraceptive use is their decision:

> *They [husbands] have to understand that the physical change and the problem are for the woman to bear, men will never understand it the way a woman does and prioritize it. You don't need to tell your husband anything, come to the clinic and take injections in three-month intervals. In case of pills it's the same, come and get it from the clinic, you don't need to tell your husband.* RHSTEP Provider/Counselor

Women discussed many strategies for procuring contraceptive methods secretly, including going themselves to purchase a method, asking others to purchase the method for them, and asking their own family members to accompany them to obtain a method.

> *Take for example, they [husband and in-laws] say that it is not necessary to take all such measures [use contraceptive methods]. Then what we do is to take them secretly. We also go the places secretly for procuring the medicines etc. We have to save life.* OCC Client

Most women described using pills privately, but several women described having their father or brother bring them to the health facility to access injectables and tubal ligation. One woman described a strategy to obtain a tubal ligation without the husband's permission:

> *After two daughters were born, her husband wants more. But she does not want, she will not take any more children. Both of her children were born through caesarian. Now she will get ligation done. They had a lot of argument on this issue…There are two daughters – until a son is born he wants to have children. After that she said that no – she will not take so many children, she had two caesarian. She will have the problem to carry…She did not inform [her husband about the tubal ligation]. It was performed without informing. Her brother has signed [the tubal ligation procedure's consent form].* RHSTEP Client

Participants also described private use of MR services. One RHSTEP staff member described how both the woman and her attendant, typically the mother-in-law or husband, sign the informed consent for the MR procedure, but under certain circumstances women come for MR services without permission from their families:

> *When the woman has two or three babies but the husband wants more, then the woman comes by herself or with her friend, or when the woman is physically weak in that case we provide [MR] service.* RHSTEP Provider/Counselor

Avoiding Forced MR

Though forced MR was described by several participants, only one strategy for avoiding forced MR was mentioned. An RHSTEP staff member explained a strategy women request:

> *Normally a wife when she wants to bear a child, the husband or the mother-in-law tell her that the time is not ripe for bearing a child. She is brought here [RHSTEP] for undertaking a MR. Then the wife requests us to tell that MR is not possible as the child is now too big as per the ultrasonic report. The wife wants to have the child wholeheartedly. She complains that the husband and the in-laws do not want the child because they do not want to keep her in the family. If a child is born to her, then she cannot be divorced. In fact, the wife wants to keep the child in order to keep her family intact.* RHSTEP Provider/Counselor

Discussion

This qualitative study finds that RC is perpetrated by husbands and other family members and is bidirectional, with some women being coerced to become pregnant or keep a pregnancy against their will and others being coerced to avoid pregnancy or to abort a pregnancy against their will. Reasons for RC included husband and family member's lack of knowledge or misinformation about contraceptive methods, religious prohibition of contraceptive use, a desire to maintain power or control over a woman, or not valuing a woman beyond her reproductive capacity. Husbands and in-laws are often the primary decision-makers about women's reproduction, but women and providers reported coping strategies women use to overcome RC and regain their reproductive autonomy, ranging from convincing family members to private use of contraception and abortion.

RC was complex and bidirectional with women receiving blame for reproductive outcomes even when they were not in control of their reproduction. In families that did not want more children, even though women were typically given few options for controlling their fertility (not allowed to use contraception and presumably not allowed to refuse sex), they were still blamed for unwanted

pregnancies. In families that wanted more children when the woman did not, women were blamed for not getting pregnant when the family desired or for having a girl when a son was desired. Some women were in situations where their husband and in-laws disagreed about childbearing and received competing pressure and even violence from both husbands and in-laws. Obstruction of contraceptive use was the most common type of RC described by participants, but women also reported obstruction to receiving MR for an unwanted pregnancy and pressure to use contraception or MR against her will. This is in line with previous studies, which have demonstrated the bidirectional nature of RC, both pressure to become pregnant or keep an unwanted pregnancy and pressure to avoid pregnancy or abort a wanted pregnancy (Miller et al., 2014).

Many reasons for RC were reported. The most common reason was misinformation and method-related reasons, which were not always related to pressure to have a child. For young, nulliparous women, the obstruction was primarily due to a fear of future infertility if she used contraception. For other women, the obstruction was due to misinformation about other harmful effects on women's health such as cancer or concerns about side effects like weight gain. Some participants suggested that the perceived cost associated with treatment for side effects was a reason for RC. Religious reasons were also listed, especially for women married to religious men who worked in mosques or madrasas, with women saying that their husbands or families prohibited any contraceptive use on religious grounds. We also found an intersection between IPV and RC with women experiencing RC because the husband or family members sought to control her. This is in line with previous studies (Miller et al., 2014), but we also found more explicit types of control such as RC to force her to marry and to force her to end her education early. Finally, we found that women's low status in the household was a reason for RC with her primary value being in her ability to produce children, especially sons. As a result, her perspective on reproduction was disregarded.

Contraceptive sabotage was mentioned by some participants, primarily throwing pills away or insisting that an IUD be removed, but it was not as common as in other studies of reproductive coercion (Fay & Yee, 2018; Miller et al., 2014). Most previous research on RC has been conducted in the West and has identified covert tactics men use such as hiding a woman's contraceptive pills, removal of a condom during sex, or breaking condoms (Miller et al., 2014). In this setting, we did not find evidence of covert tactics being used, rather husbands overtly denied women access to contraception. It is likely that in this setting, covert tactics are not needed as it is more culturally acceptable for family members to directly control women's access to and use of contraception and other reproductive health services.

This study's findings should be viewed in light of its limitations. Data were collected from a small sample of providers and women receiving MR/PAC and violence support services in three Medical College Hospitals located in urban areas of Bangladesh. As a result, findings may not generalize to other geographic settings such as rural areas of Bangladesh. This sample only consists of a care-seeking population, and women who are able to access MR/PAC and violence support services may differ from those who are unable to access these services. In addition, though interviewers were trained and received extensive support and oversight, social desirability bias may have affected responses.

Conclusions

RC in Bangladesh was found to be complex with women experiencing RC from husbands as well as other family members. The various forms of RC call for different types of interventions to mitigate the impact on women's reproductive autonomy. Findings suggest that programs should improve men's knowledge about contraception and dispel myths to reduce the knowledge gap between men and women and increase support for women who desire to use contraception. We also find that women are already implementing a variety of coping strategies, which can be shared more broadly so that other women experiencing RC can implement strategies to regain their reproductive autonomy.

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