

BRIEF SNAPSHOT

Contraceptive coercion by healthcare providers and systems

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This summary highlights a brief from the UW Collaborative for Reproductive Equity (CORE) and the Reproductive Equity Action Lab (REAL) on **contraceptive coercion**, a common and concerning way that healthcare providers and systems can threaten reproductive autonomy.

Contraceptive coercion refers to **pressure to use** (upward coercion ↑) or **not use** (downward coercion ↓) a birth control method despite one's wishes. Providers' interactions with patients and healthcare system policies or initiatives can create such coercion.

Contraceptive coercion is common and varied



A recent national study found that **more than one in six** (18%) reproductive-aged people assigned female at birth experienced coercion during their last contraceptive care visit, and **over one in three** (42%) had experienced it at some point in their lifetime. **Upward coercion** is most common and often involves recommending the use of, or refusing to remove, long-acting reversible contraceptive (LARC) methods such as IUDs and implants. Discouraging or prohibiting individuals who want permanent contraception (such as tubal ligation) from obtaining it is a common form of **downward coercion**.



Some groups face a higher risk of contraceptive coercion

Contraceptive coercion does not occur randomly or uniformly. Historical and ongoing inequities shape healthcare practices. Research shows that **racial and ethnic minorities**, people who identify as lesbian, gay, bisexual, queer, or other **diverse sexualities**, and **people with disabilities** are more likely than their white, heterosexual, and non-disabled peers to experience contraceptive coercion.



Contraceptive coercion happens in Wisconsin

In Wisconsin, research suggests that many contraceptive clients' **preferences are unmet** and sometimes **disregarded**. In one study, numerous Wisconsinites indicated that healthcare providers had not honored their preferences for contraceptive selection or removal, and Black and white participants reported that providers are more likely to recommend LARC methods to lower-income women of color. There is also evidence that Catholic healthcare systems in Wisconsin contribute to coercion by restricting contraceptive options available to patients.



Healthcare strategies can reduce contraceptive coercion

Contraceptive coercion **violates patients' autonomy** and their ability to make voluntary decisions about their reproductive health. It is linked to lower use of preferred methods, poorer mental health and well-being, and other negative outcomes. **Providers, systems, and policymakers** can reduce contraceptive coercion through person-centered care, sufficient training and reimbursement for LARC insertion *and* removal, and anti-bias training and education.

View the full brief at go.wisc.edu/coercion.