



Addressing Coercion in Contraceptive Care

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Coercion in contraceptive care—that is, pressure from a healthcare provider to use or not use birth control—undermines patients’ reproductive autonomy and makes it more difficult for people to access their desired contraceptive methods. Specifically, existing qualitative research has highlighted healthcare providers’ biases and coercive practices including **providers targeting specific groups for contraceptive intervention** and **pressuring patients to use or keep using long-acting contraceptive methods they did not want to use**. Scholars and activists have also begun to **critique common healthcare models that promote long-acting reversible contraceptives (LARCs)**, including intrauterine devices (IUDs) and implants, above or before other contraceptive methods.

These coercive practices occur in the shadow of a long history of reproductive injustices. Across U.S. history, social norms, governmental policies, and public health programs have promoted the reproduction of some groups, such as affluent white women, and restricted that of others, such as poor women and women of color. For example, the eugenics movement, which was prominent in the U.S. in the late 19th and early 20th centuries, sought to improve the genetic quality of the human population through selective breeding and through restricting the reproduction of people they deemed “unfit” or “undesirable.” One common method of restricting “undesirable” reproduction was through **forced and coerced sterilizations** of targeted populations which included people of color, immigrants, people with disabilities, and those living in poverty. Although the frequency of these sterilization abuses dropped by the end of the 21st century, **reports of coercive sterilization practices continue to emerge**, oftentimes targeting imprisoned and immigrant detainee populations.

Despite growing concerns over coercion in contraceptive care, few studies have described the frequency and manifestations of contraceptive coercion. My research explores this area, using a national survey to document how often patients perceive coercion in their contraceptive care, which groups of people are at risk of contraceptive coercion, and how contraceptive coercion is related to patients’ health and autonomy.

My findings reveal that contraceptive coercion is relatively common, with over one in six participants reporting coercion during their last contraceptive counseling and over one in three reporting it at some point in their lifetime. Upward contraceptive coercion—that is, pressure to use birth control—is more common than downward contraceptive coercion—or pressure to *not* use birth control.

In particular, many patients reported that their healthcare provider made them use or keep using the birth control pill when they did not want to. In one participant’s open-ended description of her experience with contraceptive coercion, she described being refused contraceptive implant removal, stating that her provider “fought me on extracting Nexplanon. She wanted me to follow through with it for the 4 years its meant to be used. But it made me extremely sick. I had been on it for 5 months and in the first 2 months I gained 25lbs, I was extremely depressed, suicidal, aggressive and acting extremely unlike myself...They refused to believe me

and were pressuring me to keep it until I threatened to cut it out myself. Only then did they agree to remove it from my arm.”

Patients were also commonly refused desired tubal ligations. One participant described this experience, stating: “I have had 2 successful healthy pregnancies at a very young age but also a tubal pregnancy a few years after and then a miscarriage in 2020. Despite being at an advanced age a tubal ligation was ‘out of the question’ because I ‘might get married again.’ Which is ridiculous.”

Groups facing structural oppression, especially Black participants and gay/lesbian participants appear to be particularly at risk of experiencing contraceptive coercion. For example, one Black woman wrote: “I wanted to stop using birth control pills. Instead, my doctor made me switch to another brand with fewer hormones in it to see if that would help...I feel like as a black women in her 30's with fibroids I am written off a little.” Additionally, many participants who described their sexual orientation as gay, lesbian, bisexual, queer, or something else other than heterosexual (LGBQ+) described how their “provider disregarded [their] sexuality” and pressured them to use or not use birth control. As one LGBQ+ participant stated, “I wanted to get an IUD. The MD told me that I was too young (I was 19) and would want to have children within 5 years. I told her that I did not want to have children. She told me that I was wrong and I would get married and want to have kids. I still do not want children.”

Finally, my findings show that people who experience contraceptive coercion are less likely to be using their preferred contraceptive method(s) and have worse mental health and well-being than people who did not experience contraceptive coercion. Participants described ways that experiencing contraceptive coercion was “traumatic” and made them “feel hopeless, ignored, and frustrated...like I didn’t possess bodily autonomy.” Participants explained that coercion in their contraceptive care led them to “limit seeking healthcare as much as possible” and/or seek out providers that valued their contraceptive preferences.

My research suggests that contraceptive coercion is relatively common, and minoritized communities are likely at increased risk. This is not surprising given our nation’s troubled history of reproductive injustices.

These findings highlight opportunities to improve healthcare inequities and patient reproductive autonomy by providing patient-centered care. Such care should be focused on the patient, tailored to their needs and preferences, and involve patients’ active participation in close cooperation with their healthcare provider. Beyond the interpersonal dynamics involved in clinical care, we need initiatives to address contraceptive coercion at a systems level. For example, providers need to be given enough time with patients to truly assess patient needs and implement patient-centered care. Systems must also shift their emphasis away from contraceptive uptake and instead toward reproductive autonomy and the delivery of patient-centered care. As such, organizations and healthcare systems should measure contraceptive care success using patient-centered measures like patients’ use of their preferred contraceptive method(s) rather than more traditional measures like contraceptive uptake or use of highly effective contraceptive method(s). We also need healthcare guidelines and legislative measures that prevent forced contraceptive use while also ensuring access to the full range of contraceptive methods.

Addressing contraceptive coercion through patient-centered care and systemic changes is essential for upholding reproductive autonomy and promoting equitable healthcare.

Read more in Laura Swan and Lindsay Cannon, “**Healthcare Provider-Based Contraceptive Coercion: Understanding U.S. Patient Experiences and Describing Implications for Measurement**” *International Journal of Environmental Research and Public Health* 6, no. 21 (2024): 750