Reproductive coercion across three low to middle-income country contexts: Measurement, prevalence and associations with contraceptive use

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Significance/Background

Reproductive coercion (RC) is a form of gender-based violence (GBV) consisting of specific male partner behaviors that compromise female reproductive autonomy.[1,2] In the U.S., where this construct was first conceptualized and measured, RC is found to be distinct from intimate partner violence (IPV) and proximally associated with multiple poor reproductive health outcomes (e.g., contraceptive failure, unintended pregnancy).[3,4] However, little data exist on RC, its measurement, prevalence or connections to reproductive health in LMIC contexts.

Statement of research questions

1) Can a measure of RC originally developed in the US be adapted to assess such behavior across multiple distinct geographic and cultural contexts - Francophone West Africa (Dosso, Niger), East Africa (Nairobi, Kenya), and South Asia (Uttar Pradesh, India)?

2) What is the prevalence of RC across three samples of women of reproductive age (a population-based sample of married adolescents in Dosso, Niger; an urban clinic-based sample from Nairobi, Kenya; a representative population-based sample of women of reproductive age living in 25 districts of Uttar Pradesh, India)?

3) How is RC associated with women's and girls' recent family planning (FP) use across these three contexts?

4) Do differences in mix of FP methods available and utilized across these settings relate to differences observed in associations of RC with FP use?

Methods

Based on the three observed dimensions of reproductive coercion (RC; contraceptive coercion, contraceptive sabotage and pregnancy coercion), the measure of RC validated in the U.S. was adapted to each country context. Survey data were collected across three populations in three countries: a representative sample of married female adolescents ages 13-19 years across three districts of the Dosso region of Niger (n=1136); a representative sample of women ages 15-49 years in Uttar Pradesh, India (n=1770); and women and girls ages 15-49 seeking FP counseling across four clinics in Nairobi, Kenya (n=142). Surveys were conducted via verbal interviews with trained female RAs in the local language preferred by the participant, and data were recorded via tablet computers. All analyses exclude women who were either sterilized or pregnant at the time of the survey. Internal reliability of RC assessments, prevalence of RC and associations of RC with modern contraceptive use were determined.

Results

One in ten (9.8%) married female adolescents in Dosso, Niger; 12.1% of women ages 15-49 in Uttar Pradesh, India; and 40% of female FP clients in Nairobi, Kenya reported ever experiencing RC (6-item scales; Cronbach's alphas 0.73-0.87). Married adolescents in Niger experiencing RC were more likely to have used a modern method of contraception in the past 12 months, but only in cases where husbands were not aware of this use (i.e., covert use; AOR 1.93, 95% CI 1.03-3.64); this association of RC and increased odds of recent FP use, but only covert use, was also seen among female FP clients in Nairobi, Kenya (AOR 5.09, 95% 2.32–11.17). In contrast, women ages 15-49 in Uttar Pradesh, India were 80% *less* likely to have used a modern FP method based on experiences of RC (AOR 0.19, 95% CI 0.09-0.37). All associations were adjusted for demographics and experiences of IPV, thus these results reflect the independent contribution of RC to FP use beyond that which may be related to other forms of partner abuse.

Discussion questions

Why might the odds of convert FP use (i.e., use without male partner knowledge) and not overt FP use increase based on exposure to coercive attempts to limit their control over their reproductive choices?

Qualitative data from the U.S., India and Kenya indicate that women and girls facing male partner opposition to their use of FP will attempt to identify strategies to use FP without others knowing. This includes choosing to use FP methods that are more difficult for others to detect (e.g. injectable contraception and intrauterine devices) and accessing FP services in places, during times, and with people that will allow her to access these services without her partner's knowledge.

Why might the odds of women's and girls' FP use increase in one context and decrease in another based on exposure to similar forms of reproductive coercion?

As discussed above, the type of FP use that may increase in the context of RC is use without the knowledge of a male partner, and that such use will often involve use of methods that are more difficult for a male partner to detect. In Kenya and Niger, the methods more difficult to detect, injectables and IUDs, are widely available and are prevalent among the mix of modern spacing methods. In Kenya, injectables accounted for 48% of all method use. Similarly, in Niger, injectables accounted for 46% of modern spacing method use, the most commonly used form of contraceptive used among our sample of married adolescents. In contrast, injectable forms of contraception were not available in Uttar Pradesh at the time of the study, and the leading forms of contraception used were male condoms (45%), "standard days" (i.e., rhythm method; 28%), and oral contraceptive pills (16%). As opposed to injectable contraception, the three methods most commonly used in India are difficult or impossible to use without partner knowledge/cooperation. Thus, the relative availability and use of methods of FP that are difficult for partners to detect is likely to be responsible for the increased covert use among women experiencing RC in Kenya and Niger, and the reduced use of any form of contraception among women experiencing RC in India.

Knowledge contribution

Reproductive coercion is a prevalent form of GBV that compromises female reproductive autonomy in multiple contexts globally. Interventions to address RC should include availability of forms of contraception that women and girls may use without the knowledge of others, and FP counseling and education that addresses RC and reflects the needs of many women and girls to use methods covertly.

References

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