"When they force a woman, it's to save her life": Community perceptions of contraceptive coercion in an anonymized sub-Saharan African country

By Leigh Senderowicz,[1,2]

[1] Department of Gender and Women's Studies, University of Wisconsin-Madison

[2] Department of Obstetrics and Gynecology, University of Wisconsin-Madison

Short Abstract (148 of 150 words)

In recent years, the silence around coercion in family planning research has begun to break, but we still know very little about how contraceptive coercion manifests or how communities make sense of coercion coming from health providers. Here, we use data from 17 focus group discussions and a reproductive justice lens to understand how women respond to the pressure their communities feel to adopt a contraceptive method. Results show broad acceptance of provider coercion in cases where a woman is not perceived to be able to properly care for children, and in cases of high parity or closely spaced births. Acceptance of coercion appears closely linked with belief that providers are acting in the best interest of the mother and her children. We find that the discourse around birth spacing in particular seems to have been weaponized as a way to control women's reproduction and justify contraceptive coercion.

1. Introduction

Over the past few decades, few family planning scholars have engaged actively with issues of contraceptive coercion (Gold, 2014; Harris et al., 2016). Since the 1994 International Conference on Population and Development codified a condemnation of coercion into international policy (UNFPA, 1994), the vast majority of scholarship tended to assume that coercion was not taking place(Bongaarts and Sinding, 2009), and instead focused on things like quality of care, barriers to access and other impediments to contraceptive use(Campbell et al., 2006; Sieverding et al., 2018; Tumlinson et al., 2015). In recent years, however, this silence on issues of coercion has begun to break (Brandi and Fuentes, 2020; Gilliam, 2015; Nandagiri, 2021). Researchers and thinkers have begun to pay attention to the myriad of ways, both subtle and overt, that health providers can constrain contraceptive decision-making, through practices ranging from biased counseling to refusal to remove provider-dependent methods(Britton et al., 2021; Gilliam, 2015; Senderowicz, 2019; Zeal et al., 2018).

Although some evidence of coercion is coming from the Global South (Britton et al., 2021; Senderowicz et al., 2021; Towriss et al., 2019; Yirgu et al., 2020), much of the literature on contraceptive coercion has been from Global North settings, where racial, disability, queer and reproductive justice activists have been drawing attention to the ways that these intersecting axes of oppression also serve to stratify reproduction along these lines (Center for Reproductive Rights, 2017; Colen, 1995; Gilliam et al., 2009; Holliday et al., 2017; Ross et al., 2017). A recent study from the UK, for example, found that "Those who are young, from ethnic minorities, or considered unsuitable parents may be disproportionately targeted" by providers for LARC use and that "many face a struggle getting the contraceptive removed if they change their mind" (Wooler, 2021). Authors have found similar evidence of racial/ethnic bias, targeting of

young people, and other forms of discrimination in the United States as well (Brandi et al., 2018; Higgins et al., 2016; Manzer and Bell, 2021).

This line of research has been particularly vigorous in recent years due to the growing prominence in the United States of the reproductive justice (RJ) framework. The RJ framework was developed by Black women in the US in the mid-1990s to articulate an agenda for reproductive freedom that prioritized not only the right to prevent or end a pregnancy (the overwhelming priorities of white feminists, to that point), but the right to have children, and to parent those children in safe communities (Ross et al., 2017). RJ focuses not only on the barriers to contraceptive use and abortion, but the barriers to having a wanted child has had an important impact on the subjects and framing of US-based family planning research. However heretofore, the RJ framework has been much less meaningfully applied to research in the Global South, where population control is still very much integrated into mainstream family planning programs, and family planning research is far more interested in promoting contraceptive uptake than it is examining the racialized, gendered and colonial narratives that undergird these programs (Hendrixson, 2018; Hendrixson and Hartmann, 2019; Kuumba, 1999, 1993).

As a result, we know very little about how women and communities in sub-Saharan Africa understand or experience contraceptive coercion within interactions with health systems. In this piece, we use data from 17 focus group discussions with women of reproductive age in rural and urban settings in an anonymized sub-Saharan African country, applying a reproductive justice lens to explore how women respond to the pressure they and their neighbors feel from health workers to adopt a contraceptive method. We examine the ambivalence they express, the conditions they feel sometimes justify coercion, and how they make sense of the emphasis providers put on contraceptive use.

2. Methods

The data from this study come from a larger mixed-methods parent study on contraceptive coercion and autonomy. Due to the sensitive nature of the subject matter and the findings we report, the authors have made the decision to anonymize the country setting and other identifying details.

2.1 Sampling and data collection

The data we use here come from the focus group discussion (FGD) phase of this study. We conducted 17 focus group discussions with women of reproductive age (15-49 years-old). Due to reproductive health disparities in between rural and urban settings, we divided our FGDs evenly between the capital city and series of much smaller rural communities outside of the capital. We used key informants and our local research collaborators to create our sampling strategy, which was purposive, and designed to maximize variation and obtain a diversity of opinion across a wide range of sociodemographic characteristics (Coyne, 1997; Patton, 1990).The breakdown of focus groups across these attributes is shown in Table 1. Since the vast majority of women over 25 years-old in this setting are married or in-union, we did not create separate categories for marital status among women of this age group. For younger women (ages 15-24), however, we expected marital status not only to vary, but to have an important effect on contraceptive access, and thus included this category in our sampling strategy. In addition to rural/urban status, age, and marital status, we made an effort to include a diversity of educational levels and religious backgrounds.

[Table 1]

Our study team trained eight experienced local women data collectors to moderate the focus groups, which were conducted in the country's national colonial language as well as two

dominant non-colonial languages, according to respondent preference. Training emphasized study goals as well as non-directive probing and value-neutral moderation techniques. FGD moderators took a semi-structured approach to guiding the discussions broadly around issues of autonomy, access and quality of care in family planning services, according to respondent interest. The FGD guide included questions on sociodemographic background, previous use of contraception, past experiences with family planning services providers, reproductive desires, fertility intentions, gender roles in decision-making, and views on childbearing. We pre-tested FGDs guides with key informants for clarity and content. All FGDs were audio-recorded, translated and transcribed verbatim with personal identifiers removed. Researchers and field supervisors closely monitored the data as it was collected for quality, making changes to the guide as needed throughout the fieldwork period.

2.2 Data analysis

Our multidisciplinary study team used a modified grounded theory approach based on Straus and Corbin to guide or team coding for the analytic phase of this work (Corbin and Strauss, 2014; Giesen and Roeser, 2020). After initial data familiarization, our team of four coders and one senior reviewer used Dedoose software to free code the first few transcripts. Based on these free codes, we generated an initial list of codes that we began to organize under code families. Once we generated this initial code list, each transcript was then coded by two coders. We convened weekly team meetings to discuss potential changes to the code list (new codes, collapsing codes together, etc.) as well as memos, and other issues of note that had arisen during the previous week. Through this iterative process, we generated main themes and performed axial coding to link concepts to one another and infer meaning from individual codes (Corbin and Strauss, 2014). We present these findings with illustrative quotes.

2.3 Protection of human subjects

All relevant ethics boards reviewed and approved this study. These include the Institutional Review Board of the Office of Human Research Administration at the Harvard T. H. Chan School of Public Health in Boston, USA, the national ethics committee of the country where the study took place, and the local ethics committee at one research site. Written informed consent was obtained from all adult participants (ages 20 and above). For minors (ages 15–19), written parental informed consent was obtained in addition to written assent from the minor. We assigned all participants pseudonyms and retained no identifying respondent information.

3. Results

The focus group discussions included an enormous range of stories from women about contraceptive coercion in their communities coming from health workers. Respondents typically framed stories in terms of events that happened to neighbors, relatives or friends, and much more rarely framed stories in terms of their own personal experiences with coercion. perhaps due to the social desirability bias that focus groups tend to evoke (Hollander, 2004). Respondents freely discussed issues of coercion and shared knowledge/experiences of it in all of the focus groups, indicating that this phenomenon is fairly well-known and widespread throughout both rural and urban areas, as well as among women from different age groups and sociodemographic backgrounds. Respondents seldom (if ever) used the formal word "coercion" in their discussions, but instead framed their experiences using words like "forced," "pressured," "obligated," "demanded," and "insisted" to describe how health workers compelled women to use a contraceptive method.

In many cases, respondents shared these stories of coercion without condemnation of the practice or of the provider who had done it. Instead, there seemed to be a wide range of

rationalizations, justifications of contraceptive coercion expressed, and a fairly widespread acceptance of the practice under certain circumstances. These circumstances include: 1) when a woman is perceived as not being able to care for a child properly; 2) when a woman's childbearing is seen as too rapid; and 3) when it is considered to protect the health or life of the woman.

3.1 Theme 1: Coercion for women perceived as not being able to care for a child properly

The idea that there are some women or couples who are not able to properly care for a child, and could thus be prevented from getting pregnant by a health worker via imposed contraception was one of the most common scenarios respondents described. According to respondents, impediments to properly caring for a child that could prompt this type of contraceptive coercion most notably included poverty and mental illness, among other factors. For instance, in one focus group, the respondents shared the following exchange:

> ***Wendy**:* *I'm saying, like crazy women often [have contraception imposed on them]. There are crazy women that they force to end their procreation. We even saw a women who hangs out next to the cemetery, they got her pregnant, and when she gives birth, they get her pregnant again but no one knows who got her pregnant. So they came and took her to the hospital to tie her tubes so they could end it.*
>
> ***Sydney**:* *In this case, if the health worker did that, no one would blame him.*
>
> ***Sofia**:* *Because he's doing his job now?*
>
> ***Sydney**:* *Yup, you see!*
>
> *[All talking together]…*
>
> ***Laurel**:* *In this case, was it the family who chose what should be done?*
>
> ***Wendy**:* *No! Crazy people don't even have family.*
>
> ***Sydney**:* *Where would she have a family?*
>
> ***Caroline**:* *A crazy woman can leave her house and come walk around here.*
>
> ***Wendy**:* *She speaks [a certain ethnicity's language], she wears a wig, she can even put on perfume and it smells good, but it's after she walks by that you know that she doesn't have all her faculties. She came*

here to one of our streets and we noticed one day that she was pregnant. She gave birth again and they came again to take the baby and leave. From what we know, she got herself pregnant again and they went to end her ability to procreate. [Inaudible]

***Marissa**:* *In that case, it's normal.*

FGD1 (urban, married, catholic, over 25)

This exchange demonstrates a wide consensus among the respondents that the authorities/health workers were justified in performing a tubal ligation on this woman without her consent, since she got pregnant more than once and appeared to have some form of mental illness or perhaps intellectual disability. Laurel asked about the woman's family, implying that the operation perhaps should not have been performed without the consent of the woman's next of kin, but overall, the respondents express overall agreement with her forced sterilization, given the perception that this woman not was able to properly care for a child,.

Much more commonly, respondents spoke of situations in which a family lacked financial stability, and providers used this rationale to impose a contraceptive method to prevent them from having children they are thought to ill-afford.

***Interviewer**:* *In your experience, have they ever forced a woman to use family planning?*

***Marissa**:* *Yes, the health workers often force people. Because I have neighbor who, every two years, every year, every two years, she has a baby. The man, too, he doesn't work. He doesn't work, heh! [to accentuate her point]. He just stays home. And every year with a baby. And one day she does to give birth, and she couldn't. She tried to give birth in vain. And the third day when the providers took her health card and noticed the number of kids and her age, today the women isn't even thirty years old. But she has six or seven kids. When she finished giving birth…they sat the husband down in the health center to reprimand him. And it was under his very eyes that they gave it [a contraceptive method] to his wife. That same day they gave her the five year method [the implant]. They told him that they were going to tie his wife's tubes, and he begged pardon, saying the five years [the implant] is fine. And it's there they gave the implant to his wife. Even today they haven't*

take out the implant. Their child is four years old now and she's resting now, finally.

***Caroline**: She finally has her life.*

FGD1 (urban, married, catholic, over 25)

In this excerpt, Marissa shares that her neighbor's husband does not work and implies that those parents do not have the financial means to support a large family. Marissa seems to understand this unemployment and poverty as salient justification for the health providers limiting the neighbor's childbearing with an implant for which she did not appear to give consent. This sentiment is echoed by another respondent in a different focus group, talking about how health workers respond to women with high parity:

***Danielle**: …[I]f it's her ninth child, they [the health workers] will forbid her from having any more kids and put her on contraception.*

***Interviewer**: But if she has any more kids, what will the health workers say?*

***Danielle**: They would tell her to rest. If you don't have any means of support, what will you do to take care of all of those kids?*

FGD9 (rural, married, Muslim, over 25)

These excerpts and many more like them throughout the focus groups demonstrate the ways that health workers, family planning providers, and others within the community, have assumed the role of arbiter of fitness for parenthood. If for reasons of perceived financial instability, mental instability, or other cause, these authorities esteem that the woman may not be well-positioned to look after a(nother) child, these focus group reports indicate that providers often intervene to "forbid" future pregnancy and impose contraception on women without their consent.

3.2 Theme 2: Coercion for women whose childbearing is considered too rapid

In addition to deploying concern for the wellbeing of future children, respondents frequently shared narratives around birth spacing and the speed at which women are bearing children as grounds for contraceptive coercion. One respondent summarized this thinking,

saying, “If your children aren’t spaced, it becomes an obligation for you to use the implant.”

Other respondents went into more depth in their responses:

> ***Alison**:* *If you align your births too closely also, and at delivery you suffer a lot, the health workers will force, they will obligate [contraceptive use]. Yes, that also happens.*
>
> ***Interviewer**:* *You say you don’t want it, but they say you must do it?*
>
> ***Alison**:* *Yes, that happens here because, you can see the suffering that you have endured, for you, you have given birth and it’s over, but the way in which the health workers saw you suffer, they, they’re going to place it [the contraceptive method] before you have even realized it.*
>
> FGD12 (rural, married, Christian, over 25)

Here, the respondent uses the suffering that a woman experiences during childbirth as a justification for contraceptive coercion among women presumed to space their births too closely together. Similarly, another focus group discussed the need for the stomach to “cool down” in between births as a reason that forced contraception may be justified:

> ***Marissa**:* *Even when they force certain women to do it [use a contraceptive method], it’s just to save their life. Know that if she gets pregnant again right away, before her stomach cools down [inaudible], they [the health workers] will tell you to rest for a little. They won’t tell you to stop the births, but to wait for your stomach to cool down a little before another one comes to lie inside of it. If not, if you repeat the births, this one comes out, the stomach hasn’t cooled down, another enters, and he also leaves, the stomach isn’t yet cool, another one enters again. By the end, that’s going to bring another problem.*
>
> ***Sofia**:* *Ah! And if you die leaving them behind, that’s also not good.*
>
> FGD1 (urban, married, Catholic, over 25)

In this way, the women in this focus group describe the contraceptive coercion as benefiting not only the woman herself, but her children as well.

Resistance to this kind of pressure was rarely described, with most narratives ending with the woman leaving the clinic with an unwanted implant or other provider-dependent method.

However, from time to time, the respondents would describe the consequences for women who refused to be pressured into using contraception, even after hearing arguments around birth spacing from their providers. For example:

> ***Sarah**: Me, I know someone who, six months after delivery, she got pregnant. Six months after that birth, she got pregnant, three times in a row…When she came [to the health center], the health workers told her to get the injectable… They tried to obligate her but she kept refusing. So the health workers told her that she if comes back here with another pregnancy, she would have to do all of her weigh-ins [her routine prenatal care] in [a distant municipal center], and even to give birth, that she should go there, because they just couldn't with her anymore.*
>
> FGD10 (rural, married, Muslim, over 25)

In this case, the health workers refused to provide routine prenatal care to a woman because they disagreed with her decision not to use contraception, and because they felt her pregnancies were spaced too closely together. Thus, paradoxically, we see health providers refusing to provide maternal health care to a woman in the name of birth spacing and maternal health.

Sometimes, providers go beyond insisting that a woman adopt an implant to space their children, and use force to insert the implant regardless of the woman's contraceptive desires. Shelly tells us:

> ***Shelly**: Yes, the health workers do it [force women to use contraception].They often say to other woman that they shouldn't have any more children because they're tired now. But if these people get pregnant again and the day of their delivery arrived, on the birthing table whether they want it or not, they [the health workers] put it [the implant] in the arm*
>
> FGD13 (rural, married, Christian, over 25)

The stories Shelly and Sarah share are indicative of the broader ways in which the logic of birth spacing seems to have been weaponized and turned against women, as a tool to get them to use contraception, even against their will.

3.3 Theme 3: Coercion to protect the life or health of the woman

This concern for women's health and life as a reason for contraceptive coercion extends more broadly throughout the respondents narratives, encompassing not just closely spaced births, but an array of scenarios in which contraceptive coercion is positioned as a practical solution to an array of women's health problems. The quotes in the previous section, for example show how coerced contraceptive use is considered a solution to the health problems that ostensibly arise from closely spaced births. In addition to closely spaced births, however, respondents frequently discussed contraceptive coercion in relation to women with high parity. For example:

> ***Interviewer***: *Are there cases where they constrain a woman to use a contraceptive method?*
>
> ***Hannah***: *Yes, the health workers do that. They often say to other women that they shouldn't have any more children because they're tired now. But if these people get pregnant again and the day of the delivery arrives, on the birthing table, whether they want it or not, they [the health workers] put it [the implant] in their arm.*
>
> ***Interviewer***: *The very day of delivery?*
>
> ***Hannah***: *Yes, the day of delivery, right before you give birth during labor. Because they [the health workers] told you to use a contraceptive method and you refused, then you got pregnant again. If you come and give birth in that health center, they're going to place an implant in you even if you don't agree so that you don't create any problems for them. Unless you go give birth in [larger municipal town].*
>
> FGD13 (rural, married, Christian, over 25)

In this example and many like it, the provider's judgement that the woman has had "enough" or "too many" children, or that the woman's body is "tired" and needs to "rest" is used to understand and justify why an implant or other provider-dependent method is inserted without the free, full and informed consent of the user.

In the case of women who have C-sections, there appear to be even greater constraints on their ability to seek wanted future pregnancies than for women who deliver vaginally.

Respondents throughout the focus group discussions brought up C-sections frequently, reporting a shared understanding from providers that one must not get pregnant again for five years after delivering via C-section:

> ***Lyn**: A third person that I see that they forced, it's my brother-in-law's wife. The first birth was by C-section, and they [the health workers] said that, with the C-section, if it's not after five years, she should not give birth anymore. But they didn't counsel her to use family planning, and she came back to the house. Just one year later, she got pregnant again, you see? When it happened again after a year, she was able to manage, and when she did the C-section, the second operation, they told the man [the woman's husband] that if you want it or not, we're going to give the five year method [the implant] to the woman. So they gave her the implant. So really, it was by force.*
>
> ***Sofia**: If you give birth by C-section, indeed, you get summoned. The providers summon you and your husband…*
>
> FGD1 (urban, married, Muslim, over 25)

Respondents also shared the belief that repeated C-sections were dangerous, and that coercion can be appropriately used in these types of cases to allow women and their bodies to "rest":

> **Janet:** *There are some who can have C-sections for their first three pregnancies. So the health workers can tell this kind of woman that if they don't rest, it's not good for them. So these are the women that they have obligated to use family planning.*
>
> FGD 11 (rural, Christian, over 25)

Often, the justification for this type of contraceptive coercion was connected to perceived risks for their health, including the risk of the death, as in the following excerpt:

> ***Katherine**: There are certain women who have ten children or eleven, even fifteen. So they obligate them not to have any more children, by placing an IUD in them.*
>
> ***Interviewer**: Why do they tell them not to have any more children?*
>
> ***Katherine**: Because the woman is tired, and there's a risk that it won't be easy for her.*
>
> ***Interviewer**: In what way wouldn't it be easy for her?*
>
> ***Katherine**: If she's not careful, she could die.*

***Interviewer**: Was it the health workers who told her she could die, or who was it who told her?*

***Danielle**: The health workers know what they're doing. That's why they tell the woman not to have any more kids.*

FGD9 (rural, married, Muslim, over 25)

However, as this excerpt demonstrates, the connection between high parity, tiredness, health risks, and ill-health seem vague and perhaps not fully understood by the respondents. Instead, the respondents assert a stalwart belief in both the expertise and the good will of the health providers, stating that whatever they do is for the health wellbeing of the women. We see this expressed clearly in the following exchange:

***Faith**: During delivery, if you're tired, they tell you to use the injectable or the implant. There are also times when they administer the method to the woman without her consent. It's for her well-being.*

***Interviewer**: Do you think it's okay for a health provider to force a woman to adopt a contraceptive method?*

***Caroline:** But when they force a woman, it's to save her life.*

***Lyn**: It's her life they want to save, you see!*

FGD1 (urban, married, Catholic, over 25)

4. Discussion

These findings show that contraceptive coercion may be startlingly commonplace throughout this setting. While the qualitative focus group methodology employed here does not allow us to measure the incidence or prevalence of coercion at the population level, the sheer number of examples shared, coupled with the ease and almost blasé nature of the conversations respondents share, indicate that contraceptive coercion is a phenomenon with which most are well acquainted. Rather than expressing surprise or shock at stories of contraceptive coercion shared with their groups, respondents for the most part expressed a sort of tentative approval based on faith in the health care providers, and the shared understanding that whatever providers may be doing is for the women's own good.

The fact that the respondents, for the most part, seem to widely accept the practice of contraceptive coercion finds considerable support in the maternal health literature. The study of practices such as disrespect and abuse (D&A) during delivery, for example, have shown that

> "women's previous experiences of D&A at healthcare facilities, for childbirth or other visits, may "*normalize*" disrespectful or abusive care. Women expect such behavior and therefore do not think it is abnormal, illegal, or ethically wrong. As a result of normalization, clients may not be able to distinguish between acceptable standards of care and those violating their patient and human rights." (Abuya et al., 2015)

Research has found that this type of normalization of abuse from health care providers may be particularly common in settings where women tend to experience "disrespect, violence, or *'patriarchal privilege*'" outside of health facilities, habituating them to a loss of control and autonomy over their bodies [emphasis original]. The nascent study of contraception coercion can borrow from the considerable body of maternal health literature on obstetric violence to help inform approaches to both conceptualize and challenge this type of normalization. Complex and nuanced discussions from that field around the roles of provider intentionality, cultural relativity, and the subjective experience of abuse have much to offer the study of this type of provider-based contraceptive coercion (Freedman and Kruk, 2014).

Many of the terms that women used to discuss and make sense of the insistence from providers that women use a contraceptive method are closely tied with the discourse around birth spacing in this context. The ideas that women must "rest" between births because their bodies will get "tired," that births "lined up one after the other" or spaced "too closely" present a grave threat to maternal come directly from the narratives that many family planning programs use to generate demand for family planning (Conde-Agudelo et al., 2007; Morroni and Glasier, 2020; Naz and Acharya, 2021). These results show the ways that this discourse, initially intended to promote women's health, has been corrupted and weaponized against those same women to

justify practices violate a central tenet of the reproductive justice framework: the rights to have wanted children without interference.

These data, along with previous findings from this study (Senderowicz, 2019), provide evidence that contraceptive coercion is a far more commonplace phenomenon in global family planning programs than most believe. Rather than the rare but sensational stories of contraceptive coercion the global family planning field has tended to discuss in the past, the types of contraceptive coercion discussed here come from the sort of everyday provider interactions that will never make global headlines. And yet, they still represent a profound breach of the most sacred tenets of reproductive rights, contravening the very core of reproductive justice. The global family planning community must work to radically reframe our goals and practices away from promoting contraceptive uptake, and instead center contraceptive autonomy as the primary motivation for our work moving forward.

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Tables

Table 1: Focus group discussion respondent attributes

Focus group #	# of participants	Religion	Site	Age Group	Education	Marital Status
1	10	Mixed	Ouagadougou	25-49	Some school	Married
2	7	Mixed	Ouagadougou	25-49	Some school	Married
3	10	Mixed	Ouagadougou	25-49	No school	Married
4	10	Muslim	Ouagadougou	25-49	No school	Married
5	8	Mixed	Ouagadougou	15-24	Some school	Married
6	10	Mixed	Ouagadougou	15-24	No school	Married
7	11	Mixed	Ouagadougou	15-24	Some school	Unmarried
8	10	Mixed	Ouagadougou	15-24	Some school	Unmarried
9	9	Muslim	Nouna	25-49	No school	Married
10	8	Muslim	Nouna	25-49	No school	Married
11	6	Christian	Nouna	25-49	No school	Married
12	6	Christian	Nouna	25-49	No school	Married
13	11	Christian	Nouna	25-49	No school	Married
14	10	Muslim	Nouna	15-24	Some school	Married
15	6	Christian	Nouna	15-24	No school	Unmarried
16	8	Christian	Nouna	15-24	Some school	Unmarried
17	6	Muslim	Nouna	15-24	Mixed	Unmarried