Reproductive coercion

Emma Bell **12th August 2019**

Query: What is the evidence base for **reproductive coercion**, i.e. overt or subtle coercion to use or not to use contraception, particular methods, to be sterilised, etc. Can be particularly aimed at women from minority group, women living with disabilities, adolescents, etc.

Contents

1. OVERVIEW

This query explores the evidence for coercion in family planning and maternal health settings. Despite decades of emphasis on quality of care, research continues to describe incidents of poor-quality client–provider interactions in family planning provision and maternal health services. This is particularly the case for women from marginalised and vulnerable populations, including women living with HIV, women engaged in the sex trade, women who use drugs, adolescents, transgender women and women with disabilities.

A scale has been developed to understand disrespect and abuse in maternal health services and there is a relatively extensive body of research on the range of obstetric violence experiences by women (see query 252) (Bowser and Hill, 2010). The framework includes physical abuse, non-confidential care, non-consented clinical care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in facilities. However, Harris et al (2015) found that research tools to capture the prevalence or impact of *negative* client experiences in family planning programmes are rarely used, which has impacted on the body of research in this setting.

This query highlights research related to non-consented clinical care and services; however, it is important to recognise that the other categories of violence, discrimination and abuse can act as coercive forces on women and girls right to make informed choices about their SRH lives and the authors themselves recognise that the categories are interlinking and overlapping (Bowser and Hill, 2010).

Non consented clinical care

Drugs or procedures are administered without client's knowledge or without expressed permission; clients are not provided full and accurate information about the drug or procedure that is administered. Clients are also not given an opportunity to choose among other available options; they are not given the opportunity to opt out of receiving a procedure or drug. Consent must relate to the treatment, be informed, be given voluntarily, and not be obtained through misrepresentation or fraud. Relatedly, coercion in family planning consists of actions or factors that compromise individual autonomy, agency or liberty in relation to contraceptive use, or reproductive decision making through force,

violence, intimidation, or manipulation (Harris et al, 2015).

Examples also featured in this query include: excessive or inappropriate medical treatments in childbirth, such as doctors doing caesarian sections for reasons related to their social or work schedules or financial incentives; or adhering to obstetric practices that are known to be unpleasant, sometimes harmful, and not evidence based, including shaving pubic hair, giving enemas, routine episiotomy, routine induction of labour, and preventing women having companions in labour (Flávia Pires et al, 2002)

Key findings:

Coerced sterilisation

Evidence suggests that people belonging to certain population groups, including people living with HIV, poor people, persons with disabilities, indigenous peoples and ethnic minorities, and transgender and intersex persons, continue to be sterilised without their full, free and informed consent**.** Women and girls continue to be disproportionately impacted. Cases of coerced abortion and use of long-term acting contraceptives have also been reported. For example,

- Women belonging to racial and ethnic minorities, such as Roma, indigenous populations or poor women in certain countries, have been explicitly targeted for forced or coerced sterilization (CEDAW 2016; Holt, 2003; Centre for Civil and Human Rights, 2003; Open Society Foundation, 2011). However, due to a lack of recent data it is unclear whether this practice continues against minority, indigenous and poor women.
- There is some evidence to suggest that forced or coerced sterilisation is practiced on women and girls living with disability (DRI, 2015; Spratt, 2012; Kenya National Commission on Human Rights, 2012). For example, a study by Disability Rights International (2015) found that 40% of women interviewed, all with psychosocial or psychiatric disabilities, had been forcibly, surgically sterilised or had been coerced by their families to undergo the procedure (DRI, 2015).
- In many countries, transgender and often also intersex persons have to undergo sterilisation surgeries as a condition on receiving gender affirmative treatment and gender-marker changes. for example, fourteen European countries still require forced sterilisation for legal gender recognition. Intersex persons may be involuntarily subjected to so-called sex-normalizing or other procedures as infants or during childhood, which, in some cases, may result in the termination of all or some of their reproductive capacity (WHO, 2014).
- Women living with HIV are subjected to the practice of forced or coerced sterilisation. A recent study involving 955 interviews with women living with HIV about their experiences of violence in seven Latin American countries found that 19% felt coerced into having an abortion or sterilisation in their lifetimes (ICW Latina et al, 2019). Rowlands and Amy found in their review of studies (2009-2015) that there is evidence of this practice taking place in 27 countries (2018). Much of the evidence is from the People Living with HIV Stigma Index which found that women living with HIV can be given advice not to have a child and can feel coerced to terminate a pregnancy.
- Some Demographic Health Surveys ask about whether sterilisation is performed without informing women the impacts of the procedure or informing them about alternatives or possible side effects. The Kenya DHS found that in 2003 almost 10% had not been informed that sterilization was permanent (Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro, 2003).

Obstetrics violence

There are several studies exploring obstetric violence (or discrimination and abuse in such settings) in low resource settings (see Query 252). Although, they do not always include a focus on non-consented care (which includes coercion), studies from South Africa, Kenya, Peru, India, Tanzania and Ethiopia found that women felt they did not always provide informed consent for the procedures and treatment they underwent during childbirth. A systemic review of the mistreatment of women during childbirth in health facilities (Bohren et al, 2015) found that many women reported frequent and painful vaginal examinations during labour, which they viewed as excessive and dehumanizing. Vaginal examinations were sometimes conducted in a non-private setting and women may not have consented to examinations. For example, in Tanzania 100% of women living with HIV and 79.8% of women not living with HIV were not asked for consent during vaginal examination.

There is a lack of evidence on obstetric violence (specifically non-consented care) faced by women from different socially excluded groups. However, one study explored how age, social position or class, and linguistic and cultural background intersect and place women in varying positions of control and vulnerability to obstetric violence in state health institutions in Colombo district, Sri Lanka (Sando et al, 2014). Further, the People Living with HIV Stigma Index data shows that women living with HIV report feeling that health professionals try to impose their belief/view with respect to the method of giving birth and infant feeding practices.

Denial of SRHR information and services

The evidence suggests that women and girls, particularly from socially excluded groups, can also experience denial of SRHR information and services that would enable them to (and their guardians) to make decisions about their SRHR lives.

- Girls and unmarried women can be prevented from accessing and using modern forms of contraception due to discrimination, stigma, and a lack of appropriate information[1] (Nalwadda, 2011). Some countries have laws that require parental notification or authorisation for SRH service access (Center for Reproductive Rights, 2017).
- Several studies highlight how girls and young women with disabilities are often infantilised, disempowered and lack voice, choice and control to make decisions about their own bodies and sexualities (Jones et al, 2018). Girls with disabilities have significantly poorer access to sexual health information and services, due to restrictive gender norms (Jones et al, 2018).
- The People Living with HIV Stigma index has documented instances of health care workers denying family planning to women living with HIV because of their HIV status or family planning being a condition of access to life saving ARV treatment.
- In a study of violence against trans women in seven Latina American countries some trans women reported being denied health services for themselves or a family member they were accompanying (Lanhan et al, 2018).

Gaps in the literature:

- There is a lack of data on coercion in SRH settings generally as well as for specific socially excluded groups, such as women and adolescent girls living with a disability. A lack of recent studies makes it impossible to determine whether the practice of coercion is still practiced for different groups in different settings.

[1] https://www.familyplanning2020.org/ayfp

- The research often fails to illustrate what coercion looks like in different SRH settings. Coercion is often not recognized as unacceptable by service users and can even be enshrined in law, and research techniques do not always enable coercive practices to be captured.

- Little information was found on coercion in SRH services in humanitarian settings.

2. Methodology

The methodology for this query is described below.

Search strategy: Studies were identified through searches using Google and relevant electronic databases (PubMed, Science Direct, and Google Scholar) for priority sources. Key search terms included: family planning, abortion, sterilisation, obstetric violence AND non-consented / consensual care, coercion AND research AND women, (adolescent) girls, trans women, transgender, sex workers, drug use, ethnic minorities, sexual minorities, minorities, intersex, disability, living with a disability, women (and girls) living with HIV.

Criteria for inclusion: To be eligible for inclusion in this rapid mapping, evidence had to fulfil the following criteria:

- **Focus**: Research, studies and grey literature on coercion and non-consensual care in sexual and reproductive health services.
- **Time period**: 2000 – July 2019.
- **Language**: English and Spanish.
- **Publication status**: publicly available – in almost all cases published online.
- **Geographical focus**: Low resource settings and middle-income countries

3. Evidence base

3.1 Coerced sterilisation (and long-term contraception and abortion)

In some countries, people belonging to certain population groups, including people living with HIV, poor people, persons with disabilities, indigenous peoples and ethnic minorities, and transgender and intersex persons, continue to be sterilised without their full, free and informed consent. Other individuals may also be at risk of coercive sterilisation, such as people who use drugs. While both men and women are subject to such practices, women and girls continue to be disproportionately impacted (WHO, 2014).

Cases of coerced abortion and use of long-term acting contraceptives have also been reported, however, research has tended to focus on coerced sterilisation.

Indigenous and ethnic minorities: Women belonging to racial and ethnic minorities, such as Roma or indigenous populations, may be explicitly targeted for forced or coerced sterilization. Members of the Roma minority have been coercively or forcibly sterilised in the Czech Republic (CEDAW 2016; Holt, 2003), Hungary[2] and Slovakia (Center for Reproductive Rights and Poradna pre obcianske a ludské práva (Centre for Civil and Human Rights), 2003). Many of these cases involve women emerging from a caesarean section to learn that they were sterilised without ever being asked. In other cases, women in labour are told that sterilisation is required immediately and are asked to sign a consent form—sometimes hastily handwritten, barely legible, or using an unfamiliar language or Latin terms.

There have also been studies highlighting poor women in countries such as India and Uzbekistan have been forcibly sterilised (Open Society Foundation, 2011).

[2] A. S. v. Hungary, United Nations Committee on the Elimination of Discrimination against Women, CEDAW/ C/36/D/4/2004 (2006), http://www.escr-net.org/caselaw/ caselaw_show.htm?doc_id=1053033

Women and girls with disabilities: Sexual health in people with a disability, particularly intellectual disabilities, has either been ignored or treated as a problem, and historically addressed through the use of involuntary sterilisation across the globe. The practice has even been enshrined in national laws (Servais, 2006). There is some evidence to suggest that involuntary sterilisation is *still* practiced on women and girls living with disability. Involuntary sterilisation is done to control the fertility of women, especially women with an intellectual disability. Involuntary sterilisation is also unnecessarily used as a method for managing menstruation. There are also reports of women with disabilities being coerced to take long-term forms of contraceptive or to undergo abortions due to a widespread view that they should not have children (see studies below).

- **Mexico:** A study by Disability Rights International (2015) found that 40% of women interviewed, all with psychosocial or psychiatric disabilities, had been forcibly, surgically sterilised or had been coerced by their families to undergo the procedure (DRI, 2015)[3]. Girls are also at risk. In 2014, DRI found an institution for children with disabilities in Mexico, Casa Experanza, had a policy of forced sterilisation of every girl admitted to the facility.[4] Although this example focuses on an orphanage rather than a health centre, health professionals are complicit if they are conducting the procedures.
- **Kiribati, the Solomon Islands and Tonga:** A three-country situation analyses found that women with disabilities underwent involuntary contraceptive use and sterilisation. This was most often carried out on the instigation of families or medical professionals because of a genuine dilemma: women were repeatedly raped and becoming pregnant, and their families or medical professionals wanted to help them but felt unable to prevent rape and assumed the woman could not manage her own fertility. In the Solomon Islands for example, three of the five women interviewed had undergone a tubal ligation by instigation of either a close female relative (sister and mother) or a doctor. One woman's mother had arranged for an IUD to be inserted into her daughter without the daughter's knowledge, while another woman had been given one dose of Depo-Provera without giving her full informed consent. (Spratt, 2012)
- **Kenya:** A public inquiry into violations of SRHR found that some of the women living with a disability (number not given) claimed that owing to their disability, health care providers forcefully and without their consent executed female sterilisation. Often the relatives colluded with the health workers to carry out sterilisation. Some women with disabilities said they were subjected to forced abortions by care givers or relatives who are responsible for the pregnancy to avoid embarrassment at home (Kenya National Commission on Human Rights, 2012).
- **Orissa, India:** A study of 12 districts[5] documented the prevalence of abuse of women with physical disabilities compared to women with mental challenges. It found that 6% of women with physical disabilities and 8% with mental disabilities had been forcibly sterilised (Mohapatra and Mohanty, 2004).

Trans and intersex persons: In many countries, transgender and often also intersex persons are required to undergo sterilisation surgeries that are often unwanted, as a prerequisite to receiving gender affirmative treatment and gender-marker changes. for example, fourteen European countries still require forced sterilisation in legal gender recognition. In the first case of its kind under the European Social Charter, the Committee of the Social Charter found in 2018 that the legal requirement for transgender persons in the Czech Republic to undergo medical sterilization in order to

[3] Additionally, over 40% also reported being abused by their gynaecologist, which included sexual assault and rape.

[4] DRI - http://www.driadvocacy.org/women-with-disabilities/

[5] The research design was a case-comparison study using written questionnaires. A sample of 729 women, 595 with physical disabilities and 134 with mental challenges was compiled from women responding to a state level survey.

have their gender identity recognized seriously impacts a person's health, physical and psychological integrity, and dignity (TGEU, 2018) .

Intersex persons may be involuntarily subjected to so-called sex-normalizing or other procedures as infants or during childhood, which, in some cases, may result in the termination of all or some of their reproductive capacity. Children who are born with atypical sex characteristics are often subjected to cosmetic and other non-medically indicated surgeries performed on their reproductive organs, without their informed consent or that of their parents, and without taking into consideration the views of the children involved (WHO, 2014).

Women living with HIV are subjected to the practice of forced (involuntary) sterilisation under the guise of protecting maternal health and preventing the birth of infants with HIV. Some women are not asked to give consent, or a third-party consent on their behalf. Others are given insufficient information about sterilisation or fed misinformation. The circumstances under which such women have been asked to sign consent forms for sterilisation include fear, coercion, intimidation, and undue influence (Rowlands and Amy, 2018).

Rowlands and Amy found in their review of studies (2009-2015) that there is evidence of this practice taking place in 27 countries. For example,

- **South Africa:** a nationwide survey of 10,473 people living with HIV found that 7% of women living with HIV reported that they had been forcibly sterilised because of their HIV status (SANAC, 2014).
- **Uganda:** a survey of 1,107 people living with HIV revealed that, of the 89 women who had been sterilised, 12 (13%) stated that they had been coerced (NAFOPHAN, 2013).
- **Kenya:** forced sterilisation has been documented in more than 40 testimonies from women living with HIV (Kasiva and Kiio, 2012).
- **El Salvador, Honduras, Mexico and Nicaragua**: a multi-country study showed that one-quarter of a sample of 285 WLWH had experienced pressure to be sterilised (Jendall and Albert, 2015).
- **Bangladesh, Cambodia, India, Indonesia, Nepal and Vietnam**: In a study conducted in six Asian countries, 38% of women living with HIV (86 of a sample of 228) felt coerced into sterilisation (WAPN+, 2012).

A more recent study involving 955 interviews with women living with HIV about their experiences of violence in seven Latin American countries found that 19% felt coerced into having an abortion or sterilisation in their lifetimes (ICW Latina et al, 2019).

In 2008 the International Community of Women Living with HIV/AIDS (ICW) noted how women could be coerced. After an ICW survey of women living with HIV in Namibia found that 40 out of 230 (17%) women participating in their project for young women living with HIV, had been sterilised without their informed consent, they documented cases in detail. Women reported being given forms to sign when they were minutes from giving birth and at other moments of extreme duress. In some instances, patients were forced to undergo the operation as the only means of gaining access to medical services. ICW also documented cases of women who were given false information about the need for sterilisation and the rate of mother-to-child HIV transmission. Patients said they were afraid to question hospital workers and doctors about the sterilization because they feared losing access to lifesaving medical treatment if they antagonized the medical professionals. (Ahmed and Bell, 2008; Mallet and Kalambi, 2008; Nair, 2011).

Women living with HIV *also* report receiving advice from health care workers to terminate pregnancies or not have children because of their HIV status. The table below provides examples from countries where the People Living with HIV Stigma Index was carried out.

Advice and coercion by health workers relating to women's SRHR choices[6]

Actions by health workers reported by women living with HIV	Bangladesh (2008)	Dominican Republic (2008)	Ethiopia (2010)	Uganda (2013)
Advice not to have a child	**27%**	**28%**	**44%**	**35%**
Coercion into sterilisation	**1%**	**20%**	**4%**	**13% (of those who have been sterilised)**
Coercion into termination of pregnancy	**2%**	**0%**	**2%**	**12%**

Women in general - The 2014 Kenyan DHS illustrates how sterilisation may be performed without informing women the impacts of the procedure or informing them about alternatives. The DHS found that among women who had been sterilised, 51.2% (18.8% in 2003) had been told about side effects or potential problems with sterilisation, and 77.4% (21.3% in 2003) had been informed of other contraceptive methods that could be used (Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro, 2015). In 2003 almost 10% had not been informed that sterilization was permanent (Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro, 2003).

3.2 Coercive care during childbirth (and postnatal)

Studies on obstetric violence (or discrimination and abuse in such settings) in low resource settings do not always include a focus on non-consented care (which includes coercion). However, there are a few studies that give details about the prevalence and type of non-consented care that women can experience (or fear) in maternal health services. For example,

- **Globally:** A systemic review of the mistreatment of women during childbirth in health facilities (Bohren et al, 2015) found that many women[7] reported frequent and painful vaginal examinations during labour (in one study 82% of women in Palestine reported pain or severe pain and 68% reported discomfort during vaginal examinations – Hassan et al, 2012)., which they viewed as excessive and dehumanizing. Vaginal examinations were sometimes conducted in a non-private setting and women may not have consented to examinations (see study below from Tanzania).
- **Eastern Cape, South Africa:** Qualitative research[8] at health care facilities providing maternity service found that women complained that they did not provide consent for medical procedures such as cesarean section. When women were asked to provide consent prior to a procedure, they were not always adequately informed of the risks and benefits and felt that the health worker only went through the motions of obtaining consent. (Human Rights Watch, 2011).
- **Kisumu, Kenya**: A qualitative[9] study found that fears related to HIV limited women's uptake and health workers' provision of labor and delivery services. Some women avoided or feared facility-based delivery due to anxiety about HIV tests given without consent (Turan al, 2008)
- **Peru:** In an observational cross-sectional study of women in nine hospitals,[10] almost 3 in 4 (74.6%) had experienced non-consented care (Montesinos-Segura, et al, 2018).

[6] The People Living with HIV Stigma Index has been conducted in over 100 countries and information is provided on a range of coercive practices by health care workers.
[7] The aggregate number for the studies is not given.
[8] Interviews with patients, medical staff, health officials, and experts
[9] In-depth qualitative interviews with 17 maternity workers, 14 pregnant or postpartum women, four male partners and two traditional birth attendants; as well as structured observations of 22 births; were conducted at four health facilities.
[10] 1528 participants were surveyed within 48 hours of live delivery (April and July 2016).

- **Uttar Pradesh: India:** A study of public and private sector maternity facilities found that all women (275 mothers) in the study encountered at least one indicator of mistreatment. There was a high prevalence of not offering birthing position choice (92%) and routine manual exploration of the uterus (80%) in facilities in both sectors. Private sector facilities performed worse than the public sector for not allowing birth companions and for perineal shaving, whereas the public sector performed worse for not ensuring adequate privacy, not informing women prior to a vaginal examination and for physical violence (Sharma et al, 2019).
- **Addis Ababa, Ethiopia:** A facility-based study[11] which assessed service providers' personal observations of mistreatment during childbirth and their perceptions of respectful maternity care (found that almost half (50.3%) of participants reported that service providers do not generally obtain women's consent prior to procedures.[12] (Asefa et al, 2018)

Women living with HIV report feeling that health professionals try to impose their belief/view with respect to the method of giving birth and infant feeding practices. The People Living with HIV Stigma Index has been conducted in many countries and asks about whether health professional try to impose his/her belief/view with respect to method of giving birth and infant feeding practices among a number of questions. Data for a selection of countries is provided below.

	Health professional tried to impose his/her belief/view with respect to (women only)	
	Method of giving birth	Infant feeding practices
Bangladesh (2008)	2%	13%
The Dominican Republic (2008)	5%	6%
Ethiopia (2010)	5%	7%
Uganda (2013)	26%	25%

- **Dar es Salaam, Tanzania**: the study explored whether women living with HIV were more vulnerable to mistreatment during childbirth in Dar es Salaam than HIV negative women. The direct observations of labour recorded the following types of mistreatment: “partitions did not provide privacy” to women during childbirth (HIV-positive women: 94.4%, HIV-negative women: 91.3%) and “women were not asked for consent during vaginal examination” (HIV-positive women: 100.0%, HIV-negative women: 79.8%) (Sando et al, 2014).

Socially excluded groups - The author of this query found limited studies on obstetric violence, specifically non-consented care, against women living with disabilities, young women, transgender women, ethnic minority and indigenous women and women who are sexual minorities. However, one study explored how age, social position or class, and linguistic and cultural background intersect and place women in varying positions of control and vulnerability to obstetric violence in state health institutions in Colombo district, Sri Lanka. In their dataset, younger women, poorer women, and women who did not speak Sinhala seemed to experience more obstetric violence than those with relevant social connections and better economic positions. The women in the study rarely reported obstetric violence to legal or institutional authorities, nor within their informal social support networks. research from Mexico suggests that clinicians’ stressful work environment and class-based

[11] The study was conducted in August 2013 in one hospital and three health centres with a total of 57 health professionals who had assisted with childbirth during the study period completed a self-administered questionnaire.
[12] One-quarter (25.9%) reported having ever witnessed physical abuse (physical force, slapping, or hitting) in their health facility. They also reported observing privacy violations (34.5%), and women being detained against their will (18%).

stereotypes of low-income women resulted in the routinizing of inhumane medical practices such as unnecessary cervical examinations (Smith-Oka, 2013).

3.3 Denial of family planning services

The evidence suggests that women and girls, particularly from socially excluded groups, can experience coercive practices that enforce methods to prevent them having children. However, they can also experience denial of SRHR information and services that would enable them to (and their guardians) to make decisions about their SRHR lives (WHO, 2014).

Girls and unmarried women - many young people are prevented from accessing and using modern forms of contraception due to discrimination, stigma, and a lack of information[13]. Some countries have laws that require parental notification or authorisation for SRH service access (Center for Reproductive Rights, 2017). PACT conducted a global survey with 209 young people. Thirty-eight per cent said that they have not always been able to access SRH and/or harm reduction services without restrictions when they needed them. A study in Uganda exploring health care providers' perspectives on contraceptive use and service provision to young people aged 15-24 in two rural districts in Uganda found that providers had misconceptions about contraceptives, negative attitudes towards the provision of contraceptives to young people, and they imposed non-evidence-based age restrictions and consent requirements. Thus, most providers were not prepared or were hesitant to give young people contraceptives (Nalwadda, 2011).

Women and girls with disabilities - Queries for the UK Government Disability Inclusion Helpdesk on HIV and SRH highlight evidence that information on SRH is often not accessible to people with disabilities and that gender can be a key predictor of access to information and knowledge, disadvantaging women and girls (Bell and Corby, 2019; Fraser and Corby, 2019). Girls and young women with disabilities can be even more disadvantaged. Several studies highlight how girls and young women with disabilities are infantilised, disempowered and lack voice, choice and control to make decisions about their own bodies and sexualities (Jones et al, 2018).

Jones et al takes stock of current evidence from low- and middle-income countries, drawing on findings from a thematic evidence review combined with emerging findings from the Gender and Adolescence: Global Evidence (GAGE) survey and qualitative research baseline studies in Bangladesh, Ethiopia, Jordan and Palestine. Due to disability-related stigma (as well as cost, and physical accessibility issues) the access of adolescents with disabilities to sexual and reproductive health care lags behind that of their peers without disabilities. Girls with disabilities have significantly poorer access to sexual health information and services, due to restrictive gender norms.

Women and girls living with HIV - The People Living with HIV Stigma index has documented instances of health care workers denying family planning to women living with HIV because of their HIV status. Prevalence varies widely – for example, in Uganda 86.7% of women reported being denied family planning services because of their HIV status in the past 12 months compared to 6.9% of women in Ethiopia. In Bangladesh very few women had been denied family planning or SRHR services due to being HIV-positive. However, the majority of women (67%) had not told their health care worker that they were living with HIV and many hid their status in order to access health services. Women's access has also been compromised in some settings when access to live saving antiretroviral treatment for HIV is tied to the condition that they use a form of contraception, for example 17% of women in Uganda and 14% of Ethiopia experiencing such conditionalities (see People Living with HIV Stigma Index reports).

Trans women – In a study of violence against trans women in seven Latina American countries some trans women reported being denied health services for themselves or a family member they were accompanying, particularly in El Salvador. Some healthcare staff told them directly they were being

[13] https://www.familyplanning2020.org/ayfp

denied because they were “different” and they should get health services elsewhere. In other cases, denial of services was more discreet. Staff said they were unable to find their medical records, or switched the patient to a different doctor without explanation. One participant described being denied surgery because nurses were unsure whether she should be treated in the men's or women's health services. Further experiences of abusive and discriminatory behavior towards trans women by health care workers is described in the study (Lanhan et al, 2018).

Women in general – There is evidence that women are not always given a full range of information to make an informed choice. The 2013 Kenyan DHS reveals that 60% of current users of modern contraceptive methods were informed about potential side effects of their method, 52% were told what to do if they experienced side effects, and 79% were given information about other methods. Since the 2008-09 KDHS, only one of these indicators, being informed about alternative methods (61% in 2008-09), has improved. Users were slightly more likely to receive information about side effects or problems associated with a method from a government medical facility (63%) than from a private facility (55%) (Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro, 2015)

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