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Reproductive Coercion and Abuse Among Forcibly Displaced Populations Worldwide: Evidence from a Systematic Review

TRAUMA, VIOLENCE, & ABUSE
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and Karen Block¹

Abstract

Reproductive coercion and abuse (RCA) is a significant public health issue, with high prevalence expected in forcibly displaced populations. Despite its severe health impacts, studies on the extent, determinants, and impacts of RCA in forcibly displaced populations are notably lacking. This systematic review examines forcibly displaced women's experiences of RCA, its perpetrators, associated factors, and health consequences. We conducted a systematic search across nine databases—Medline, CINAHL, Web of Science, PsycINFO, Embase, Global Health, Scopus, Emcare, and SocIndex—on July 30, 2024, using targeted search terms related to RCA and forcibly displaced populations. We included studies of any design (qualitative, quantitative, and mixed methods) published at any time and in English, regardless of study settings. We used a socio-ecological framework to guide our narrative analysis of the findings. A total of 15 studies were included in the review, demonstrating various forms of RCA. These included coerced and unwanted sex, intentional contraception misuse, forced pregnancy, forced abortion, imposition of contraception without consent, control over reproductive decisions, forced marriage, and physical abuse for failing to give birth to male offspring. RCA was found to be supported and exacerbated by a range of challenges situated across multiple socio-ecological levels: individual (economic dependency, accommodation), relationship (partner), community (community members, religious and cultural norms), institutional (armed forces, international forced migration), and societal and global levels (country-level policies, state actors, international forced migration). The findings underscore the need for targeted interventions that address the underlying socio-economic, legal, and cultural factors contributing to RCA in these settings.

Keywords

reproductive coercion, abuse, refugees, forcibly displaced populations, health and wellbeing

Introduction

Reproductive coercion and abuse (RCA) is a form of gender-based violence (GBV) that has emerged as a significant public health issue since its conceptualization in 2010 (Grace & Anderson, 2018; Miller & Silverman, 2010). RCA is defined as any intentional act to control a woman's reproductive decisions or undermine their autonomy and has profound implications for maternal and child health in two critical ways. First, RCA adversely affects women's mental health, contributing to anxiety, depression, and trauma-related disorders, which, in turn, can result in inadequate prenatal care, unhealthy behaviors during pregnancy, and increased risk of complications during postpartum recovery (MacDonald et al., 2023; Miller & Silverman, 2010). Second, RCA severely disrupts adherence to sexual and reproductive health practices, leading to reduced contraceptive use, unintended

pregnancies, and delayed or inadequate postnatal care (Sheeran et al., 2022). These challenges not only endanger women's well-being but also have far-reaching consequences for maternal and child health, including heightened risks of pregnancy complications, preterm birth, stillbirth, low birth weight, and maternal and infant mortality (MacDonald & Tarzia, 2023; MacDonald et al., 2023; Miller & Silverman,

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2010; Sheeran et al., 2022). Furthermore, long-term impacts of RCA can destabilize family relationships, resulting in chronic stress that negatively affects women's health and contributes to developmental issues in children (Grace & Anderson, 2018; McKenzie et al., 2024; Moulton et al., 2021). The social and economic consequences of RCA also perpetuate cycles of poverty, violence, and inequality, as women who experience RCA often face barriers to education and employment, limiting their ability to achieve self-sufficiency and support their families (Loutet et al., 2022; MacDonald & Tarzia, 2023). Collectively, these outcomes underscore the urgent need for targeted interventions that address RCA within the broader context of maternal and child health, ensuring that comprehensive support systems are in place to protect and empower affected individuals (Grace & Anderson, 2018; MacDonald & Tarzia, 2023; McKenzie et al., 2024; Moulton et al., 2021; Sheeran et al., 2022).

Research demonstrates that RCA is pervasive across all socio-demographic groups, manifesting variably depending on the socio-economic context (Borrero et al., 2015; Coggins & Bullock, 2003; Grace & Anderson, 2018; Hathaway et al., 2005; Holliday et al., 2017; Moulton et al., 2021; Nikolajski et al., 2015; Paul et al., 2017). However, RCA is particularly prevalent among women who experience intersecting forms of structural discrimination and inequity, such as financial hardship, disability, polygamy, limited access to education, and social, health, and/or geographical marginalization (Borrero et al., 2015; Holliday et al., 2017). These factors are common among forcibly displaced populations (e.g., individuals or groups compelled to leave their homes due to conflict, persecution, violence, human rights violations, including refugees, asylum seekers, and stateless individuals) worldwide, suggesting a high incidence of RCA in these groups (Islam et al., 2022b). Consequently, RCA may significantly contribute to poor health outcomes among forcibly displaced populations, particularly in maternal and child health (Islam et al., 2022b). Despite its significance, RCA is often overlooked in existing literature, policies, and programs. Addressing RCA in these settings presents unique challenges, including cultural barriers to reporting (Suha et al., 2022). Moreover, a primary focus by policymakers and program designers on meeting basic needs—such as food, shelter, and maternal healthcare—reduces addressing RCA to a secondary concern (Gebreyesus et al., 2020; Islam et al., 2022b; Khan et al., 2024). Additionally, programs related to sexual and reproductive health in forcibly displaced settings tend to focus on women and have limited capacity to include partners or the broader community (Khan & Khanam, 2023). These limitations hinder efforts to improve sexual and reproductive health outcomes of refugee and forcibly displaced women. As such, they pose a threat to maternal and child health, including maternal and child mortality, jeopardizing the achievement of global health targets, such as those outlined in the sustainable development goals to be achieved by 2030 (Fund, 2015).

Most available research on RCA has focused on the general population, highlighting behaviors such as controlling pregnancy outcomes, exerting pregnancy pressure, or engaging in contraceptive sabotage, often driven by rigid gender roles, social inequalities, and family pressure (Borrero et al., 2015; Coggins & Bullock, 2003; Grace & Anderson, 2018; Hathaway et al., 2005; Holliday et al., 2017; Moulton et al., 2021; Nikolajski et al., 2015; Paul et al., 2017). However, research specifically examining RCA in forcibly displaced populations is limited, with existing studies reporting diverse findings regarding the nature, extent, and determinants of RCA in these contexts (Bhatia, 2023; Chang et al., 2014; Gebreyesus et al., 2020; Hegde et al., 2012; Rahman et al., 2024; Schoevers et al., 2010; Wirtz et al., 2016). To address this gap, we have conducted a systematic review focusing on forcibly displaced populations globally. Our review aimed to explore women's experiences of RCA, the health-related consequences of RCA, and the factors associated with RCA.

Methods

We performed a systematic review adhering to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2010) (Supplemental file 1). We included relevant and accessible studies that focused on RCA, the factors associated with it, and the impacts of RCA on forcibly displaced women.

Search Strategy

On July 30, 2024, we conducted a comprehensive literature search across nine databases: Medline, CINAHL, Web of Science, PsycINFO, Embase, Global Health, Scopus, Emcare, and SocIndex. The search strategies were developed using a combination of free text, title/abstract keywords, and medical subject headings related to RCA (e.g., reproductive coercion, coercive reproductive practices, reproductive pressure, reproductive control, sabotage, autonomy, and abuse) among forcibly displaced populations (e.g., refugees, displaced persons, migrants, asylum seekers, internationally displaced persons, and conflict-induced displacement). No restrictions were imposed on the study setting and year of study. Boolean operators (AND, OR) were used to combine the search terms. The detailed search strategies and results for each database are presented in Supplemental Tables 1 to 9 (Supplementary file 2). Additional studies were identified by examining the websites of selected journals and the reference lists of the included articles.

Eligibility and Exclusion Criteria

Studies were included if they were peer-reviewed articles published in English, focused on forcibly displaced populations, and reported any form of RCA by any perpetrators, including partners, family members, or state-based actors. Studies were excluded if they did not specifically identify

RCA, involved populations other than forcibly displaced, or reported only intimate partner violence without linking it to reproductive rights.

Study Selection

Two authors (Khan MN and Brown GT) independently reviewed all articles. They initially screened titles and abstracts, and articles selected in this phase underwent full-text review. Disagreements were resolved through discussion, with the involvement of the senior author (Block K) if necessary. The review process was managed using COVidence and EndNote X20.1 software (Clarivate Analytics).

Data Extraction

Data were extracted from the included studies using a word template specifically designed for this review by Khan MN and Brown GT and verified by all authors. The template captured details about study design, sample size, setting, forms of RCA, perpetrators of RCA, qualitative and quantitative findings, and statements by participants related to RCA (in qualitative studies).

Quality Assessment of Included Studies

We utilized a Mixed Methods Appraisal Tool (version 2018) for qualitative, mixed methods, and quantitative studies to evaluate the quality of the included studies (Hong et al., 2018). Two authors (Khan MN and Brown GT) systematically conducted this assessment and compared the scores in several domains, including aims, data collections, research design, analysis, and bias. Any discrepancies in scoring were resolved through discussion with the senior author, Block K.

Data Analysis

The included studies were predominantly descriptive and qualitative, with significant variation in design, sampling, and data analysis methods, which precluded the possibility of quantitative synthesis and meta-analysis. Therefore, we employed a narrative synthesis approach to consolidate the findings across all retrieved studies, guided by the socio-ecological model. This model is widely recognized as a key framework for understanding, responding to, and preventing GBV (Heise, 1998; Krug, 2002). It has been previously applied in country contexts to illustrate how RCA functions as a multi-level system of gendered violence operating at internalized, interpersonal, institutional, and societal levels. In addition to this concept, we also considered Fulu and Miedema's (2015) recommendation to expand the socio-ecological model by including an overarching global level when studying GBV. This expansion is crucial, as GBV is a phenomenon that transcends international borders—an issue particularly relevant when examining the experiences of

forcibly displaced populations. This expanded conceptual model guided the data analysis and informed the data extraction for each identified study, structuring the systematic review to illustrate the diverse challenges forcibly displaced women encounter regarding RCA across five socio-ecological levels: individual, relationship/interpersonal, community, institutional, and societal and global levels.

Results

Study Selection

The study selection process is presented in Figure 1. We identified 636 studies from nine databases after removing duplicates, and two additional studies from reference lists, specialized journals, Google, and Google Scholar. Covidence identified a further 78 duplicates during the export of selected studies, as such they were deleted. After screening 560 studies based on predefined inclusion and exclusion criteria, 516 were excluded. Of the 44 studies retrieved, 24 were excluded during the full-text review, leaving 15 studies included in this review.

Quality Assessment of the Included Studies

Of the 15 studies included in this review, 12 were high-quality, 2 were moderate quality, and 1 was low quality (Supplemental Tables 10–12 in the Supplementary file 2).

Background Characteristics of the Included Studies

The background characteristics of the included 15 studies are presented in Table 1. Included studies were conducted in diverse settings, including healthcare facilities (Bhatia, 2023; Gebreyesus et al., 2020; Schoevers et al., 2010), and forcibly displaced population camps (Chang et al., 2014; Hegde et al., 2012; Rahman et al., 2024; Schoevers et al., 2010; Wirtz et al., 2016) across multiple countries, such as Britain (Bhatia, 2023), Ethiopia and Colombia (Chang et al., 2014; Wirtz et al., 2016), Rwanda (Eastman et al., 2023), Israel (Gebreyesus et al., 2020), Thailand (Hegde et al., 2012), Spain (Jiménez-Lasserrotte et al., 2020), Lebanon (Khawaja & Hammoury, 2008), the USA (Lipson et al., 1995), Uganda (Loutet et al., 2022), Bangladesh (Rahman et al., 2024), and Australia (Russo et al., 2020). The study designs varied, with qualitative methods (e.g., interviews, focus groups) used in 8 of the 15 studies (Eastman et al., 2023; Gebreyesus et al., 2020; Jiménez-Lasserrotte et al., 2020; Rahman et al., 2024; Russo et al., 2020; Wirtz et al., 2016; Wirtz et al., 2014), while five studies were mixed-methods (Chang et al., 2014; Hegde et al., 2012; Lipson et al., 1995; Loutet et al., 2022; Schoevers et al., 2010). Sample sizes varied widely, from small qualitative studies with fewer than 20 participants (Eastman et al., 2023; Hegde et al., 2012; Jiménez-Lasserrotte

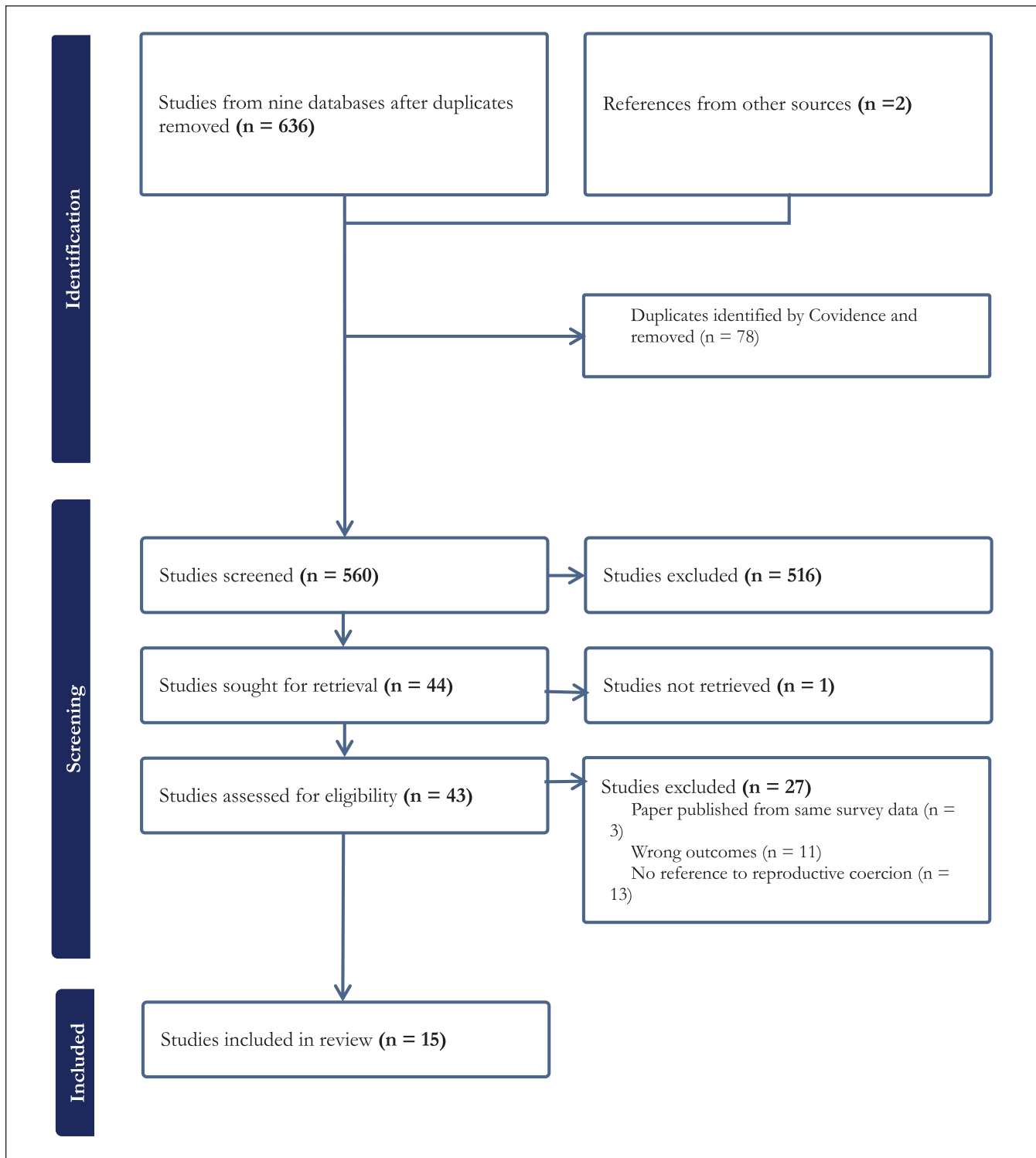


Figure 1. PRISMA diagram to select studies addressing reproductive coercion and abuse among refugees or forcibly displaced population worldwide.

PRISMA=preferred reporting items for systematic reviews and meta-analyses.

Table 1. Descriptive Characteristics of the Included Studies.

Author	Country	Setting	Study Design	Sample Size	Origin Country
Bhatia (2023)	Britain	Healthcare facility	Empirical data-based study	40	Sudan, Zimbabwe, Eritrea, Nigeria, Morocco, Somalia, Congo, and Uganda
Chang et al. (2014)	Ethiopia and Colombia	Ethiopia and Colombia	Mixed-method study	A total of 62 individuals participated in 17 focus group discussions, and 502 individuals were included in the quantitative study from Ethiopia and Colombia. This included 37 refugees in 11 focus group discussions and 314 refugees in the quantitative study	Not clearly mentioned
Eastman et al. (2023)	Rwanda	Mugombwa Refugee Camp	Qualitative study	16 adolescent girls between the ages of 10 and 19 from primary and secondary schools living in the Mugombwa refugee camp. These girls were selected through purposive sampling using the school attendance sheet	Democratic Republic of the Congo
Gebreyesus et al. (2020)	Israel	Israeli and Eritrean healthcare facilities and Eritrean community	Qualitative study	In-depth interviews were conducted with 25 key informant healthcare and service providers, including 20 Israelis, one American, and four Eritreans, all with experience working with the Eritrean asylum-seeking community in Israel. Additionally, 12 in-depth interviews were conducted with community members (6 with women and 6 with men), and 8 focus group discussions (4 with male and 4 with female members of the Eritrean asylum-seeking community) involved a total of 44 participants	Not clearly mentioned
Hegde et al. (2012)	Thailand	Thai-Cambodia border	Mixed-methods study	15 migrant women aged 18 to 28, who had been living in Thailand for at least 1 year, were recruited for a survey using snowball and purposive sampling. Among them, 10 unmarried women were identified as having engaged in premarital unsafe sex, risky sexual behaviors, and inconsistent contraceptive use, resulting in unintended pregnancies and unsafe abortions. These 10 women were subsequently selected for in-depth interviews	Cambodia
Jiménez-Lasserrotte et al. (2020)	Spain	Spanish Red Cross' facilities	Qualitative study	26 women who crossed the Mediterranean Sea in a small boat in the last 5 years of the study were included in in-depth interviews	Africa
Kevin and Agutter (2020)	Australia	This study examined two-time frames, 1947–1953 and 2013–2017, to analyze the forms of RCA present in each period	Empirical data-based study	Not clearly mentioned	Different countries, although primarily focused on Somali refugees
Khawaja and Hammoury (2008)	Lebanon	Pregnant refugee women attending an antenatal clinic in Sidon, Lebanon	Quantitative study	351	Palestinian
Lipson et al. (1995)	USA	San Francisco Bay Area, USA	Mixed-methods study	The study included 38 telephone interviews, 7 community meetings, and a survey of 196 Afghan families. Additionally, 6 years of ethnographic research involving more than 200 Afghans, and their health providers provided extensive contextual data	Afghanistan
Loutet et al. (2022)	Uganda	Bidi Bidi Refugee Settlement	Mixed-methods study	The qualitative study included 58 sexual violence survivors aged 16–24 years, 8 elders, and 10 healthcare providers. The quantitative survey included 120 youths aged 16–24	South Sudan
Rahman et al. (2024)	Bangladesh	Refugee camps, Cox's Bazar, Bangladesh	Qualitative study	In-depth interviews were conducted with 48 purposively selected participants, including 12 individuals from each of the following four community stakeholder groups: majlis (Rohingya leaders), imams (religious leaders), schoolteachers, and married men	Myanmar
Russo et al. (2020)	Australia	Australia	Qualitative study	A total of 57 Afghan women and men participated in 6 focus groups and 20 semi-structured interviews	Afghanistan
Schoevers et al. (2009, 2010)	Netherlands	Primary healthcare facilities and temporary shelters	Mixed-method study	A total of 100 women were recruited for the study from primary healthcare facilities or temporary shelters across the country between January 2006 and July 2008. Of these, 47 women lived in semi-rural areas in the southeast of the Netherlands (Nijmegen, Den Bosch), while 53 resided in large cities (Amsterdam, Rotterdam, The Hague)	Originating from 32 different countries
Wirtz et al. (2016)	Ethiopia and Colombia	Data were collected in March 2011 in Addis Ababa and three camps in the Jiiga area, and in San Jose del Guaviare and Quibdó in June 2012	Qualitative study	A total of 108 participants were included, with 77 from Ethiopia and 31 from Colombia	Burundi, Democratic Republic of Congo, Eritrea, Somalia, Sudan
Wirtz et al. (2014)	Colombia	San Jose de Guaviare and Quibdo, Colombia	Qualitative study	Thirty women who identified themselves as survivors of GBV were included in in-depth interviews, and 31 service providers participated in 6 focus group discussions	Not clearly mentioned

GBV = gender-based violence.

Source: Bhatia (2023), Chang et al. (2014), Eastman et al. (2023), Gebreyesus et al. (2020), Hegde et al. (2012), Jiménez-Lasserrotte et al. (2020), Kevin and Agutter (2020), Khawaja and Hammoury (2008), Lipson et al. (1995), Loutet et al. (2022), Rahman et al. (2024), Russo et al. (2020), Schoevers et al. (2009), Wirtz et al. (2016, 2014).

et al., 2020) to larger mixed-methods studies (Chang et al., 2014; Khawaja & Hammoury, 2008; Loutet et al., 2022) involving several hundred participants.

Reporters of RCA and Level of Challenges as Per Socio-Ecological Model

We summarized the reporters, perpetrators, level of challenges as per socio-ecological model, and types of RCA in Table 2 and Figure 2, with broad findings related to RCA detailed in Supplemental Table 13. The included studies report evidence of RCA from women (Hegde et al., 2012; Jiménez-Lasserrotte et al., 2020; Kevin & Agutter, 2020; Khawaja & Hammoury, 2008; Russo et al., 2020; Schoevers et al., 2010; Wirtz et al., 2014, 2016), healthcare providers (Bhatia, 2023; Gebreyesus et al., 2020; Lipson et al., 1995), youth (Eastman et al., 2023; Loutet et al., 2022), and community members (Lipson et al., 1995). The cases of RCA are linked to various levels of challenges. At the societal and global levels, issues such as restrictive legal frameworks and inadequate healthcare access are prominent (Bhatia, 2023; Jiménez-Lasserrotte et al., 2020). At the community level, factors like community norms and economic conditions play a significant role (Chang et al., 2014; Hegde et al., 2012; Loutet et al., 2022). Other community-level challenges included barriers within healthcare settings, including discrimination and communication challenges, which affect access to contraception and reproductive health services (Gebreyesus et al., 2020; Schoevers et al., 2009). Finally, at the relationship level, dynamics within individual relationships, such as economic dependency, accommodation, and interactions with intimate partners and family members, contribute to RCA (Eastman et al., 2023; Wirtz et al., 2014).

Perpetrators and Types of RCA

Perpetrators identified include women's partners (Chang et al., 2014; Eastman et al., 2023; Hegde et al., 2012; Jiménez-Lasserrotte et al., 2020; Kevin & Agutter, 2020; Khawaja & Hammoury, 2008; Lipson et al., 1995; Loutet et al., 2022; Russo et al., 2020; Wirtz et al., 2014, 2016), healthcare providers (Gebreyesus et al., 2020; Schoevers et al., 2010), local community members (Bhatia, 2023; Rahman et al., 2024), religious leaders (Rahman et al., 2024), and state or military forces (Kevin & Agutter, 2020; Loutet et al., 2022; Wirtz et al., 2014, 2016). In summary, the following types of RCA were reported among forcibly displaced communities: forced marriage (Chang et al., 2014; Loutet et al., 2022; Suha et al., 2022; Wirtz et al., 2016), forced and unwanted sex (Bhatia, 2023; Chang et al., 2014; Hegde et al., 2012; Khawaja & Hammoury, 2008), intentional contraception misuse (Eastman et al., 2023), forced pregnancy (Chang et al., 2014; Wirtz et al., 2016), forced abortion (Chang et al., 2014; Schoevers et al., 2010; Wirtz et al., 2014), denial of women's contraceptive agency

(Gebreyesus et al., 2020; Russo et al., 2020), control over reproductive decisions (Jiménez-Lasserrotte et al., 2020; Rahman et al., 2024), and physical abuse by husbands for not bearing enough sons (Lipson et al., 1995).

Forced marriage: Forced marriage was reported among forcibly displaced populations in Colombia, Uganda, and among Afghan refugees in Australia (Chang et al., 2014; Loutet et al., 2022; Wirtz et al., 2016). Specifically, refugees in Ethiopia reported a prevalence of forced marriages ranging from 9.5% to 19.7%, while internally displaced persons in Colombia reported a much lower rate of 4.17% in the same study (Chang et al., 2014; Wirtz et al., 2016). In Uganda, forced marriages were commonly reported among young girls in refugee settlements (Loutet et al., 2022). The reported perpetrators of forced marriage were either the intimate partner (Chang et al., 2014; Loutet et al., 2022; Wirtz et al., 2016) or both the partner and armed forces (Loutet et al., 2022; Wirtz et al., 2016).

Forced and unwanted sex: While forced and unwanted sex (rape) is a broader form of GBV, it can also contribute to RCA. Forced sex as a form of RCA that directly interfered with reproductive autonomy (e.g., forced pregnancy or contraceptive sabotage), was evident in several included studies, with perpetrators being intimate partners or local community members (Bhatia, 2023; Chang et al., 2014; Hegde et al., 2012; Khawaja & Hammoury, 2008). In the UK, women without legal status experienced unwanted sex due to transactional relationships driven by economic dependency (Bhatia, 2023). In Colombia, approximately one in five refugee women reported experiencing forced sex (Chang et al., 2014), while in Lebanon, the prevalence was even higher, with approximately one in four women affected (Khawaja & Hammoury, 2008). Similarly, in Thailand, migrant women faced non-consensual and unprotected sex as a result of their economic reliance on partners (Hegde et al., 2012).

Intentional contraceptive misuse: Intentional misuse of contraception was prevalent among adolescents and young adults in refugee populations (Eastman et al., 2023). Eastman et al. (2023) described cases where boys deliberately sabotaged condoms to cause pregnancies, with one participant recounting, "*There is a time when you can have sex with a boy thinking that you are using a condom while a boy has already made a hole at the head of the condom.*"

Forced pregnancy: Forced pregnancy was reported in various contexts with the perpetrators being either partners and/or military forces (Chang et al., 2014; Wirtz et al., 2016). For example, refugees in Ethiopia reported that 15.8% of all pregnancies in the population were forced (Chang et al., 2014). In Uganda, early and forced marriages frequently lead to early pregnancies, a situation further exacerbated by severe socio-economic conditions (Loutet et al., 2022).

Forced abortion: Forced abortion was commonly reported as a form of RCA, with perpetrators including both the military forces of the host country and intimate partners (Chang et al., 2014; Russo et al., 2020; Schoevers et al., 2010; Wirtz

Table 2. Overview of Reproductive Coercion and Abuse: Reporters, Perpetrators, Challenges, and Types.

Author	Reporters of Reproductive Coercion	Perpetrators of Reproductive Coercion	Level of Challenges	Type of Reproductive Coercion
Bhatia (2023)	Healthcare providers and support workers	Local community members due to the illegal status of the refugees and asylum seekers	Country policies and programs related to refugees and asylum seekers, informed by global responses to forced migration (social and global levels)	Unwanted sex, unwanted pregnancy
Change et al. (2014)	Refugees, internally displaced persons	Partners	Community-level challenges, characteristics of the refugees	Forced sex, forced pregnancy, forced marriage, forced abortion
Eastman et al. (2023)	Boys	Partners	Community-level challenges, characteristics of the refugees	Intentional contraceptive misuse, unprotected sex, unwanted pregnancy
Gebreyesus et al. (2020)	Healthcare providers, service providers	Healthcare facilities, healthcare providers	Country policies and programs (social level), healthcare facility-level barriers (community level), discrimination, communication challenges (relationship level)	Accessing contraception, imposing contraception without respondents' choice
Hegde et al. (2012)	Women	Male partners	Community-level challenges, economic dependency due to the lack of earning opportunities for women (relationship and social levels)	Nonconsensual, unprotected, and coercive sex
Jiménez-Lasserrotte et al. (2020)	Women	Husbands	Country-level policies and programs (social level)	Control over reproductive decisions
Kevin and Agutter (2020)	Women	Partners, Australian state	Partners, Australian state (relationship, social and global levels)	Restricted reproductive autonomy
Khawaja and Hammoury (2008)	Women	Partners	Community-level, respondents' level, and partner-level characteristics	Forced sexual intercourse
Lipson et al. (1995)	Healthcare providers, women, community members	Male partners, societal norms	Community-level challenges, partner characteristics	Denial of access to medical care, beaten by husband for not bearing enough sons
Loutet et al. (2022)	Youth, elderly, healthcare providers	Partners, armed forces	Community-level challenges, poverty (social and global levels)	Rape, early and forced marriages, pressured non-use of contraception
Rahman et al. (2024)	Religious leaders, women	Religious leaders, community members	Community-level norms, religious factors (social and global levels), partners (relationship level)	Control over pregnancy termination, control over access to healthcare services
Russo et al. (2020)	Women and partners	Partners, religious beliefs	Community-level challenges, partner characteristics (relationship level)	Contraception prohibition, control over reproductive decisions, coercion against abortion
Schoevers et al. (2010)	Women	Support organizations, healthcare providers	Country-level policies and programs (social and global levels), healthcare facility-level policies and programs (community level)	Forced abortions, barriers to accessing healthcare
Wirtz et al. (2016)	Women	Military forces, partners	Women and their partners' characteristics (interpersonal and relationship levels)	Forced pregnancy, forced marriage
Wirtz et al. (2014)	Women	Military forces, partners	State-level organizations (social level), partners	Forced abortion, coercive control over reproductive health, coercive control over contraception

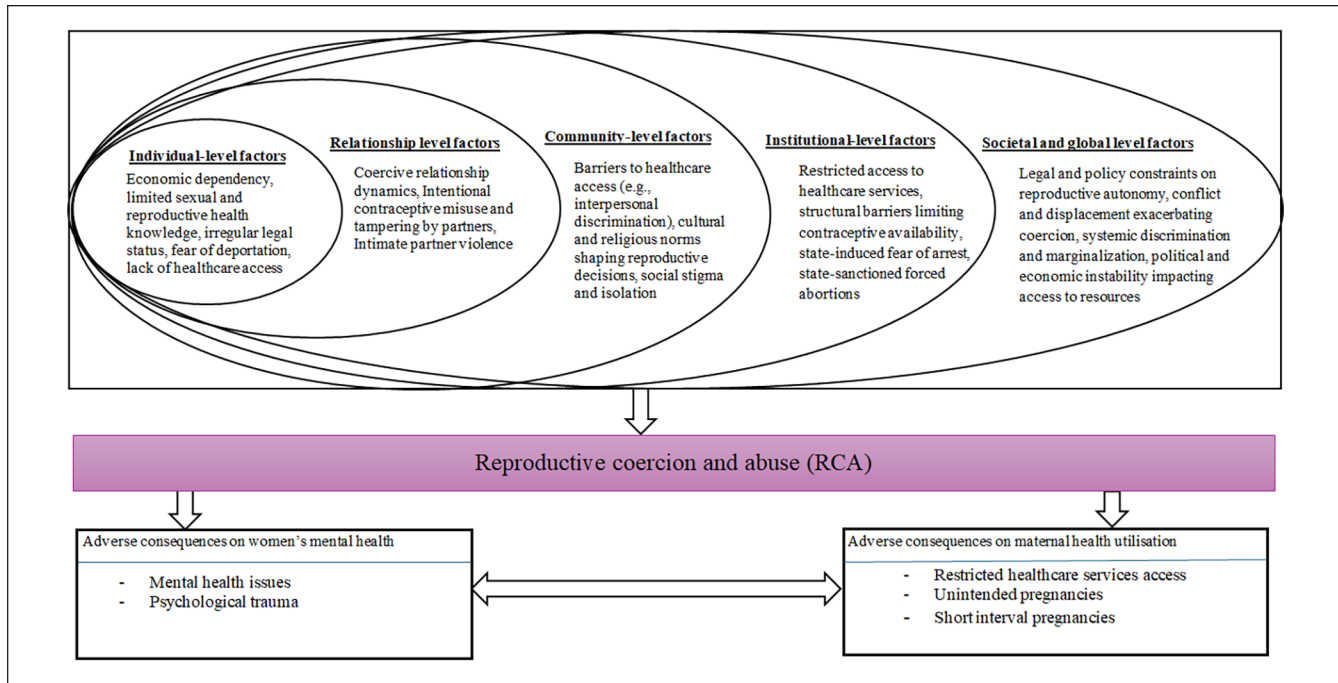


Figure 2. Socio-ecological model of factors contributing to reproductive coercion and abuse (RCA) among forcibly displaced women and its associated adverse consequences based on 15 studies we included in this review.

et al., 2014). In Colombia, survivors described forced abortions during violent displacements, with one participant recounting severe coercion: “*They forced me to make ‘picas’ . . . I was 6 months and a half pregnant*” (Wirtz et al., 2014). Among Afghan refugees in Australia, participants reported experiencing forced abortions while in Afghanistan, describing forms of coercive and physical violence used by partners in an attempt to terminate pregnancies (Russo et al., 2020).

Denial of women’s contraceptive agency: Denial of women’s contraceptive agency was also reported among forcibly displaced populations, with the main perpetrators being partners, religious leaders upholding their religious beliefs, and healthcare providers (Gebreyesus et al., 2020; Russo et al., 2020). In Israel, Eritrean asylum seekers faced barriers and structural discrimination, leading to situations where healthcare providers imposed contraception choices on women (Gebreyesus et al., 2020). Afghan refugees in Australia reported that they experienced forced prohibition of contraception while they were in Afghanistan based on religious beliefs (Russo et al., 2020).

Control over reproductive decisions: Control over reproductive decisions was reported as another form of RCA, perpetrated by partners, religious leaders, or community leaders (Jiménez-Lasserrotte et al., 2020; Rahman et al., 2024). In Spain, a woman was directed by her husband to give birth alone in Europe, demonstrating the control he exerted over her reproductive decisions (Jiménez-Lasserrotte et al., 2020). Similarly, in Bangladesh, access to pregnancy termination

services is tightly controlled by religious and familial authorities, with participants describing how approval from husbands and in-laws is required for such decisions (Rahman et al., 2024).

Physical abuse by husbands for not giving birth to enough sons: Physical abuse related to not bearing enough sons was reported among Afghan women refugees in the USA. This practice was reported as being rooted in cultural beliefs where sons are often valued for carrying on the family name and providing economic support (Lipson et al., 1995). While there was limited information regarding the concept of “enough” sons, it would appear to vary depending on the family or community’s cultural exceptions.

Factors Contributing to Reproductive Coercion Across Different Context

Women experienced RCA in the context of complex and interconnected social, relational, legal, material, and economic conditions. Economic dependency and irregular legal status was found to exacerbate coercion, as seen in cases where fear of deportation and lack of healthcare access contributed to women’s experiences of abuse (Bhatia, 2023). Economic dependency, alongside limited sexual and reproductive health knowledge, also contributed to coercive relationship dynamics (Hegde et al., 2012). Conflict and displacement further heightened these issues, with refugees and internally displaced women frequently experiencing forced sex, forced pregnancy, and forced marriage (Chang

Table 3. Summary of Critical Findings.

The review identified various forms of RCA, including coerced and unwanted sex, intentional contraception misuse, forced pregnancy and abortion, imposition of contraception without consent, control over reproductive decisions, forced marriages, and physical abuse related to gender expectations

RCA is influenced by multiple socio-ecological factors, including individual vulnerabilities such as economic dependency, relationship dynamics involving partner interactions, community norms shaped by cultural and religious beliefs, societal policies at the country level, and global issues like armed conflict and migration

The health consequences of RCA are severe, leading to physical injuries, psychological trauma, and negative reproductive health outcomes for affected women

RCA = reproductive coercion and abuse.

et al., 2014; Wirtz et al., 2016). Intentional contraceptive misuse and tampering by partners also played a role, with RCA consisting of deliberate sabotage of contraceptive methods (Eastman et al., 2023). Barriers to healthcare access, including interpersonal discrimination, severely limited the availability of contraceptive services (Gebreyesus et al., 2020). Cultural and religious norms shaped reproductive decisions and access to care, influencing women's choices and experiences (Rahman et al., 2024). Additionally, state-induced fear of arrest, restricted access to healthcare services, and structural barriers contributed to state-sanctioned forced abortions, particularly affecting those lacking support (Schoevers et al., 2010). Finally, violence and coercive control, including forced marriage and forced reproductive health interventions, highlighted how intimate partner violence interacts with structural factors to severely impact the reproductive autonomy of women who have been forcibly displaced (Wirtz et al., 2014).

Impact of RCA in Forcibly Displaced Contexts

The included studies associated RCA with various outcomes, including but not limited to unintended pregnancies (Bhatia, 2023; Chang et al., 2014) and short interval pregnancies, psychological trauma, mental health issues, restricted healthcare access (Lipson et al., 1995; Schoevers et al., 2010), and restricted autonomy (Kevin & Agutter, 2020). However, none of the studies directly linked RCA to these outcomes.

Discussion

The aim of this systematic review was to explore the extent of RCA among forcibly displaced women worldwide, focusing on forms of RCA, perpetrators, associated factors, and health and social impacts. A total of 15 studies were included from 9 databases and specific journal websites, reporting various forms of RCA among forcibly displaced populations globally. The majority of the included studies were high quality (12 out of 15 studies). Forms of RCA identified include forced marriage, forced and unwanted sex which directly interfered with reproductive autonomy, intentional contraception misuse, forced pregnancy, forced abortion, imposition of contraception without the respondent's choice,

control over reproductive decisions, and physical abuse by husbands for not giving birth to enough sons. Intimate partners were identified as the major perpetrators of RCA, though other perpetrators included community members, healthcare workers, armed forces, and state actors. Economic dependency, legal status, religious norms, and household-level characteristics were often reported as exacerbating experiences of RCA (Table 3).

RCA was found to influence marital dynamics, sexual decision-making, contraception, and pregnancy, with the majority of the included studies reporting forced marriage, forced and unwanted sex, intentional contraception misuse, unwanted pregnancy, and unwanted abortion. While forced and unwanted sex are broader phenomena within the spectrum of GBV, in this review, these factors were all directly related to women's reproductive autonomy. These findings mirror patterns of RCA observed in non-refugee contexts, though direct comparisons are difficult due to limited data (Moulton et al., 2021). Nevertheless, RCA described in this study is consistent with previous reports of higher occurrences of unwanted pregnancy, lower contraceptive use, and short birth intervals among forcibly displaced women and girls. Evidence clearly demonstrates that these factors contribute to adverse maternal and child health outcomes in forcibly displaced contexts worldwide (Islam et al., 2022a, 2022b; Khan et al., 2021; Khan & Khanam, 2023).

RCA was found to be supported and exacerbated by a range of challenges situated across multiple socio-ecological levels (Fulu & Miedema, 2015; Warling et al., 2023). These challenges included insecure legal status, religious norms, and household-level characteristics, which were also associated with poorer maternal and child health outcomes in forcibly displaced population (DeSa et al., 2022; Khan et al., 2021). At the societal and global levels, women were found to experience challenges related to legal and visa status, fear of deportation or discrimination, and the trauma of displacement. These issues can prevent women from reporting abuse or seeking formal assistance, which increases their risk of ongoing coercion and abuse (Bhatia, 2023; Hulley et al., 2023). Additionally, forcibly displaced populations face challenges stemming from the breakdown of social structures and the loss of community support that existed prior to relocation (Islam et al., 2022a; Ziersch et al., 2020). This

Table 4. Summary of Implications for Practice, Policy, and Research.**Policy implications**

Develop targeted policies addressing RCA in forcibly displaced populations, considering socio-economic, legal, and cultural factors.

Strengthen legal frameworks to protect women from RCA and ensure access to justice for survivors. Incorporate RCA into public health strategies to effectively address reproductive health needs in these communities

Practice implications

Equip healthcare providers with training to recognize and respond to RCA, ensuring supportive care for survivors. Promote community discussions to challenge harmful norms and educate about reproductive rights and consent. Implement trauma-informed care practices to create safe environments for survivors and facilitate their healing

Research implications

Conduct more comprehensive studies on RCA's extent, determinants, and health impacts among forcibly displaced populations. Utilize longitudinal studies to understand the long-term effects of RCA and identify effective interventions. Investigate how factors like age, ethnicity, and socio-economic status influence experiences of RCA, enabling tailored interventions

RCA = reproductive coercion and abuse.

disruption often leaves women more susceptible to coercion and abuse, particularly in the context of the instability and insecurity associated with displacement (Bhatia, 2023; Ziersch et al., 2020).

At the relationship level, economic dependency further exacerbates this vulnerability, as displaced women may rely more heavily on male partners or community members, who may exploit this dependency to exert control over reproductive decisions (Bhatia, 2023; Hegde et al., 2012). Family members can also play a significant role in RCA, as reported in other studies, although this was not observed in the studies we reviewed (Suha et al., 2022; Wirtz et al., 2016). These dynamics are often driven by longstanding religious and cultural norms, disadvantaged socio-economic status, and the absence of robust legal protections for women's rights (Crawley, 2022; Islam et al., 2022a; Pittaway et al., 2017). They are compounded by the fact that programs in refugee and displaced settings related to maternal and child health tend to focus only on women themselves rather than including their partners and communities (Hawkins et al., 2021; Njue et al., 2022). This can leave entrenched social and community norms unaddressed, allowing issues like forced marriage and male-dominated decision-making in contraception to persist. As a result, progress among women in these settings is often limited, particularly in reproductive-related decisions, where their decision-making power remains constrained. These existing community-level challenges are further compounded by institutional state-level coercion, which is prevalent in forcibly displaced communities (Kevin & Agutter, 2020; Wirtz et al., 2014, 2016). The study reported instances where community-level actors, such as community or religious leaders dictated contraception choices, overrode women's reproductive preferences and even perpetrated forced abortion (Gebreyesus et al., 2020; Rahman et al., 2024). These forms of coercion highlight how systemic factors, including governmental or institutional policies, can exacerbate risk factors for forcibly displaced women, stripping them of autonomy over their sexual and reproductive health.

Several additional factors further contributed to this institutional coercion. In some cases, governments and organizations may prioritize population control or public health objectives over individual rights, leading to policies that pressure or coerce women into specific reproductive choices. For example, limited resources in refugee or forcibly displaced settings may result in an emphasis on certain contraceptive methods that are more cost-effective or easier to distribute, without considering individual needs or preferences (Chalmiers et al., 2022). Additionally, language barriers can restrict institutions from having comprehensive discussions with women about contraception options, leading to the imposition of contraception without regard for their desires (Gebreyesus et al., 2020). In some cases, healthcare providers or officials may exploit their positions of authority, further contributing to the erosion of reproductive autonomy. Cultural biases within institutions and stigma also play a significant role (Islam et al., 2022a). For instance, certain officials or healthcare providers may hold prejudices against refugees or specific ethnic groups, influencing decisions about who receives care and what type of care is provided (Hall et al., 2015). This can lead to discriminatory practices that further marginalize refugee women, particularly in reproductive health matters. While the motivations behind sexual violence may or may not be directly related to reproductive control, forced sex by state-level actors, such as military personnel, can manifest as another form of RCA. Refugee women are severely restricted in accessing legal recourse or advocacy in response to both RCA and sexual violence, making it difficult to effectively challenge coercive practices or seek justice (Bhatia, 2023) (Table 4).

Regardless of the intentions of perpetrators of RCA, it is found to be linked with various adverse maternal and child health outcomes, including unintended pregnancies (Bhatia, 2023; Chang et al., 2014), short-interval pregnancies, psychological trauma, mental health issues, and restricted healthcare access (Lipson et al., 1995; Schoevers et al., 2010). These factors are crucial in contributing to poor maternal and child health outcomes, including very high

maternal and child mortality, in the context of forcibly displaced populations. RCA in these populations must be addressed if we are to focus on improving these outcomes in line with the 2030 targets set in the sustainable development goals, while also emphasizing the key principle of leaving no one behind. The lack of interventions addressing RCA and its adverse impact has largely left this issue unaddressed over the years, both in general and clinical settings. Therefore, integrating RCA-focused strategies into healthcare policies and programs is essential to ensuring comprehensive reproductive health support for forcibly displaced populations.

This review has several strengths and a few limitations. A notable strength is its comprehensive scope, which covers a broad range of studies from multiple databases and journal websites, providing a thorough overview of existing research into RCA among forcibly displaced populations. This extensive coverage of diverse forcibly displaced population groups in various global contexts suggests this study's findings, in terms of types of RCA and its perpetrators, are broadly generalizable. Moreover, the majority of the included studies were high quality, suggesting the reliability of the findings. The review also benefits from including diverse types of coercion, allowing for a nuanced understanding of how reproductive autonomy is compromised. Additionally, the focus on systemic factors, including governmental policies and social norms, offers valuable insights into broader issues affecting refugee women's reproductive rights. The review findings highlight the importance of the socio-ecological model when working to identify the key types of exacerbating factors, such as economic dependency, legal status, and loss of community support. Correctly identifying and understanding the levels of these challenges is crucial for developing targeted interventions.

However, the review has some limitations. The reliance on available studies means that some forms of RCA or specific populations within forcibly displaced communities may be underrepresented, affecting the comprehensiveness of the findings. For instance, coercion related to accessing reproductive healthcare services is often cited as a major factor in adverse maternal and child outcomes in refugee or forcibly displaced population contexts (Khan & Khanam, 2023; Khan et al., 2024). However, none of the included studies explored this issue, so it was not reported. Direct comparisons with RCA patterns across different forcibly displaced contexts are also challenging due to varying social and cultural norms, which limit the ability to fully contextualize the extent of RCA in these settings. Additionally, due to research team capacity, only articles published in English were included, and reporting bias or methodological limitations in the included studies could affect the consistency and reliability of the findings. Many programs and interventions in forcibly displaced population settings focus solely on women, often overlooking the role of partners and communities in perpetuating RCA. Finally, the review may not fully account for

unique contextual factors affecting specific forcibly displaced populations, such as regional cultural practices, ongoing conflict, or political conditions, which could influence the prevalence and nature of RCA.

Conclusion

We found that multiple and distinct forms of RCA were commonly reported as experienced by refugee and forcibly displaced women and girls globally. The most common forms of coercion include forced marriage, forced sex, intentional contraception misuse, unwanted pregnancy, and forced abortion. Factors such as economic dependency, legal status, religious norms, and loss of community support exacerbate women's vulnerability to RCA. Perpetrators include intimate partners, community members, healthcare providers, and state actors. Addressing these challenges requires interventions involving multiple stakeholders, including partners and communities, as well as efforts to address harmful social norms and provide legal protections. Improving access to comprehensive reproductive health services, enhancing healthcare facilities' capacity through provider training, and addressing systemic challenges in the healthcare delivery system are crucial for supporting the reproductive rights and overall well-being of refugee women.

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Authorship Contributions

MNK and KB developed the study concept. MNK and GT-B reviewed the articles independently, extracted data, and assessed study quality. MNK conducted the formal analysis and drafted the manuscript. GT-B checked the results and critically reviewed the manuscript. KB critically reviewed and edited all previous versions of the manuscript. All authors approved the final version of this manuscript.

Data Availability Statement

All relevant data are included in the manuscript and its supplemental file.

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Supplemental Material

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