

In this brief, we overview a concerning way that healthcare providers and systems can threaten reproductive autonomy: contraceptive coercion. While pressure to use or not use contraception can happen within a variety of contexts, from intimate partner relationships to families to the criminal justice system, here we focus on contraceptive coercion that happens at the healthcare level—that is, individual healthcare providers’ interactions with patients and/or a healthcare system’s policies or initiatives, that lead people to feel pressured to use or not use a birth control method against their wishes.

Executive summary

- ✔ Contraceptive coercion, which refers to pressure to use (upward coercion) or not use (downward coercion) birth control despite one’s wishes, is common in healthcare settings.
- ✔ Upward contraceptive coercion is the most common form and often involves provider and healthcare system recommendations to use long-acting reversible contraceptive (LARC) methods such as IUDs and implants. Patients often report pressure to use LARC methods during pregnancy and immediately after childbirth. Another example of upward coercion occurs when providers refuse to remove LARC methods that patients express a desire to stop using.
- ✔ One of the more common forms of downward contraceptive coercion occurs when individuals wishing to obtain permanent contraception, such as tubal ligation, are discouraged or prohibited from doing so.
- ✔ Multiple studies show that people from systematically marginalized groups are more likely than others to experience contraceptive coercion by healthcare providers or systems. These inequities especially harm people of color, those living on lower incomes, and LGBTQ+ individuals. Both historical and present-day racism, reproductive injustice, and other historical harms influence present-day practices of contraceptive care, especially among Black and Latine women.
- ✔ In Wisconsin, research suggests that many contraceptive clients’ preferences are not only unmet but are, in some cases, actively disregarded. Both Black and white Wisconsinites in one study reported that healthcare providers are more likely to recommend LARC methods to lower-income women of color.
- ✔ To reduce contraceptive coercion, providers, healthcare systems, and policymakers can enact multiple strategies. These strategies include: person-centered contraceptive care, in which patients’ individual preferences set the tone for the contraceptive recommendations and care; sufficient training in, and reimbursement for, LARC insertion *and* removal; and anti-bias training and education about racism and reproductive injustice.
- ✔ That said, fully realizing reproductive autonomy and justice requires more than changes in healthcare. It requires equitable access to education, housing, employment, childcare, public safety, and other social and economic supports that provide people with the resources, opportunities, and power to achieve reproductive well-being.

Reproductive autonomy

is the right and power to make decisions about one’s reproductive health and access services without barriers, interference, or coercion.

What is contraceptive coercion?

Access to contraceptive care is essential for reproductive health and autonomy—the right and power to make and act on decisions about your health. However, when contraceptive care involves interpersonal or system-level coercion, patient autonomy is undermined. In these cases, *contraceptive coercion* refers to pressure from healthcare providers or systems on persons to use (upward coercion) or not use (downward coercion) contraception despite their wishes.



Upward coercion refers to pressure to use contraception, even when the person doesn't wish to. This includes urging a person to use any form of contraception—for example, a provider tells a patient presenting for HPV screening that she needs to use birth control, even when the patient isn't engaging in sexual activity or doesn't wish to use a contraceptive method at all. Upward coercion also includes pressuring a person to use a specific method or type of method—for example, strong or repeated recommendations from a provider to use an IUD even if the patient wishes to use condoms, or presenting the pill as the optimal if not the only contraceptive option to an adolescent patient.¹



Downward coercion refers to pressure to *not* use contraception at all, or not use a specific method—for example, resistance from a provider when a patient asks for tubal ligation, or a health insurer's refusal to cover permanent contraception (sometimes referred to as sterilization). Downward coercion also includes *restricting* contraceptive services. For example, some officials argued that contraceptive services were “non-essential” during the early months of the COVID pandemic.² Additionally, many Catholic healthcare systems fail to offer sterilization services or other contraceptive care,³ and Medicaid policies have made it harder for individuals living on low incomes to obtain desired sterilization services compared to those with private insurance.^{4,5}

Contraceptive coercion shows up in many ways

Coercive contraceptive practices vary. Coercion “sits on a spectrum and need not involve overt force or violence,”⁸ but can unfold in subtle ways or interactions as well. In a review of global research, researchers scanned the scientific literature for evidence of (LARC-specific) coercion,¹⁴ then grouped that evidence into categories. Below we present several of those categories that show up in healthcare settings.

Refusal to remove IUDs and implants is coercion

Patients report^{6,7,8} that healthcare providers sometimes refuse to honor their requests to remove IUDs and implants—a violation of reproductive autonomy. Providers may feel professional pressure to ensure use of these long-acting reversible contraceptives (LARCs). Some physicians have reported feeling guilty or as if they had “failed” when a patient wanted their IUD removed, particularly because major medical organizations have strongly promoted LARC use.⁹

Consequences of refusals include lowered patient satisfaction, harms to the doctor-patient relationship,¹⁰ unwillingness to use LARC methods in the first place,¹¹ and threats to reproductive freedom and personal agency.¹²

Some advocates and social media influencers encourage IUD self-removal to disrupt this power imbalance.¹³ However, self-removal of IUDs is not always possible depending on the length of the string and the shape of the person's endocervical canal. And self-removal is not an option at all for people who have contraceptive implants.

Table 1. Types of contraception coercion which occur in healthcare settings, based on Boydell et al., 2023¹⁴

CATEGORY	DEFINITION	EXAMPLE(S)
Nonconsensual	Healthcare provider ignores or fails to seek the patient's consent for the contraceptive care delivered.	Doctor inserts an IUD after delivery without the birthing person's knowledge or consent. ¹⁵
Conditional	Person is told that she must use a particular contraceptive method in order to access desired services.	Provider tells a patient they cannot leave the hospital after giving birth unless she first has an IUD or other method of contraception inserted.
Biased and directive counseling	Healthcare provider uses pressure, selective information, intimidation, or scare tactics to direct a patient to use a particular contraceptive method. Method choice or options may be influenced by counselor personal biases (explicit or implicit), pressure or coercion from a counselor or partner, or institutional ideology. ¹⁶ Particularly powerful at vulnerable moments such as just after birth or just after abortion, this type of coercion involves favoring some methods and discouraging others without sound medical rationale. ¹⁷	Counselor tells a patient that her desired method—the birth control pill—is “ineffective” and that she should use an implant instead. Catholic community hospital refuses to provide patient with desired tubal ligation.
Incentives	Healthcare provider or system uses bonus, reward, or payment to get clients to use certain (or any) methods.	Healthcare system uses provider incentives to increase LARC uptake among patients. Program offers money to substance users to be sterilized or use contraception. ¹⁸
Restrictive laws or policies	Rules and regulations that influence contraceptive choices or restrict options.	President Johnson's 1964 War on Poverty encouraged people living on low incomes to prevent pregnancies. Recent cuts to Title X, the only federal program dedicated to family planning services, led reproductive health clinics to close in states such as Wisconsin. ¹⁹ The federal government mandates a 30-day waiting period for Medicaid sterilization requests. ²⁰
Restricted options	Provider or healthcare system offers only limited access to the full range of FDA-approved contraceptive methods, or insurance only covers certain methods (or none at all).	Employer with a religious objection to contraception excludes contraceptive coverage from their insurance plan (as permitted by the Affordable Care Act).

Contraceptive coercion by healthcare providers and systems is common

In a recent study conducted by Dr. Laura Swan and team with a national sample of 1,197 reproductive-age people assigned female at birth, over one in six (18%) experienced coercion at their last contraceptive care visit, and over one in three (42%) had experienced coercion in contraceptive care at some point in their lifetime. This research also found that upward coercion was more common than downward coercion—nearly four times as common at patients' most recent visits, and more than twice as common across people's lifetimes.²¹ When the authors pulled a Midwest-only sample of participants from the sample ($n=276$), the results were nearly identical: 14% reported either upward or downward contraceptive coercion at their last visit, and 41% reported contraceptive coercion at some point in their lives.²²

Participants in this study also reported coercion in contraceptive care related to every kind of method. Some of the most common were pressure from healthcare providers to use or not use the birth control pill or IUD, pressure to use the birth control shot, and pressure to not use implants or permanent contraception such as tubal ligation.²¹

Other state-specific and regional studies show similarly high rates of contraceptive coercion. A 2019 survey found that 37% of people in the Appalachian region had experienced coercion in their contraceptive care (30% upward and 16% downward coercion).²³ In Delaware and Maryland in 2021, 26% of current LARC users reported pressure to get a LARC, and 11% of people who had ever used a LARC reported pressure to keep a LARC.²⁴



Socially marginalized people are more likely to experience coercion

Contraceptive coercion does not occur randomly or uniformly. Providers, healthcare systems, and policies are more likely to exert coercive practices on people facing forms of social oppression—especially, people of color, those living on lower incomes, young people, and LGBTQ+ individuals.

For centuries, the healthcare system and providers have abused the reproductive autonomy of people of color, especially Black and brown women. Such efforts have involved both pressured and outright forced contraceptive use in order to limit childbearing, including connections between the 19th century birth control movement and eugenics;²⁵ U.S. compulsory sterilization programs that targeted poor women of color, people with disabilities, and people with mental illness; and aggressive marketing of Norplant, a five-year contraceptive implant with a number of side effects, to young, urban, African American, and Latine communities in the 1990s.^{26,27}

In more recent years, compelling evidence suggests that many healthcare providers guide patients of color toward higher-efficacy methods more often than their white patients. In one study, researchers showed video vignettes with patients of varying sociodemographic backgrounds to physicians, then asked the physicians whether they would recommend an IUD for the patient shown in the video.²⁸ For those videos depicting patients with low socioeconomic status, doctors were significantly more likely to recommend IUDs for Latinas

and Blacks than whites. These findings track with a recent survey of over a thousand reproductive-age people in the U.S., in which racial/ethnic minorities were significantly more likely than white participants to experience contraceptive coercion at their last healthcare visit: 55% versus 14%.²⁹ Qualitative research with young Black and Latina women has also documented their experiences of implicit pressure from providers to use certain contraceptive methods.³⁰

Sexual identity shapes contraceptive coercion, too. People who identify as lesbian, gay, bisexual, queer, or other diverse sexualities, hereafter referred to as LGBTQ+, are more likely than heterosexual-identified people to experience contraceptive coercion. While some LGBTQ+ individuals want and need contraceptive care,³¹ recent research suggests they are less likely to receive person-centered care and less likely to receive their desired contraceptive method than their heterosexual counterparts.^{32,33} In a recent study of over 1,000 sexually-diverse people who had ever received contraceptive counseling, upwards of a quarter of LGBTQ+ participants reported upward contraceptive coercion at their last reproductive healthcare visit—significantly more than heterosexual respondents.³⁴

People with disabilities have long faced threats to their bodily autonomy in healthcare.³⁵ Emerging evidence suggests people with disabilities are more likely to experience contraceptive coercion and discriminatory and dismissive care than their non-disabled peers, including provider refusal of some methods, disregard of adverse interactions with pre-existing health conditions, or dismissal of their sexuality.³⁶

Evidence from multiple studies shows that contraceptive coercion happens in Wisconsin, too

A growing evidence base from Wisconsin documents pressure from healthcare providers and systems to use or not use contraception, as well as inability to access one's desired method.

In one qualitative study in Dane County, Dr. Jenny Higgins and team conducted focus groups and interviews with 50 cisgender women from various racial and socioeconomic backgrounds about their experiences with, and interactions with providers about, LARC and other contraceptive methods.⁷ While many women in this study, especially white women, described healthcare professionals as a trusted source of information, a number reported that providers had not always honored their preferences regarding contraceptive selection or removal. The following participant described a prior experience of upward coercion:

“ I was pressured to use NuvaRing at one point. And I hated it. And I knew I was going to hate it and I told them [my providers] I was going to hate it. But they were like “No, it’s the greatest thing ever. You’re never going to have a problem with it.” And I used it for a week and I absolutely hated it and took it out.
~Josie, white

One participant also described facing resistance when she wanted her IUD removed a month or two after its insertion:

In one study,
55%
of racial/ethnic minorities
VS **14%**
of white people experienced
contraceptive coercion at
their last visit.

Source: Swan et al., 2023 ²⁹

“ I told them that I wanted it out and they said that it’s really expensive and that the IUD’s the best option. I got some resistance there. I was a little emotional at the time and she [the provider] didn’t even care, it seemed. ~Heather, white

Study participants from a variety of racial and socioeconomic backgrounds also indicated that providers may be more likely to recommend IUDs and implants to women of color, women living on low incomes, and patients deemed uneducated or unintelligent by providers. For example:

“ Young African American women are more pressured [to use LARC] from my point of view. Even if they’re in a responsible relationship or state of mind or set of circumstances, or even if they’re just going in for education, providers can be very judgmental. ~Loretta, African American

This same participant described how she had seen cousins and nieces “lectured to” about birth control by providers, “even when they were responsible.” Other women of color in the study described prior reproductive injustices, either historical or personal, that increased their wariness of LARC recommendations.

“ Birth control in general makes me really wary because it was meant to keep people like me from procreating and having more of us, right? I don’t really trust doctors because I don’t know what subconscious things are going on when certain methods are being recommended to me. ~Sandra, Latine

In other words, while Wisconsinites from a variety of racial and socioeconomic backgrounds expected LARC recommendation, women of color were (understandably) more wary of experiencing this pressure firsthand.

There is also evidence that Catholic healthcare systems in Wisconsin can contribute to contraceptive coercion by restricting the contraceptive options available to patients. One CORE study found that one-in-twelve women in Wisconsin rural counties served only by a Catholic-affiliated hospital reported being turned away without receiving desired reproductive care.³⁷ Especially for those women denied tubal ligations, long delays in seeking care elsewhere were common.

Contraceptive coercion can have meaningful consequences

Experiencing contraceptive coercion in healthcare settings is linked to a range of negative outcomes, including lower likelihood of using one’s preferred contraceptive method^{23,38} as well as associations with poorer mental health and well-being.³⁹ One possible reason is that coercive counseling can undermine patients’ sense of control over their contraceptive decision-making.⁴⁰ People who have experienced coercion describe feelings of shame, frustration, disempowerment, and emotional distress, and some report that these experiences reduce trust in healthcare providers and make them more likely to avoid future healthcare encounters.^{41,42}

Importantly, contraceptive coercion is harmful in its own right. Regardless of its effects on contraceptive use, mental health, or healthcare engagement, it violates patients’ autonomy and ability to make voluntary decisions about their reproductive health.

Healthcare providers and systems can act to reduce contraceptive coercion

Below we outline steps that healthcare providers, health systems, and policymakers can take to reduce contraceptive coercion. But these actions alone will not address coercion’s deeper historical and structural

causes. Because some communities have experienced more reproductive harms than others, the same contraceptive recommendation may be experienced differently by different patients. Truly person-centered care requires recognizing how social circumstances, past harms, and structural inequities shape patients' experiences of contraceptive counseling.

PROVIDER STRATEGIES TO REDUCE CONTRACEPTIVE COERCION

- ✓ High quality anti-bias training and education about racism and reproductive injustice^{41,43,44}
- ✓ Training and professional norm-setting that explicitly moves contraceptive counseling away from paternalistic assumptions about what methods are “best” for particular patients and toward care that is defined by patients' own priorities, goals, and lived experiences^{16,43,45,46}
- ✓ Training in person-centered contraceptive care, in which patients' individual preferences set the tone for counseling and recommendations^{16,45}
- ✓ Sufficient training in LARC insertion *and* removal to ensure that providers can both offer and discontinue methods in a timely, patient-directed manner^{43,47–50}

HEALTHCARE SYSTEM STRATEGIES TO REDUCE CONTRACEPTIVE COERCION

- ✓ Avoid the use of “targets” or performance metrics tied to LARC uptake or other specific methods⁵¹
- ✓ Ensure adequate reimbursement and clinical processes for removal of LARC methods⁴³
- ✓ Support contraceptive care shortly before, during, and immediately after giving birth that emphasizes informed consent, ongoing choice, and the ability to initiate, decline, or discontinue contraception without pressure during a clinically and socially vulnerable time^{52–54}
- ✓ Create clinical conditions that allow for adequate time for counseling and the ability to build and sustain trusting patient-provider relationships, which are often constrained by institutional pressures^{41,55,56}

HEALTHCARE POLICY STRATEGIES TO REDUCE CONTRACEPTIVE COERCION

- ✓ Ensure that Medicaid patients can obtain all desired, FDA-approved contraceptive methods, including sterilization, without unnecessary administrative, financial, or timing barriers^{45,57}
- ✓ Align coverage and reimbursement policies with principles of reproductive autonomy rather than cost containment alone⁴¹
- ✓ Fully fund Title X, the federal family planning program for people living with low incomes and those who are un- or under-insured, to enable the program to meet the growing demand for affordable, person-centered contraceptive care⁵⁸
- ✓ Ensure that Title X's standards protect people's ability to obtain the contraceptive method of their choice⁵⁹
- ✓ Require referral processes when providers claim the right to refuse to provide contraception, a particular method, or information about options⁶⁰

 These healthcare strategies are important steps to reduce contraceptive coercion. Action must also be taken to address contraceptive coercion in contexts not covered in this brief, such as intimate relationships⁶¹ and the criminal justice system.^{62,63} Yet, following the example of reproductive justice,⁶⁴ fully realizing reproductive autonomy requires equitable access to education, housing, employment, childcare, public safety, and other social and economic supports that provide people with the resources, opportunities, and power to achieve reproductive well-being. 

Suggested citation

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