MEETING REPORT

**INTERAGENCY GENDER WORKING GROUP**

GENDER-BASED VIOLENCE TASK FORCE

# Exploring the Impact of Reproductive Coercion on Sexual and Reproductive Health Outcomes

**August 31, 2022**

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## Meeting Report

# Exploring the Impact of Reproductive Coercion on Sexual and Reproductive Health Outcomes

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This meeting report was written by Francesca Alvarez of the Population Reference Bureau (PRB), with contributions from Joy Cunningham and Alyssa Bovell of FHI 360.

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# Overview

## Background

Reproductive coercion is a form of gender-based violence (GBV) that aims to control or limit an individual's reproductive autonomy for the purpose of either preventing or causing pregnancy.[1] Reproductive coercion typically exists in three forms:

- **Pregnancy coercion:** Pressuring or forcing an individual to become pregnant against their will.
- **Sabotage of contraceptive methods:** Deliberately damaging, hiding, or interfering with contraceptive methods.
- **Controlling the outcome of a pregnancy:** Forcing an individual to terminate or continue a pregnancy against their will.[2]

Perpetrators of reproductive coercion can be intimate partners, family members, family members of one's partner, or even health providers. In many contexts, social norms, and state laws and policies make contraception and reproductive health services inaccessible to some populations, and these norms, laws, and policies serve to replicate reproductive coercion at a structural level and contribute to a climate where it can flourish.[3] Various studies have linked experiences of reproductive coercion to unintended pregnancies, poor mental health, and other forms of intimate partner violence (IPV), which can include physical, sexual, psychological abuse, and controlling behaviors.[4]

On Aug. 31, 2022, the Interagency Gender Working Group's (IGWG) GBV Task Force hosted "Exploring the Impact of Reproductive Coercion on Sexual and Reproductive Health Outcomes." This event focused on the connections between reproductive coercion, IPV, and domestic violence, as well as highlighting reproductive coercion's impacts on sexual and reproductive health (SRH) outcomes, particularly in family planning.

The event served as a forum for stakeholder dialogue and featured examples of program and advocacy approaches addressing reproductive coercion that have been successfully integrated into SRH programs. Panelists also shared considerations for funders, particularly around the roles they can play to strengthen commitments to prioritize and address reproductive coercion.

## Objectives

This IGWG GBV Task Force event aimed to:

- Explain how reproductive coercion is a form of GBV.
- Highlight the impact of reproductive coercion on SRH, particularly family planning outcomes, and explore reproductive coercion in the context of IPV and domestic violence.
- Learn directly from practitioners who have successfully incorporated interventions addressing reproductive coercion in their work on SRH, family planning, and GBV.
- Provide IGWG members with the opportunity to explore and identify possible entry points for integrating approaches to address reproductive coercion into existing and future programming and advocacy efforts.

## Format

The event began with a presentation providing an overview on the key elements of reproductive coercion, with examples as well as new findings and trends. A panel of expert implementers and researchers then shared key findings and promising practices from and challenges encountered in their programs. The panel discussion was followed by a Q&A session where attendees had the opportunity to pose questions to speakers. Panelists included:

- **Hannatu Abdullahi**, Reproductive, Maternal, Newborn, and Child Health Technical Director, Jhpiego, Nigeria
- **Jhumka Gupta (moderator)**, ScD, MPH, Associate Professor, Department of Global and Community Health, College of Health and Human Services, George Mason University
- **Elizabeth Miller**, MD, PhD, FSAHM (Fellow in the Society of Adolescent Health and Medicine), Distinguished Professor of Pediatrics, University of Pittsburgh School of Medicine
- **Jane Harriet Namwebya**, Senior Implementation Coordinator, Population Council, Kenya
- **Fura Gelzen Sherpa**, Board Member, Youth Peer Education Network, Nepal
- **Jay Silverman**, PhD, Professor of Medicine and Global Public Health and Associate Director, Center on Gender Equity and Health, University of California San Diego School of Medicine

# Key Takeaways

## Program Implementation Challenges in Reproductive Coercion

Panelists discussed several challenges program implementers face when addressing reproductive coercion in SRH programming, including:

- **Socio-cultural norms and beliefs that maintain men's decision-making power** over reproductive and family planning decisions and internalized belief of these norms among women and service providers, which can make it difficult to address reproductive coercion and IPV.
- **Limited comprehensive services** that can provide survivors of reproductive coercion and IPV with access to timely, safe, and survivor-centered care that supports their immediate and long-term health and well-being, as well as **lack of GBV referral networks**—and coordination across existing GBV services.
- **Lack of reproductive coercion-focused policies and guidelines** across levels of governance (local, regional, and national).
- **Health services infrastructure challenges,** including an inadequate supply of family planning services and access to a range of contraceptive methods.
- **Inadequate human resources and staffing,** as well as **lack of awareness, knowledge, and training on IPV and reproductive coercion,** even among health care providers.
- **Exclusion of marginalized groups** (for example, persons with disabilities and youth) in programs working to address reproductive coercion, domestic violence, and IPV.

## Promising Practices for Addressing Reproductive Coercion

Panelists shared promising practices for addressing reproductive coercion in the context of IPV and domestic violence, including:

- Acknowledging that gender inequality is at the core of all forms of GBV, panelists mentioned that **advancing equitable gender norms can address gender inequality and reduce GBV, including reproductive coercion.** Efforts to transform discriminatory systems and structures that underlie harmful gender norms—or gender transformative approaches—are necessary to impact and sustain change. These efforts should include promoting and nurturing equitable gender norms and behaviors that help reduce IPV and domestic violence and support family planning and reproductive empowerment.
- Panelists highlighted that **access to a broad range of family planning commodities and methods,** including female-controlled and long-acting methods that can be used discreetly, **and comprehensive family planning counseling for those experiencing IPV and domestic violence are key to addressing reproductive coercion.**
- Speakers acknowledged that **health providers' capacity to respond to reproductive coercion, IPV, and domestic violence using survivor-centered approaches must be strengthened**, as well as health providers' ability to direct those who have experienced violence to the appropriate services and resources. Panelists recommended conducting regular trainings on how to respond to disclosures of GBV, supporting ongoing capacity strengthening, and instituting supportive supervision structures for all staff.
- Reproductive coercion varies across contexts based on culture, geographies, norms, structures, and resources. Panelists emphasized that **context-specific and community-based models can help promote the sustainability of program goals and impacts**. For example, the clinic-based Addressing Reproductive Coercion in Health Settings (ARCHES) model, which is currently being adapted in Kenya and Nigeria, trains health care workers to screen and support survivors of reproductive coercion, as well as engages with and educates women on reproductive coercion at the community level.
- Panelists remarked that **collaborations with local organizations**, especially women's rights organizations and feminist movements working on reproductive coercion, IPV, and domestic violence, **can strengthen efforts to address GBV across all levels of the socioecological model (at individual, family, community, and systems levels)**. These efforts should include ensuring that reproductive coercion is addressed in SRH-related national health care policies and programs and that family planning is integrated into violence prevention and response efforts.

## Emerging Issues in Reproductive Coercion

Panelists discussed emerging issues, including gaps in evidence, faced by implementers while addressing reproductive coercion:

- **Greater attention is needed to determine which interventions work best at the community level** to improve support for women who experience reproductive coercion, as well as other forms of IPV and domestic violence through comprehensive, survivor-centered services and support.
- Panelists discussed the **lack of research and information available on reproductive coercion's impacts on persons with intersecting social identities and marginalized and excluded groups** (for example, persons with disabilities, gender non-binary individuals, young women, and members of the LGBTQI+ community).

In particular, women with disabilities face stigma around assumptions that they do not need or desire reproductive health services, threats of forced sterilization, and logistical challenges related to access to clinic spaces. Additionally, transgender and non-binary individuals face unique constraints on their reproductive freedom in the context of sexual exploitation. Panelists also noted the need for greater understanding of the effects of reproductive coercion on those in fragile settings and/or affected by conflict, as well as forcibly displaced persons.

- Speakers noted **more investment is needed in implementation science** to better understand the critical elements of program approaches and challenges, particularly those related to addressing the norms and beliefs of community members, health providers, and state actors regarding women's rights and reproductive autonomy. This clarity is especially important in contexts where men have traditionally had decision-making power over reproductive choices. Program implementers and health providers should better understand and balance the concept of male engagement with women's rights and choice, recognizing that not all women want male partners to be engaged in these decisions.
- Panelists pointed out the **lack of data and information around the linkages between reproductive coercion and economic abuse and justice** and noted the need for more attention to and understanding of these linkages.

# Recommendations

Key recommendations for program implementers, researchers, governments, donors, and multilateral institutions that emerged from the discussion are outlined below.

## Recommendations for **Program Implementers**

- Promote access to a wide range of contraceptive methods by working with relevant partners and groups (such as pharmacists).
- Strengthen the capacity of health providers (and others who work with individuals experiencing reproductive coercion, for example, social workers) to respond to reproductive coercion, IPV, and domestic violence using survivor-centered approaches and to provide comprehensive family planning counseling.
- Integrate efforts to address reproductive coercion within existing and future programming, particularly family planning and reproductive health programs and adolescent clinics, that center individuals' choice and agency.
- Implement context-specific and community-based models and partner with local organizations—particularly women's rights organizations and other groups addressing GBV—to address reproductive coercion.
- Raise awareness of reproductive coercion-related history in the communities and contexts implementers are working in, recognizing that this history may be traumatic for patients, especially those in marginalized groups, and that provider biases may inhibit rights-based care and reproductive empowerment. This knowledge, along with robust provider behavior change interventions, can help create inclusive, safe, and trustworthy clinical environments for patients, especially when making recommendations on appropriate contraceptive methods, and contribute to an enabling environment for reproductive empowerment.

## Recommendations for **Researchers**

- Examine reproductive coercion's impacts on persons with intersecting social identities and marginalized groups.
- Assess the linkages between reproductive coercion and economic abuse and justice.
- Evaluate and promote the adaptation and implementation of context-specific, community-centered approaches.
- Invest in implementation science to better understand the critical elements of program approaches and challenges in reproductive coercion programs.

## Recommendations for **Governments, Donors, and Multilateral Institutions**

- Incorporate reproductive coercion and IPV-related issues into national policy and program implementation frameworks.
- Invest in and strengthen partnerships with local agencies and organizations, community and survivor-centered programming, and services and support systems—including GBV referral networks—for those experiencing IPV, domestic violence, and reproductive coercion.
- Support access to family planning services and a wide range of contraceptive methods.
- Foster cross-sectoral collaboration and coordination to advance gender equality and address reproductive coercion.
- Adopt policies that promote access to comprehensive sexual education that addresses healthy relationships, communication, and openness to adolescent sexuality and gender identity.

# References


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## The Interagency Gender Working Group

The Interagency Gender Working Group (IGWG), established in 1997, is a network of multiple nongovernmental organizations, the United States Agency for International Development (USAID), cooperating agencies, and the Bureau for Global Health of USAID. The IGWG promotes gender equity in order to improve global health and foster sustainable development.