REPRODUCTIVE COERCION

Phase 2 Results from 10 PMA Sites

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PERFORMANCE MONITORING FOR ACTION

KEY MESSAGES

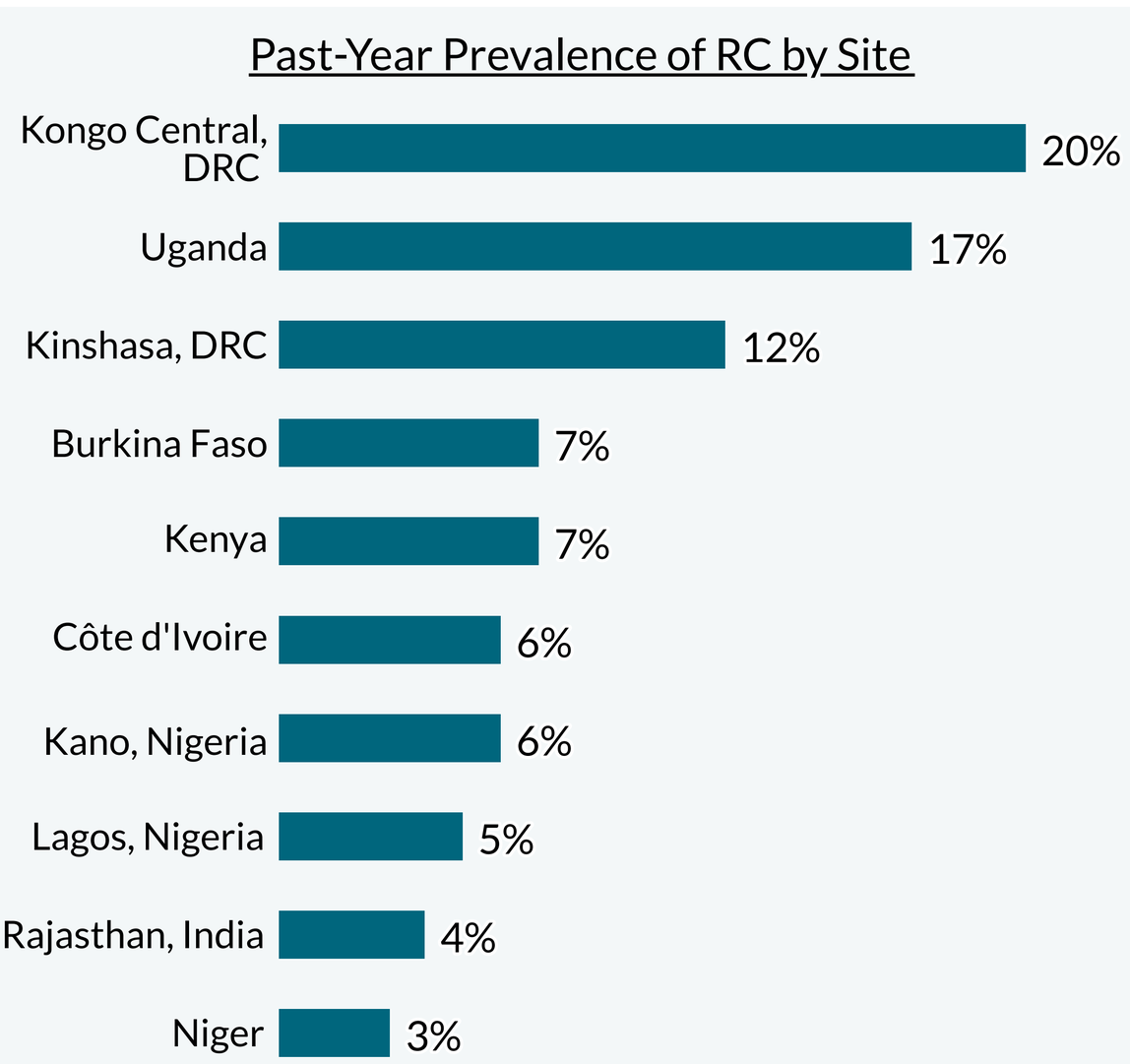
- **Reproductive coercion (RC)** is a type of abuse where a partner asserts control over a woman's reproductive health.[1]
- Prevalence of past-year RC **ranged from 3% in Niger to 20% in Kongo Central, DRC**. Polygynous partnerships were a risk factor for RC in six of the 10 study sites.
- In Burkina Faso, Côte d'Ivoire, and Kenya, **the majority of women experiencing RC experienced it in isolation or coupled with emotional intimate partner violence (IPV).**
- **Past-year RC was associated with increased odds of covert contraceptive use** in Burkina Faso, Côte d'Ivoire, and Kenya (adjusted odds ratio [aOR] range=2.84-5.77).

PMA

PMA administers annual population-based questionnaires to nationally or regionally representative cross-sections of women ages 15-49. The Phase 2 questionnaire with embedded gender-based violence questions was administered across 10 study sites (shown below) from November 2020 - May 2022. RC survey items[a] were asked among all women while IPV items[b] were only asked among married or cohabiting women. Analyses were limited to women in need of contraception. Full survey methodology is available at www.pmadata.org.

REPRODUCTIVE COERCION [1]

<u>Past-Year Prevalence of RC by Site</u>



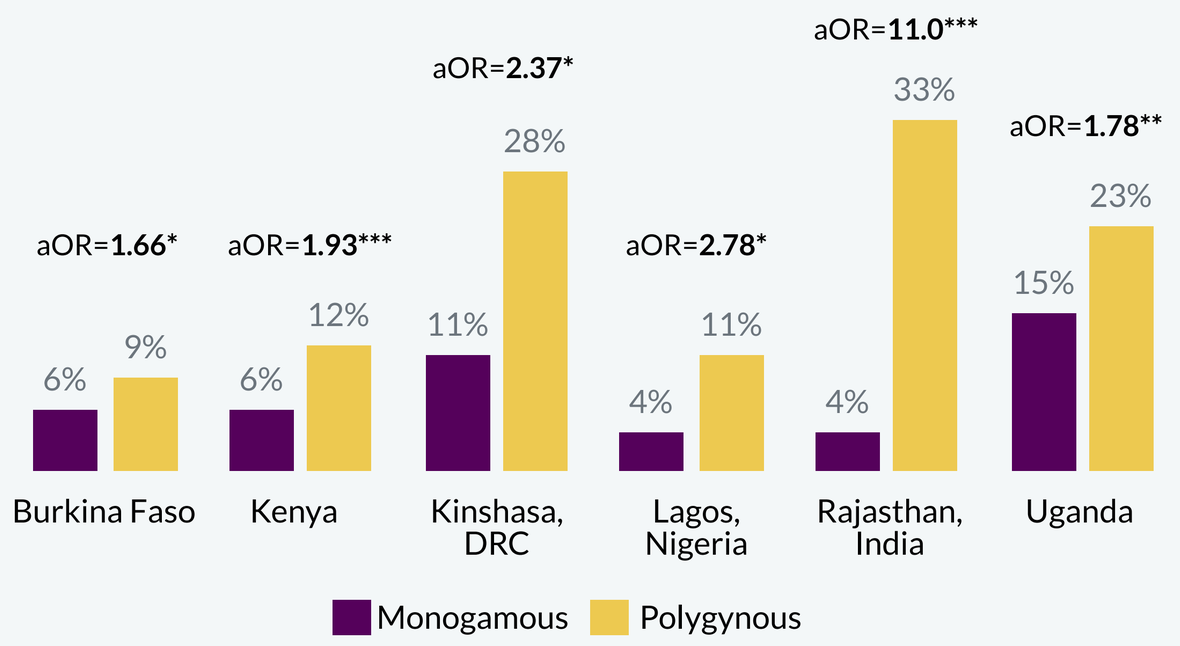
[a] **RC Survey Items: 1)** Made you feel bad or treated you badly for wanting to use a family planning method; **2)** tried to force or pressure you to become pregnant; **3)** told you he would have a baby with someone else if you did not get pregnant; **4)** said he would leave you if you did not get pregnant; **5)** taken away your family planning or kept you from going to the clinic to get family planning; **6)** hurt you physically because you did not get pregnant.

[b] **IPV Survey Items: 1)** Insulted you, yelled at you, screamed or made humiliating remarks; **2)** slapped, hit, or physically hurt you; **3)** threatened you with a weapon or attempted to strangle or kill you; **4)** pressured or insisted on having sex when you did not want to (without physical force); **5)** physically forced you to have sex when you did not want to.

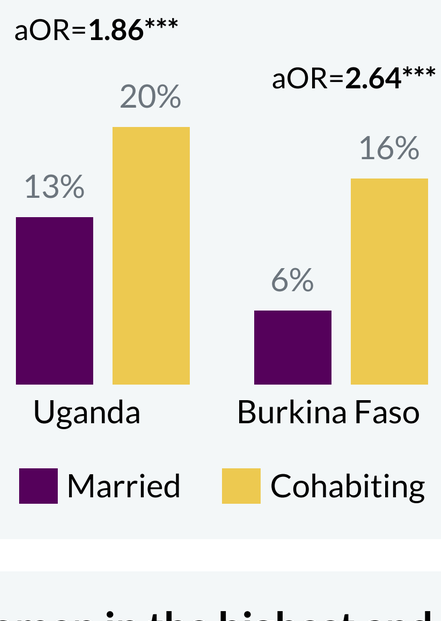
RC RISK FACTORS [1]

The prevalence of RC significantly differed across socio-demographic characteristics of women.[c]

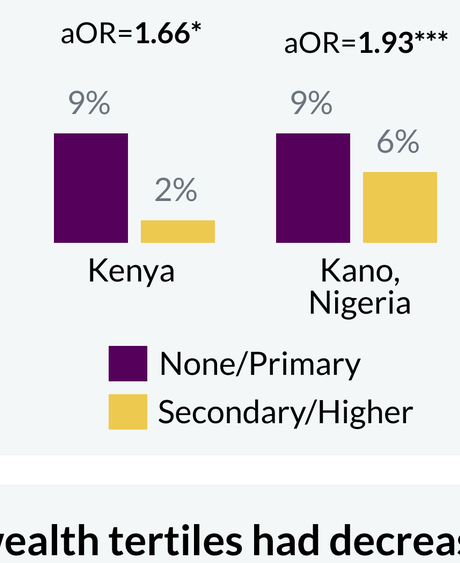
Women in polygynous partnerships had increased odds of RC compared to women in monogamous partnerships



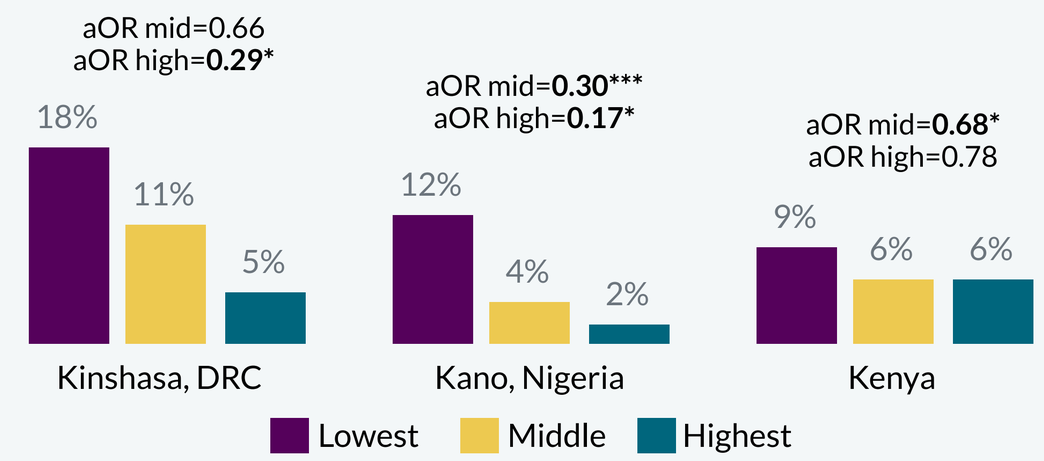
Unmarried cohabiting women had increased odds of RC compared to married women



Women with more educated partners had decreased odds of RC compared to women with less educated partners



Women in the highest and middle wealth tertiles had decreased odds of RC compared to women in the lowest tertile

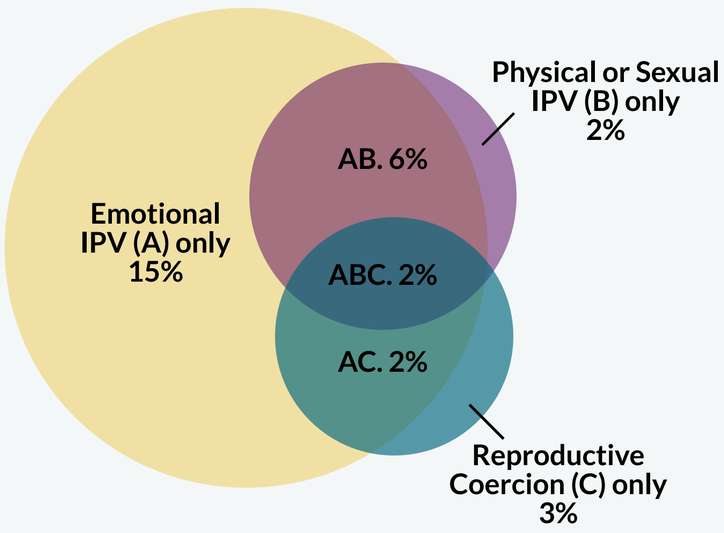


[c] Only sites with statistically significant odds are shown.
p-value: ***<0.05; **<0.01; ***<0.001**

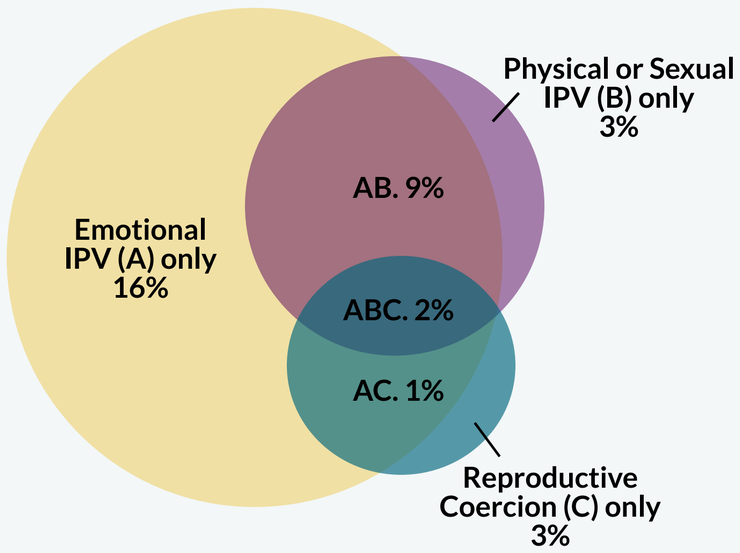
CONCURRENT EXPERIENCES OF RC AND IPV [2]

Married/cohabiting women in Burkina Faso, Côte d'Ivoire and Kenya experienced multiple types of violence in the past year. Emotional IPV was the most prevalent type of violence in each site. The majority of women who experienced physical or sexual IPV also experienced emotional IPV. Most women who experienced RC in the past year reported it in isolation, though some women (2-3% across sites) experienced RC, emotional IPV, and physical or sexual IPV, as shown in the figures below.

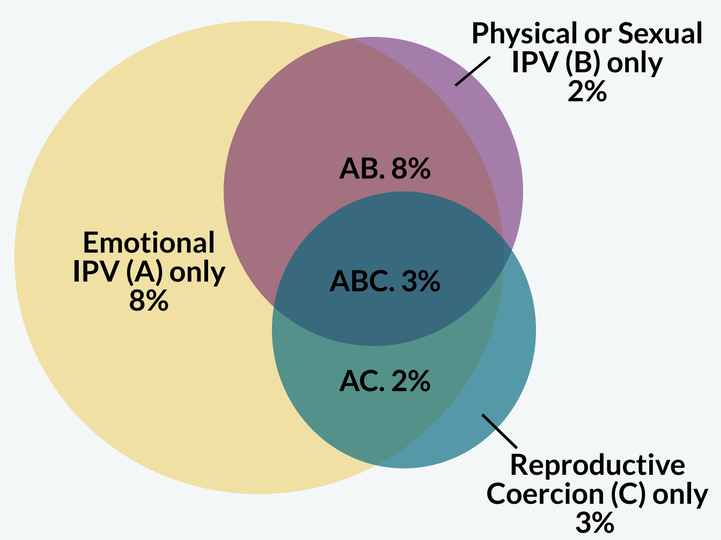
Burkina Faso



Côte d'Ivoire



Kenya



<1% not shown

RC, IPV & CONTRACEPTIVE USE [2]

Women in need of contraception in Burkina Faso, Côte d'Ivoire and Kenya experienced multiple forms of violence simultaneously, and their experiences impacted their contraceptive use.

In Burkina Faso, women had **increased odds of covert contraceptive use** if they experienced **past-year RC** (aOR=**2.84***) or **past-year emotional IPV** (aOR=**2.99*****).

In Côte d'Ivoire, women had **increased odds of covert contraceptive use** if they experienced **past-year RC** (aOR=**4.45****).

In Kenya, women had **increased odds of covert contraceptive use** if they experienced **past-year RC** (aOR=**5.77*****) or **physical/sexual IPV** (aOR=**2.35****); they had **increased odds of current contraceptive use** if they experienced **past-year emotional IPV** (aOR=**1.44***).

p-value: ***<0.05; ****<0.01; *****<0.001**

RECOMMENDATIONS

- Counteracting harmful norms, including those that promote RC and IPV, will require both empowering women and girls in their reproductive choices and bolstering men as supportive partners in reproductive decision-making.
- Screening for RC must be institutionalized within all sexual and reproductive health services, and specifically family planning services.
- Policies must name RC and IPV as detriments to women's health and include practical rights-based solutions that ensure women's privacy in contraceptive decision-making.
- Universal, affordable and judgement-free provision of covert contraceptive methods and emergency contraception are examples of solutions to help counteract RC's and IPV's reproductive health impact.

For more details on results, please check out the following publications:

1. Wood, S.N., Thomas, H.L., Guiella, G. *et al.* Prevalence and correlates of reproductive coercion across ten sites: commonalities and divergence. *Reprod Health* 20, 22 (2023). https://doi.org/10.1186/s12978-023-01568-1
2. Wood SN, Thomas HL, Thiongo M, *et al* Intersection of reproductive coercion and intimate partner violence: cross-sectional influences on women's contraceptive use in Burkina Faso, Côte d'Ivoire and Kenya *BMJ Open* 2023;**13:**e065697. doi: 10.1136/bmjopen-2022-065697

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What is PMA?
PMA collects information on knowledge, practice and coverage of family planning services in enumeration areas selected using multi-stage stratified cluster design with urban-rural and region strata. The results are regionally or nationally representative. Phase 2 data were collected between November 2020 and May 2022. For sampling information and full data sets, visit www.pmadata.org/countries

Percentages presented in this brief have been rounded and may not add up to 100%. PMA uses mobile technology and female resident data collectors to support rapid-turnaround surveys to monitor key family planning and health indicators in Africa and Asia. Overall direction and support are provided by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins University and Jhpiego. Funding is provided by the Bill & Melinda Gates Foundation.

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