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Research Article

Reproductive coercion experiences and reproductive outcomes among women in low and middle-income countries. Qualitative evidence synthesis

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ABSTRACT

Background: Reproductive coercion is behavior that another person or the partner purposefully restricts women's reproductive choices. Reproductive coercion is an emerging public health issue that was closely related to intimate partner violence but recently identified as an independent phenomenon. The aim of the analysis is to organize the qualitative evidences regarding impact of reproductive coercion on reproductive outcomes of reproductive age women in low and middle income countries.

Methods: Data bases like PubMed, PsycINFO, CINAHL, Web of Science, and Embase for published researches and openGrey and Google Scholar were searched for Gray literatures. Primary human studies, English language, studies from low and middle income countries were included. Data were identified from the involved studies using Critical appraisal skills Program. The Harden and Thomas thematic analysis approach was used to analyze and organize the evidence and the GRADE-CERQual approach was used to assess confidence in review findings. Report of the synthesis was based on the Cochrane Effective Practice and Organization of Care template.

Result: Sixteen studies from Low and Middle income Countries were included in the review. Majority of the studies were pure qualitative except few studies that were mixed studies with clear qualitative parts. Reproductive coercion manifested as pregnancy promotion, contraceptive sabotage, deceptions and forced sex. Women who were victims of reproductive coercion had unintended pregnancy, and they were forced by their partner to have abortion against their will.

Conclusion: The common types of reproductive coercion identified included pregnancy pressure, contraceptive sabotage, and controlling the outcome of a pregnancy. Unintended pregnancy and forced termination of pregnancy were the reproductive outcome commonly happening to the women because of reproductive coercions.

Keywords: Reproductive Coercion, Contraceptive Sabotage, Pregnancy Promotion, Reproductive Outcomes

INTRODUCTION

Reproductive coercion (RC) is the behavior that restricts decision making ability of the women about their reproductive health in the way they wanted to have. In RC the autonomy of the women to make her own decision was interfered by another person. This behavior includes has two big forms which is pregnancy promotion encompassing pressured or forced conception and contraceptive sabotages. The other form of RC is pregnancy prevention which includes pressured or forced contraception use, sterilization and forced abortion. Any behavior that purposefully restricts another person's reproductive options is considered RC. In order to maintain power and manipulate the relationship, RC is frequently a partner's demand to enforce their own reproductive intentions through physical, psychological, sexual, and different ways. These violent acts frequently make it difficult for women to exercise their autonomy and right to reproduction [1-6].

Reproductive coercion is a subtype of intimate partner violence (IPV) and it might help to explain the connection between IPV

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and grave consequences for sexual and reproductive health. Reproductive coercion, however, can happen without physical or sexual violence [7]. RC has been shown to be related to the threat of unwanted pregnancies aside from the risk of IPV [4].

As proven by systematic review of the United States by Grace and Anderson, RC was significantly more likely to be associated with women experiencing other forms of IPV, women of lower socioeconomic status, Latinos, and Africans. It also affects women of American descent, or mixed race [8]. Most of the existing evidences from qualitative studies are focused on the intimate partner violence and RC is the recent phenomenon that was not adequately addressed in low and middle income countries.

From this qualitative analysis, the researchers wanted to answer the question, what are the maternal experiences of reproductive coercion and their reproductive health implications in low- and middle-income countries? The objective of this analysis was to synthesize qualitative evidences of RC and reproductive health outcomes among women in low and middle income countries.

METHODS AND MATERIALS

This review utilized the Cochrane Effective Practice and Organization of Care (EPOC) for analysis of qualitative evidence and followed the Preferred Reporting Items for Systematic Review and Meta-analysis (PRISMA). This review additionally complies with the EPOC's a priori protocol [9].

Search Strategy

The first stage of search of PubMed was excuted, followed by an analysis of the text words contained in the title and abstract of the index terms used to describe the articles. The primary searches informed the development of search strategies tailored to each source. Research databases such as MEDLINE (PubMed), APA PsycINFO, CINAHL, Web of Science for published researches, and gray literature sources such as Google Scholar.

Selection Criteria

Basic Human researches, English, LMICs have been used as inclusion criteria to include the researches in the analysis. Primary studies with qualitative research designs focused on RC and reproductive health outcomes in LMICs, studies of human RC by intimate partner, family, or marriage, is eligible for inclusion. Titles and abstracts as well as full texts are reviewed by independent reviewers. Studies investigating only intimate partners or sexual violence were excluded. After searching, all identified articles were collected compiled and, uploaded to Endnote v7, and duplicates were removed. Titles and abstracts were reviewed by two independent reviewers who were members of the working teams (JM and TG) and assessed against review inclusion criteria. Full texts of the included studies were obtained and evaluated in detail using the inclusion criteria. Full-text studies that did not meet inclusion criteria have been excluded and reasons for exclusion had been provided (Appendix II). The results of the search are shown in the PRISMA flowchart [10] [Figure 1]. Any disagreements between

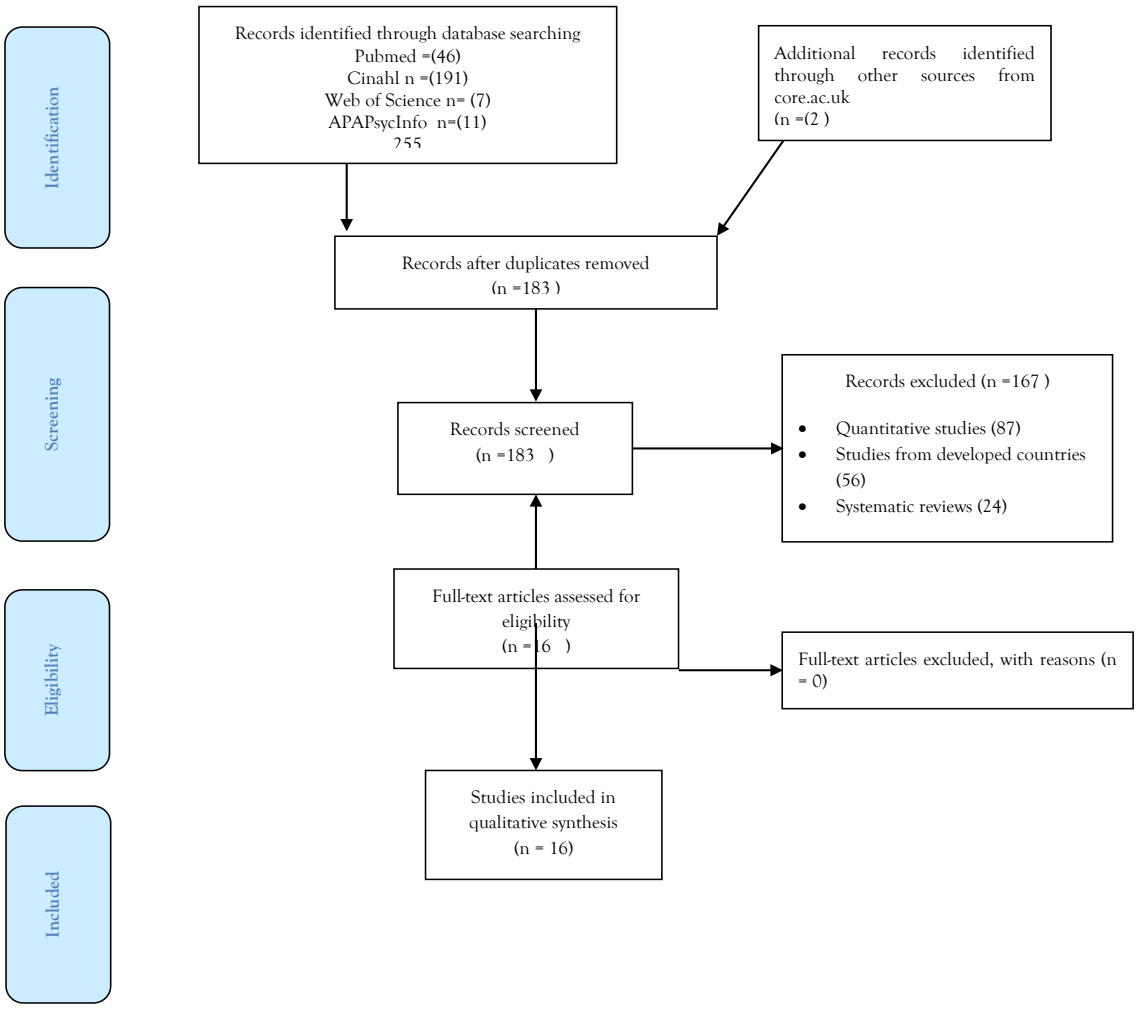

Figure1: PRISMA flow diagram showing study selection.

reviewers were resolved by discussion and no third reviewer was required.

Criteria for considering studies of this synthesis

Research types

The synthesis includes major studies using qualitative research designs such as ethnography, phenomenology, and grounded theory, primary studies that have used focus group discussions (FGDs), observations, and individual interviews as a method of data collection, and studies that utilized the thematic analysis method were included. The articles that have utilized the mixed methods design but had clear portion of qualitative findings were extracted. For the analysis of the evidences, we have included published and unpublished studies conducted in English from 2000 to September 2022 as the RC is recent phenomenon.

Topic of interest

According to definition by Marie Stopes International (MSI) Reproductive Choices, RC is birth control sabotage, the pregnancy that the male forces the women to happen, and control of the results of the pregnancy. Actions that constitute coerced reproduction includes interfering with another person's contraception, controlling the outcome of a pregnancy through the mechanism of forcing someone to have an abortion or carrying the pregnancy to term against her will, coercing a pregnancy, and sterilizing [3].

Types of participants and settings

The analysis team included studies that have focused on experiences of women regarding RC and reproductive outcomes of the women from LMICs.

Data collection and analysis

We have developed a form for this synthesis to extract data from the included studies and to assess methodological limitations; the Critical Appraisal Skills Program (CASP) was used. We analyzed and summarized the evidences using the thematic analysis approach of Thomas and Harden, the reliability of the review results was assessed using the GRADE-CERQual approach. We reported the analysis using the Cochrane Effective Practice and Care Organization (EPOC) template for qualitative evidence synthesis [11].

Study Selection

Citations identified through database searches were collated and uploaded into EndNote and duplicated removed and the screened articles then uploaded to Covalence, where further duplicates were removed. All titles and abstracts of the identified studies were screened by two independent reviewers (JM, TG) to evaluate eligibility for inclusion. Any conflicts that were arisen between the reviewers were resolved through discussion and third reviewer was not needed [12].

Data Extraction

Data was extracted from included studies by two independent reviewers (JM and TG) and reviewed by a third reviewer, TH using a Word template specifically designed for this review. The template contains information about the study setting, sample characteristics (population), objectives, design, methods of data collection and analysis, qualitative results, supporting citations, conclusions, and associated tables, figures, or images [13]. We have identified the key concepts from individual qualitative studies that were included in the analysis [14]. The extracted data included specific details about the populations, the context in which the study was conducted, culture, geographical locations, the study method, and the phenomenon of interest relevant to the review question. Findings of the analysis that extracted were assigned CERQual assessment levels as low confidence, moderate confidence and high confidence for individual studies.

Assessment of the methodological quality

The CASP tool was used to assess the methodological quality of each included study. Methodological limitations were assessed according to their purpose, methodology, study design, recruitment strategy, data collection, author reflexivity, ethical considerations, data analysis, presentation of results, and contributions to the study. Any disagreements between reviewers were resolved by discussion and no third reviewer was required. The results of the systematic critical assessment are reported in narrative form. All included studies have mentioned the phenomenon under analysis and contributed to the review.

Data Synthesis

The data were analyzed and synthesized using the thematic synthesis approach. Thematic synthesis is used to analyze qualitative data by generating meaning from people's perspectives and experiences on the phenomena. We used a three-layer analysis approach. First, we freely coded the results of the primary research line by line by though reading, then organized the idea under defined themes from each included researches. We brought similar ideas from each paper under the predetermined theme and matured the themes. Qualitative analysis was conducted using Atlas.ti 23 [15].

Evaluation of the confidence of the findings

The pooled final results were graded based on the ConQual approach for establishing confidence in the pooled results of qualitative studies and were presented in the summary of the results.

RESULTS

Study Inclusion

The database search identified 255 papers and 2 papers from the gray literature databases. After removing duplicates, 183 studies were kept for next step of screening by title and abstracts. From these 183 articles, 167 studies were removed before moving to the next level. Eighty-seven papers used quantitative methods, 56 were excluded because they were from developed countries, and 24 were systematic reviews. Finally, there were 16 articles that were eligible and included in the next step of the analysis.

Study Characteristics of included studies

Three synthetic steps were used to analyze each finding. The first step is to read and code the results line by line, organize these codes to form descriptive themes, and finally create the analysis themes included in this report [16].

Study Characteristics

All included studies were published in the last two decades and two unpublished studies were also included. Based on inclusion criteria, all included studies were conducted in LMICs. Eleven [17-28] out of the included sixteen studies have utilized pure qualitative studies while five of the studies have used mixed method design [29-31] with clear part of qualitative findings.

Confidence in Evidence from Reviews of Qualitative Studies (CERQual) includes criteria for assessing the reliability of results from the synthesis of qualitative evidence, qualities of the methods utilized, consistency, richness of the data and its importance for the synthesis. It contains four elements [Table 1]. A high-confidence article is the one whose review results are likely to adequately explain the phenomena to the level that it will be easily understandable by scientific community. Moderate Confidence is articles with the test results likely to adequately represent the phenomenon of interest. For articles marked with low confidence, the review results may well represent the phenomenon of interest. For papers with very low confidence, it is unclear whether the review results adequately represent the phenomenon of interest [32, 33].

Findings from these studies were organized into major themes that originated from the analysis.

Theme I: Types of reproductive coercion faced by women

The women in the study reported that forced sex without a condom, promotion of pregnancy (most women said men do it consciously to get them pregnant), and availability of contraceptives. They have experienced various forms of reproductive coercion, including removing condoms during intercourse while refusing to pay. Fertility promotion affects all women of childbearing age, with young women aged 15 to 24 experiencing pressure to have their first child, and others aged 25 to 49 with RC reported being associated with more children or male children. Research shows that various forms of marital sexual assault include cheating, verbal threats to have sex, and forced penetrative sex [19, 29].

Theme II: Birth control sabotage

Male partner behavior related to contraceptive administration was described by respondents across a range of forms of sabotage, from condom refusal and intentional abuse to blatant interference with women's contraceptive efforts. Participants describe their use of the barrier method as male, as their male partners expressed discomfort or anger. Because of this, even if you choose to, you'll use it incorrectly. As some respondents reported, partners monitored ovulation cycles and interfered with birth control to allow women to conceive. We compromised the durability of the condom by hiding or throwing it away [34, 35].

"He used condoms when we first started, and then he would fight with me over it, and he would just stop using condoms completely and did not care. He got me pregnant on purpose, and then he wanted me to get an abortion." (16 years of age women married to 22 years husband)

Table 1: Qualitative evidences on effects of reproductive coercion on reproductive health and outcome among reproductive age women in low and middle-income countries, summary of CERQual assessments: A qualitative evidence synthesis, 2022.

SN	Emerged themes	The reviewed literatures	CERQual assessment	Details of CERQual assessment
Types of RC				
1	Types of reproductive coercion faced by women	(19, 29)	Low confidence	There is no concerns of coherence, Low
	Forced sex without condom, pregnancy promotion and removing condom during sex, refusing to provide money for birth control.			Concerns about methodological q (methods mixed, but distinct qualitative part) and serious concerns about relevance.
Birth control sabotage				
2	Males totally dislike using barrier methods as the male partners expressed displeasure or indignation. Some males also monitored the ovulatory cycles and sabotaged the contraceptive so that the women can get impregnated. Partners disrupted condom durability by piercing condoms, hiding or discarding contraceptive pills, and flushing pills down to the toilet. Deception by male partner as they are sterile. Some men forced a woman to so that they can give permission to use permanent contraceptive method tubal ligation.	(24, 34, 35)	Moderate confidence	Minimum concern for consistency of the findings and for importance of the finds and there are mild concers related to methodological quality about reflexivity, and data analysis.
Pregnancy Pressure				
3	Partners of the women who are abusive used different tactics including verbal violence, pressure, and mistreatment, to encourage unwanted pregnancies in women. The women participated in the studies reported as they were coerced to have impregnated against their will by their intimate partners or husbands. Men deny women the freedom to choose which contraceptive method to use. After a woman becomes involuntarily pregnant, an abusive male partner prevents her from obtaining abortion services by withholding money for an abortion or preventing her from booking an abortion service. Some partners also threatened the women as he can kill her if she had an abortion. Even when men had not used contraception by themselves, they enforce the pregnancy to be taken to term by any means.	(1, 36)	Moderate confidence	Minor concerns regarding coherence and richness of the data; minor concern [studies conducted in LMICs] and moderate concern about relevance andconcerns about qualities of the methods used [reflexivity, ethics, goals, methodology, data analysis]
RC and its consequences on women's reproductive health and outcomes				
4	Unintended pregnancy due to pregnancy promotion by their male partners, severe trauma and depressive symptoms from forced abortion.	-18	High confidence	Richness of the data and coherence was maintained; minor concern [studies conducted in LMICs] and moderate concern about relevance andconcerns about methodological limitations [reflexivity, ethics, goals, methodology, data analysis]

Deception by male partner is one of the methods of sabotaging contraception. The partners deceive their women by telling them that they have taken medication that made them infertile, had operations that prevent them from impregnating women [24].

Some men forced their partner tubal ligation made for them so that they cannot get pregnant which the women considered as significant breach of her right [24].

"After I had two kids and two miscarriages, he decided that it was time for me to use birth control. . . . When he said birth control I figured he was just talking the pills or maybe the shot. He decided to force me into having my tubes tied. And that's always been heartbreak to me".

Theme III: Pregnancy Pressure

Pregnancy pressure has two fertility-promoting forms, in which the male partner wishes the female partner to conceive. Male partners who are abusive use different tactics including emotionally persuasive behaviors, like verbal abuse, pressure, and intimidation, to encourage women to get pregnant against her will. Emotionally manipulative, including threatening to end the relationship. Women also reported being forced to have sex against their will in order to get impregnated. The partner challenges their women's ability to decide fertility promotion was achieved by denying women the freedom to choose which contraceptive method to use. After the woman became pregnant, the abusive male partners prevent women from getting abortion services using different tactics. The tactics they used were not paying the money that is needed to get abortion services for the women, providing different reasons to prevent the women from going to clinic at her appointment so that she could miss the service. Even if she managed to go to the clinic with her partner at the clinic he mess things up so that she leave the clinic before getting the service. There were also partners who have threatened the women as he can kill her if she had an abortion for the pregnancy that have happened without her will.

"He really wanted the baby he wouldn't let me have, he always said, "If I find out you have an abortion," you know what I mean, "I'm gonna kill you," and so I really was forced into having my son. I didn't want to; I was 18. I was real scared; I didn't wanna have a baby. I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn't want to have a baby but I was really scared. I was scared of him".

The negative aspect of pregnancy pressure is when the partner coerces or encourages abortion through verbal or emotional pressure. Some women who wanted to have children said they experienced pressure and coercion to have an abortion. There were situations in which a man requested an abortion as soon as his partner became pregnant, even if he was not using contraception to avoid unwanted pregnancies. Threatened to kill the woman and her baby, the woman was emotionally coerced into having an abortion, accused the woman of infidelity and threatened to end the relationship. They pressured women into conceiving through constant and constant verbal pressure, threats and physical violence to conceive [1, 17, 36].

Theme IV: Consequences of reproductive coercion on reproductive health of the women

Reproductive coercion that occurred with physical violence or RC that has happened independently has ultimately led to unintended pregnancy which affected disabled women than nondisabled women [18]. Having abortion service against their will cause severe trauma and depression on the women [37]. Women were forced to have sex when they were not like to have sex because of different reasons like feeling sick. However, their partners did not listen to them and had forced sex sometimes involving other types of violence like beating the wife [38]. Male partners use the ability of women getting pregnant to put in their trap as once she get pregnant he can manipulate her. Not only being pregnant but also having children makes the women to need the partners which directly or indirectly affected their reproductive lives [36]. Even though they know as their partner is causing reproductive coercion against them, some women are unable to resist their partner because they want to continue their education and pursue their career goals [18]. From our synthesis we have found that women affected by RC were likely to have neonates having birth weight of less than 2500 grams [39].

Theme V: Other health impacts of RC

Reproductive coercion does not affect only reproductive health of women. It also affected other health dimensions of women including distress, trauma and high levels of depressive and anxiety symptoms [40].

DISCUSSION

The purpose of this evidence synthesis was to present qualitative evidence on reproductive coercion and its impact on reproductive health outcomes. Women have shared their experiences regarding reproductive coercion by their intimate partners. Ranges of tactics for RC were identified by the participants within structural themes of pregnancy promotion, contraceptive sabotage and abortion services prohibition and forced abortion. Impact of reproductive coercion on women is twofold as expressed in impact of reproductive health like unintended pregnancy, sexually transmitted diseases; women did not get contraception and abortion services when needed and non-reproductive health consequences including trauma and anger. We also found that reproductive coercion of different types were identified in our synthesis including pregnancy promotion, deception, verbal threats to obtain sex, forced penetrative sex. Our synthesis expanded the understanding related to pregnancy promotion in which the younger women were forced to have their first child from partner and from her mother in-law. In a similar manner the women older than 25 years of age were forced to have additional child or in most cases they were pressurized to have male child [19, 29].

Consistent with studies from other LMIC settings, the description of RC from this synthesis emphasized the role of both the male intimate partner and in-laws in RC execution, particularly in facilitating pregnancy [2, 41].

RC is possible contributor for unwanted pregnancies and reduced reproductive autonomy, and may be associated with outcomes such as unsafe abortions and unplanned forced births. From this synthesis, we identified grave human rights violations and restrictions on women's reproductive autonomy, as some men forced women to undergo tubal ligation, which women viewed as a grave violation of their rights [24]. From our synthesis we have found that women affected by RC were likely to have neonates having birth weight of less than 2500 grams. The literatures of intimate partner violence have demonstrated that being exposed to IPV results in poor birth outcomes like low birth weight and

it is reasonable as the reproductive coercion and birth weight are related with the same mechanism [39].

CONCLUSION

The recently developed phenomenon, RC is getting attention of public health researchers. This synthesis of qualitative researches related to reproductive coercion tried to explore the women's experiences of forced reproductive practices and their effects on reproductive health and outcomes. A variety of behaviors by male partners to try to manipulate the reproductive lives of women including when to get pregnant or not. Synthesis found common patterns in various manifestations of reproductive urges commonly triggered by male intimate partners and, in some cases, mother-in-law. Common types of reproductive coercion identified include contraceptive obstruction, fertility promotion, and forced sex. Unwanted pregnancies and forced abortions have often been the result of reproductive coercion.

Implications

Reproductive control is an understudied phenomenon that can affect the reproductive health of women with RC (unintended pregnancies, rapid repeated pregnancies, sexually transmitted infections, repeated failure to meet sexual goals). Interventions aimed at reducing RC must be at different points of action starting community teaching and screening women for possible coercion by intimate partner to plan for better care and treatment for victims. Since contraceptive use in one of risk factor for RC, during ANC discussion it is possible to provide the covert method of contraception until the partner is convinced and until she feels safe to use the overt methods of contraception. Covert contraceptive types may improve reproductive health outcomes for forced reproductive women. During prenatal care, the provider must provide individualized care in which she must be asked if she was forced to get pregnant or if she was forced to terminate the pregnancy.

Strength and Limitations

The use of the Cochrane systematic review methodology was strength of the study. The methodological quality of the included studies was high. Due to the relatively recent coining of 'reproductive coercion' as a unique phenomenon, a broad search strategy enabled us to capture experiences of behaviors defined under different terminology including reproductive control, contraceptive sabotage and pregnancy promotion. We have used many search engines to include as much as possible primary studies from LMICs. However, our review is not free of limitations, is possible that due to evolving language and scope of what is understood as reproductive coercion, some key relevant studies may not have been included as we limited our search only to literatures published in English.

RECOMMENDATIONS

For Researchers

This synthesis is focused on qualitative evidences from LMICs so, the next researchers must focus on both developed and developing countries as the phenomenon is recent and ca happen across the globe. As the phenomenon of reproductive coercion is relatively new and most of the qualitative researches were conducted in United States and other developed nations the researchers from developing world must give attention to it. The available studies are mostly quantitative and the sensitive issue may not address well using quantitative, so attention has to be given for qualitative studies.

For Health System

Based on the findings of our synthesis we recommend the health care system to include reproductive coercion assessment in maternal health care services like antenatal care services. Health professionals should ensure that best practice screening methods are used to increase detection and early intervention of reproductive coercion.

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PATIENT CONSENT FOR PUBLICATION

Not applicable

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