Journal of Critical Public Health, **Volume 2 (2025), No. 3, pp. 58-72**

Research Paper

'When they force a woman, it's to save her life': Gendered vulnerability and contraceptive coercion

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The global family planning movement's entanglements with neo-Malthusian antinatalism, negative eugenics, and coercion at its foundation have been well-documented, but how eugenic ideologies and coercive tactics have evolved to manifest in current global family planning programs is less well-understood. Here, we draw from seventeen focus group discussions with women ages 15-49 in an anonymized African country to explore contraceptive coercion and eugenic logics in contemporary family planning programs through the lens of vulnerability and imperial feminism. We explore how respondents make sense of the pressure their communities face to use contraception, with results suggesting that coercion is commonplace in this context. Respondents shared a broad sense of acceptance of provider-imposed coercion, framing those who experience such coercion as vulnerable and in need of protection by healthcare providers and global development initiatives, whether they want it or not. The rationales offered to justify contemporary contraceptive coercion in this setting – poverty, disability, multiparity– often map closely to justifications for eugenic coercion that were promulgated over a century ago. These results highlight the need for a new research agenda to understand the extent of contraceptive coercion around the world, and to refocus the global family planning field on the promotion of contraceptive autonomy.

Introduction

The first major clinical trial of the oral contraceptive pill was conducted in Puerto Rico in 1956, and involved neither informed consent nor even the knowledge among many participants that the pill was experimental (Liao & Dollin 2012). This trial was conducted among the 'poor, uneducated women' living in the Rio Piedras housing project in San Juan (Liao & Dollin 2012), and their social vulnerability was precisely the point. When birth control researchers' earlier attempts to test their pill in Boston were

thwarted by high dropout rates, a frustrated donor underwriting the research wrote that she dreamed of a 'cage of ovulating females to experiment with' (quoted in Marks 2010). That research team then turned its eyes toward Puerto Rico, a US colony that had a long history of eugenic sterilization abuse (Stycos 1954). Indeed, two decades prior, the US-appointed colonial governor of Puerto Rico had written to Margaret Sanger saying 'The tragedy of the situation is that the more intelligent classes voluntarily restrict their birth rate, while the most vicious, most ignorant, and most helpless and hopeless part of the population multiplies with tremendous rapidity' (O'Connor 2014). Ensuring that this 'helpless and hopeless part of the population' – colonized and racialized women from the Global South – would cease to have as many children was an integral reason for the development of biomedical contraception as well as for the development and spread of family planning programs around the world (Merchant 2021, Takeshita 2012).

In the decades since, global family planning programs and their entanglements with coercion have continued to be framed with these gendered, racialized, and colonial notions of vulnerability – the helplessness and the hopelessness – at their core (Kuumba 1993). Combining eugenic ideology with neo-Malthusian antinatalism, the family planning movement's founders framed fertility reduction of women in the Global South as something that would not only benefit humanity writ large, but provide protection to those women themselves, whether they wanted it or not (Connelly 2008). In the decades since, even as much about family planning politics have shifted, this paternalistic framing that we in the Global North know that Southern women need contraception even if they do not know it themselves, remains a mainstay of global family planning (Senderowicz & Maloney 2022). And yet, despite how intrinsic eugenic logics and coercive tactics have been to the birth and spread of global family planning, their contemporary manifestations remain remarkably understudied. Under-researched topics include how prevalent coercion is, how it manifests, who perpetrates it, who gets coerced, and under what rationales. This article seeks to address some of these questions, arguing that gendered and colonial logics of vulnerability and saviorism help frame the bodies of African women as prime targets for coercive contraception within broader global health initiatives. Using seventeen focus group discussions with women of reproductive age in an anonymized African country, this paper explores how notions of helplessness and vulnerability influence shared understandings and justifications for contraceptive coercion.

What We Know about Contraceptive Coercion

Even with the gaps in systematic academic research on questions of coercion, there is considerable evidence that contraceptive coercion poses a risk to reproductive rights across the globe. In addition to historical evidence of sterilization abuse, eugenics programs and population control initiatives (Merchant 2021, Reilly 2015), there is more recent evidence coming from journalists and NGOs. Examples include documented cases of Ethiopian Jews administered injectable contraception without their consent by the Israeli government, and a Tennessee judge offering shortened prison sentences to those who use a long-acting method of contraception, among many others from around the world (Dawber 2013, Dwyer 2017). In peer-reviewed literature, fewer global family planning studies have explicitly applied the term 'coercion' to their findings, but many more have documented coercive actions using the language 'provider bias,' 'low quality of care,' and 'barriers to access' (Campbell et al. 2006, Sieverding et al. 2018, Tumlinson et al. 2015). A 2022 study from Senegal, for example, discussed 'barriers in accessing removal care' to frame their finding that nearly one third of contraceptive implant users were unable to get the implant removed by a provider on their first attempt (Brunie et al. 2022). And while a taboo around naming coercion directly remains, it has begun to show signs of breaking (Bendix et al. 2020, Boydell et al. 2023, Brandi et al. 2018, Senderowicz 2019, Tumlinson et al. 2022). Reproductive health researchers have begun exploring the myriad ways healthcare providers constrain contraceptive decision-making, through coercive practices ranging from biased counseling to refusal to remove methods (Britton et al. 2021, Senderowicz 2019, Senderowicz & Kolenda 2022, Zeal et al. 2018). Others have linked global health

initiatives such as subdermal implant volume guarantees and target-based measurement approaches to coercive counseling (Hendrixson 2018, Senderowicz 2020).

Some evidence of coercion is coming from Southern settings, but much of the literature on contraceptive coercion has been based in the Global North, where critical race, disability, and queer scholars have been drawing attention to the ways that these intertangled threads of oppression serve to stratify reproduction across axes of marginalization (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 long-acting method use and that 'many face a struggle getting the contraceptive removed if they change their mind' (Wooler 2021). Researchers have found similar evidence of racial/ethnic and age biases, in the United States as well (Brandi et al. 2018, Higgins et al. 2016).

Coercion, Vulnerability, and Imperial Feminism

Research on questions of discriminatory and coercive contraceptive counseling has been particularly ascendant in the US and UK in recent years in part due to the increasing prominence 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 and bodily autonomy that prioritized not only legal rights to prevent or end an unwanted pregnancy (which were the overwhelming reproductive priorities of white feminists), but a broader conception of rights to have or not have children and to parent those children in safe and healthy communities (Ross et al. 2017). But while RJ has been transformational in many Northern contexts, the heightened attention to matrices of domination it demands has heretofore not always been extended to the global reproductive health, leading to a vast gulf between how academic research frames family planning in the Global North and the Global South. There are likely many reasons for this gulf, but one important cause is that so much global reproductive health research is funded, conducted and written by scholars from the Global North from a posture of imperial feminism (Amos & Parmar 1984).

Imperial feminism is a distinct strand of white feminism that frames women in the Global South as uniquely vulnerable to gender oppression at the hands of their backward families/cultures, compared to the ostensibly more advanced, egalitarian gender relations of the North (Mohanty et al. 1991). Imperial feminism frames women in the Global South as fundamentally oppressed, unless and until they have been empowered by Northern global health or development initiatives (Coloma 2012). This framing puts a fresh spin on Gayatri Spivak's classic notion of 'white men saving brown women from brown men,' now with white women (and white feminism) playing an active role in the savior complex (Spivak 1988). What has not changed, however, is the continued framing of brown women as vulnerable, helpless victims of a racialized patriarchy, and in need of saving. The framing around 'vulnerability' is particularly important to the way that global health and imperial feminism operate in this context. Framing Southern women as 'vulnerable' keeps the focus on the perceived deficits of these women and their families, rather than on the unequal power processes and structural forces responsible for their marginalization. Deficit framing helps global health programs maintain orientations toward saviorism without having to reckon with how racism, misogyny and coloniality impact: 1) in whom they recognize agency; 2) to whom they bestow expertise; and 3) whom they consider to be legitimate targets of intervention (Abimbola et al. 2021). The language of 'vulnerability' then, helps perpetuates the myth of passive Southern women in need of saving through North-led global health programs (Lee 2024, Mohanty et al. 1991).

In global family planning, imperial feminism manifests through the top-down provision of contraceptive technologies, as well as through norms around small family sizes and biomedical contraception as indicative of empowerment, modernity, and development (Brunson 2019). And though these programs operate throughout the Global South, African women have long been framed by Northern researchers as particularly vulnerable. The supposed vulnerability of African women to their

ecosystems (degrading), their educations (low), their poverty (overwhelming), their husbands (abusive), their cultures (backward), and their own childbearing (rampant) has helped to construct family planning programs as the solution to liberating African women. By framing male partners and family members as key barriers to gender equality and women's health (Strong 2023), and by framing African women as vulnerable to gendered oppression, the family planning literature has positioned modern contraception as a panacea (Greene & Biddlecom 2000, Senderowicz & Valley 2023).

This framing of African women as uniquely vulnerable and in need of contraception, combined with the scarcity of research on contraceptive coercion, means that we know very little about how African women experience and understand contraceptive coercion. In this article, we use data from seventeen focus group discussions (FGDs) with women of reproductive age in an anonymized African setting to explore how they make sense of pressure 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 uptake in their communities as a means to protect the vulnerable.

Methods

The data from this study come from a larger mixed-methods parent study on contraceptive coercion and autonomy. The parent study used a sequential exploratory mixed-methods approach that started first with a qualitative phase that informed questionnaire development for a subsequent quantitative phase. The parent study aimed to understand perspectives on contraceptive access with a special focus on free, full and informed decision-making. Research sites were selected due to their association with established research infrastructures. This study was realized by a transnational research team that included researchers from the United States and researchers from the main research university in the country where the research took place. Due to the sensitive nature of the subject matter and the findings we report, the researchers involved have made the decision to anonymize the country setting and other identifying details.

Over the past two decades, this country has received considerable aid, technical assistance, and programmatic support for family planning from donors, multilateral organizations, and NGOs. Programmatic goals have included contraceptive uptake targets associated with the FP2020 initiative, and performance-based financing schemes instituted by the World Bank. Along with this international support, this country has internally prioritized expanding family planning programs and won international awards for its commitments. In this way, the discourses presented in this manuscript can be understood to reflect a top-down developmental ideology as it encounters our interlocuters and their specific cultural/historical context (Thornton 2001).

Sampling and Data Collection

All relevant ethics boards approved this study, including the Office of Human Research Administration at the Harvard T. H. Chan School of Public Health, the national ethics committee of the study country, and a local ethics committee.

FGDs are well-adapted to capturing community norms and shared beliefs, not only as they existed before convening, but also as respondents co-construct them through their participation (Hennink 2013). This group-based methodology puts participants in conversation with one another to produce 'population chatter' in real time (Trinitapoli 2021). We conducted 17 discussions with focus groups of 6-11 women of reproductive age. Inclusion criteria included residency within the research area, willingness to provide informed consent in one of three study languages, and age 15-49 years inclusive. FGD facilitators recruited respondents near their homes or workplaces. Interlocutors received household soap

(a common gift) for their participation, as well as refreshments during the discussion. All participants 20+ provided written informed consent, while those aged 15-19 provided written informed assent, in addition to written informed consent from a parent/guardian.

Due to rural/urban reproductive health disparities, the team divided the FGDs between the capital city and smaller rural communities. The team used key informants and local research collaborators to create a purposive and demographically diverse sampling strategy (Coyne 1997, Patton 1990). The breakdown of focus groups across these attributes is shown in Table 1. In addition to rural/urban status, researchers included a diverse range of educational levels, marital statuses, ages, and religious backgrounds.

The study team trained eight experienced local women to facilitate the FGDs, which were conducted in the country's national colonial language as well as two dominant non-colonial languages. Facilitator training emphasized study goals as well as non-directive probing and value-neutral moderating techniques. Facilitators took a semi-structured approach to guiding discussions, and the FGD guide included questions on previous use of contraception, past experiences with family planning providers, reproductive desires, fertility intentions, gender roles in decision-making, and views on childbearing. Researchers pre-tested FGD guides with key informants for clarity and content. All FGDs were audio-recorded, translated, and transcribed with personal identifiers removed and pseudonyms applied. Researchers and supervisors monitored the data as they were collected for quality, iterating changes to the guide as needed.

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

Table 1: Focus group discussion respondent attributes

Data analysis

A multinational and multidisciplinary study team used a modified grounded theory approach based on Strauss and Corbin to guide team coding (Giesen & Roeser 2020). This diverse team was comprised of women aged 20-50 years, with backgrounds in public health, demography, sociology, and gender studies, with bachelor's, master's, and doctoral-level training, and with a range of racial, ethnic, religious, and socioeconomic backgrounds. All coders had prior experience procuring contraception. After initial data

familiarization, a team of four coders and one senior reviewer used Dedoose software to free code the first transcripts. Based on these free codes, the team generated an initial list of codes and code families. Once this initial code list was generated, each transcript was coded by two coders. The team convened weekly meetings to discuss changes to the code list, as well as analytic memos and any other issues of note. Through this iterative process, we generated themes and performed axial coding (Corbin & Strauss 2014).

Findings

The focus group discussions included a diverse range of stories from respondents about contraceptive coercion in their communities at the hands of the healthcare system. While prompts were framed broadly around norms and trends, respondents frequently responded with real-world examples and stories. Respondents typically framed their stories as events that happened to neighbors, relatives, or friends, rather than as personal experiences, perhaps due to the social desirability bias that focus groups evoke (Hollander 2004). Respondents seldom used the formal bioethics term 'coercion' in their discussions, but instead framed their experiences using less formal language including 'forced,' 'pressured,' 'obligated,' 'demanded,' 'insisted,' along with the phrase 'whether you want it or not' to describe how health workers compelled women to use contraception. In many cases, respondents shared these stories with little criticism of the provider(s) or the practice. Instead, there seemed to be a range of justifications for provider pressure, as well as an acceptance of the practice based on the understanding that providers were protecting vulnerable women and children from graver threats.

Coercion to Protect Vulnerable Women

Respondents frequently raised concern for the safety of vulnerable women as a key rationale for contraceptive coercion. This rationale was often invoked when discussing the stress of high parity on mothers' bodies, and the roles that healthcare providers played in mitigating perceived bodily depletion, often using the language of 'tiredness,' 'cooling down,' and 'rest.' This exchange between the moderator and Hannah is illustrative:

> **Moderator**: Are there cases where they [healthcare workers] 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 healthcare workers] put it [the implant] in their arm.
> **Moderator**: The very day of delivery?
> **Hannah**: Yes, the day of delivery, right before you give birth during labor. Because they 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 [the provincial capital]. (FGD13, rural, married, Christian, over 25)

In this example and many others like it, the provider's judgment that women have had 'enough' or 'too many' children, or that women's bodies are 'tired' and need to 'rest' is used to understand and justify the insertion of the subdermal implant 'whether they like it or not.' Given the limited access to healthcare in the small rural town where this FGD took place, Hannah suggested that the only other option for women who wanted to avoid this type of coercion was to travel much farther away to the provincial capital to give birth.

There were also many instances in which respondents discussed provider-imposed contraceptive coercion based on a general notion of preventing 'suffering.' Consider Alison's example:

> **Alison**: If you space 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.
> **Moderator**: 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.
> **Moderator**: They provide the method without your knowledge?
> **Alison**: Yes, because you're suffering a lot. (FGD11, rural, married, Christian, over 25)

Alison does not give specific details about what 'suffering' means in this context, but makes allusions to difficult deliveries or other health trials that have taxed the woman's body as a justification for providers to insert a contraceptive method without consent.

The focus on difficult pregnancies and deliveries was a recurring premise in many of the discussions, and for women who have C-sections, there appear to be even greater constraints on their ability to seek future pregnancies than for women who have vaginal births. Respondents throughout the FGDs brought up C-sections, reporting a shared understanding among providers and women that one must not get pregnant again for five years after delivering via C-section:

> **Lyn**: A third person that I see who they forced it's my brother-in-law's wife. The first birth was by C-section, and they [the healthcare providers] 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)

Often, the justification for contraceptive coercion was connected to a perception of grave risks for women's health, including the risk of 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.
> **Moderator**: 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.
> **Moderator**: In what way wouldn't it be easy for her?
> **Katherine**: If she's not careful, she could die.
> **Moderator**: 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 seems vague and perhaps not fully understood by the respondents. Instead, the respondents assert a stalwart belief in both the expertise and the goodwill of the providers, stating that whatever they do is for the well-being of the women. We see this expressed 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.
> **Moderator**: 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)

Coercion to Protect the Vulnerable Children and Promote Social Welfare

In addition to conceptualizing coercion as justified to protect vulnerable women, respondents also voiced support for instrumental uses of contraceptive coercion to prevent couples from having children they cannot support. The broader benefits were often invoked, with the idea that this type of coercion could be a 'win-win,' benefiting both the vulnerable mother as well as her children who are conceptualized as vulnerable in their own right. According to respondents, types of vulnerabilities that could prevent someone from properly caring for a child most notably include poverty, mental illness, and other forms of disability. Respondents spoke of situations in which women lived in financial precarity, reporting that healthcare providers often prevented women from having children they were thought to ill-afford. Marissa and Caroline offer an example:

> **Moderator**: In your experience, have they ever forced a woman to use contraception?
> **Marissa**: Yes, the health workers often force people. Because I have a 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 goes 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 subdermal implant]. They told him that they were going to tie his wife's tubes, and he begged pardon, saying the five years is fine. And it's there they gave the implant to his wife. Even today they haven't taken 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 emphasizes that her neighbor's husband does not work and cannot support a large family. Marissa seems to understand unemployment, poverty, and high parity as salient justifications for providers inserting an implant into her neighbor's arm without consent. Marissa portrays her neighbor as a passive victim of a husband's desire for more children, rather than an agentive person who could conceivably desire a large family herself. Because of this depiction, Marissa and Caroline frame the providers' imposition of a non-consented subdermal implant as a protective gift given to the neighbor – 'she finally has her life' – rather than a violation of her reproductive autonomy.

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 healthcare provider] will forbid her from having any more kids and put her on contraception.
> **Moderator**: 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, emblematic of many others, demonstrate the ways that family planning providers take on the role of arbiter of fitness for parenthood. Providers judge whether women have the means to support a(nother) child before providers allow them to leave the clinic without contraception. Otherwise, according to Danielle and other exchanges in the FGDs, providers will 'forbid' them from additional childbearing.

To enforce these prohibitions, providers here rely heavily on the subdermal implant. The implant is a long-acting reversible contraceptive (LARC) method that is notable for the fact that a healthcare provider is required not only to initiate method use, but to discontinue it as well. Thus, when providers impose an implant on a woman, she must continue to use it until she can find a provider willing to remove it. This is considered a legitimate a way for providers to protect vulnerable women and from children they are not considered fit to parent, as well as for to protect theoretical innocent babies from being born into poverty and neglect.

In addition to poverty, respondents also noted disability and mental illness as reasons women can/should be prevented from childbearing:

> **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 woman 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**: Yes, you see!
> [All talking together]…
> **Laurel**: In that case, was it the family who chose what should be done?
> **Wendy**: No! Crazy people don't even have family… 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.
> **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 was perceived to have a mental illness. Laurel asked about the woman's family, implying that the operation perhaps should not have been performed at least without the consent of the woman's next of kin, but overall, the respondents express general agreement that the forced sterilization is 'normal,' given the shared understanding of this woman's vulnerability. Also notable, while there was general support for the forced sterilization of this woman, there was little concern expressed for the repeated sexual exploitation they discuss this woman enduring. Rather than a broad notion of care for this woman's safety and security, the focus of the health system and our participants was on ensuring limiting her childbearing.

Focus group participants also frequently linked contraceptive coercion to broader international development initiatives, and to the role white people play in creating and incentivizing these norms:

> **Christie**: I think that they want to decrease the population. It's like she said [referencing the respondent who spoke just before her], they want to decrease the population. White people see that we're in the process of becoming more numerous than they are, even though we can't even work it out to have enough to eat. And they're the ones who take care of us so that we can eat. Even though we give birth [reproduce] like pigs [laughs]
> **Sally**: It's even worse than pigs, we're like chickens, all we do is lay eggs!

> **Christie:** But the way we have babies, and we don't have enough to eat and they're [white people are] the ones who come to take care of us. So they've found a solution to reduce us so we become less numerous. (FGD2, urban, married, mixed religion, over 25)

In this exchange and others like it, respondents echo shared beliefs about the purported helplessness of poor Africans, their inability to care for themselves, and their dependence on foreign aid. Here, Christie and Sally joke about the supposed animalistic nature of their community's rate of reproduction, linking it to their country's poverty and food instability, and use this explanation to justify why they think the global health and development donors who fund family planning programs are so insistent on contraceptive use generally and LARC methods in particular.

Discussion

These findings suggest that contraceptive coercion is commonplace throughout this setting. While the qualitative focus group methodology does not allow for prevalence measures at the population level, the sheer volume of examples in the seventeen FGDs, as well as the ease of the conversations, indicate that contraceptive coercion is a phenomenon with which most were well-acquainted in their day-to-day lives. Rather than expressing alarm at stories of coercion, FGD participants expressed familiarity with these scenarios. This familiarity was coupled with a sense of approval based on faith in healthcare providers, as well as the shared understanding that whatever providers and programs may be doing is for the protection of vulnerable women and children.

The findings of this analysis share several parallels to the eugenics movement of the early 20th century, when provider-imposed coercion was widely justified if the mother was deemed unfit for parenthood or her reproduction was understood as detrimental to society (Bashford & Levine 2010). Many of the same markers of unfitness from the original eugenics movement seemed to crop up again here, including disability, poverty, and the perception of irresponsible, rampant procreation by those who might place a burden on social welfare. The focus on preventing women from breeding like animals harkens back to Puerto Rico's Governor Beverley's concern about the 'tremendous rapidity' with which he thought 'the most helpless and hopeless part of the population multiplies.'

And like the earlier eugenics movement, our results also suggest that contraceptive coercion in this context is seen by many as a legitimate and routine health care activity. Here, the notion that African women need to be compelled to use contraception because they would otherwise be unable to protect themselves and their communities from irresponsible childbearing ties together gendered, racialized, and colonial notions of vulnerability and helplessness on the one side, and imperial feminist saviorism on the other. It is just these notions that allow for the continued framing of contraceptive uptake as a wide-ranging solution to so many social ills, even at the expense of bodily autonomy.

In 2010, Higgins et al. elaborated the notion of the 'vulnerability paradigm' to explain the gendered and racialized ways that describing women as 'vulnerable' reified a notion of those women as passive victims, 'mask[ing] power and agency' (Higgins et al. 2010). That same vulnerability paradigm is also very much at work here with regard to contraceptive coercion. Only by understanding poor women and women with disabilities as 'vulnerable' in their reproduction can a paternalistic, top-down imposition of contraception be framed as the obvious solution.

This imperialist feminist framing of women as victims rather than agents then leads to the assumption that women could never rationally desire large families or multiple pregnancies, and thus, healthcare providers must protect them from having these fates imposed upon them by their controlling husbands or by their patriarchal culture. If the framing were shifted to understand these women to be 'marginalized' rather than 'vulnerable,' we would be forced to confront the multiple, tangled threads of their marginalization, which include not only gender oppression, but also medical paternalism, and

neocolonial subordination within the global health system, and still to recognize their agency (Walker & Fox 2018). Rather than viewing women's marginalization holistically – rooted in unequal economic and extractive transnational relations – and seeking structural solutions (such as social safety nets) that would redress these injustices, framing these women as 'vulnerable' leaves us with a myopic understanding of both the challenges they face as well as the universe of plausible solutions to them.

A broader framing around marginalization and constrained agency would lead us to a different solution, one rooted in liberation from interlocking oppressions rather than in pressure to contracept. Framing women as vulnerable and in need of saving through contraceptive coercion is also considerably easier than addressing the root causes of inequities. Taking the example of Marissa's neighbor, who was called 'crazy,' one can imagine that tying her tubes is a much simpler solution than providing comprehensive support for people with mental illnesses and experiencing sexual exploitation. Likewise, foisting contraception on women is both an easier and cheaper solution to maternal morbidity and mortality than building well-functioning, high-quality, and equitable obstetric services.

While this study suggests that contraceptive coercion is common throughout these communities in ways that are linked to global health and development aid, the methods unfortunately do little to shed light on the mechanisms through which global discourses are translated into local care provision. This leaves this paper unable to make claims around the micro- and meso-level processes that result in macro-level policies, or around how health systems personnel understand and execute their roles. This leaves a big gap in our knowledge, and one that must be filled if we are to understand the scope of these issues and design solutions to remediate them. It also bears emphasizing that all available evidence points to contraceptive coercion as a structural phenomenon linked to macro-level policies, as opposed to the actions of bad apples or rogue providers who intend to harm (Senderowicz 2019). Indeed, a great deal of evidence points to the difficult working conditions under which healthcare providers labor, and to the many challenging constraints they seek to navigate while providing patient care.

Showing how contraceptive coercion still takes place mainstream global family planning programs, this analysis explores how the communities affected make sense of contraceptive coercion, often using tropes of vulnerability and helplessness, with deeply gendered and colonial dimensions to justify it. This study allows us to explore the continued salience of eugenic ideology within contemporary global family planning, reconfigured but still influencing norms around perceived fitness for parenthood along axes of poverty, disability and more. In conjunction with the work of reproductive justice advocates and Southern feminists, these results support the need for a drastic shift in the research agenda for global family planning away from contraceptive uptake and method use, and towards a focus on contraceptive autonomy and reproductive freedom.

Acknowledgments

The author would like to gratefully acknowledge the immense contributions of the researchers, data collectors, and countless others who contributed to this project. I extend my deep gratitude to them, as well as to the respondents who shared their time and knowledge. Versions of this analysis were presented to the Population Association of America, the African Population Conference, and the Oxford Fertility and Reproduction Seminar on Fertility and Vulnerability. I am thankful for the contributions I received there, from Dr. Rachel Hodapp, and from the editors and reviewers of this special issue.

Conflicts of interest

The author has no conflicts of interest to disclose.

Funding

The David and Lucile Packard Foundation (2016-6774), the University of Heidelberg Institute of Global Health, the University of Wisconsin Prevention Research Center, and the anonymous family foundation that supports the University

of Wisconsin Collaborative for Reproductive Equity (UW CORE) funded this research. The author was also supported by a Mentored Research Scientist Career Development Award (K01 HD113818) and a Population Research Infrastructure grant (P2C HD047873) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health (NIH). The contents of this article are solely the responsibility of the authors and do not represent the official views of the NIH/NICHD.

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