Compared to NH White, heterosexual people, those from groups facing structural oppression reported more experiences of upward contraceptive coercion— that is, pressure to use birth control. These experiences reduce reproductive autonomy and likely both reflect and perpetuate stratified reproduction and healthcare distrust.

Gay/lesbian participants were more likely than bisexual, heterosexual, and other participants to report experiencing upward coercion at their last contraceptive counseling: $X^2(3)=8.761, p=0.033$.

In logistic regression, while controlling for age and education, NH Black participants had an increased risk of experiencing upward contraceptive coercion relative to NH White participants ($OR=1.71, SE=0.36, p=0.011$). Gay/lesbian participants had a marginally significant increased risk of experiencing upward contraceptive coercion relative to heterosexual participants ($OR=1.82, SE=0.64, p=0.089$). We observed no significant differences in downward coercion by sexual orientation or race/ethnicity, nor significant differences in upward or downward coercion by gender identity.

Non-Hispanic (NH) Black participants were more likely than participants identifying with other racial/ethnic groups to report experiencing pressure to use birth control (upward coercion) at their last contraceptive counseling: $X^2(4)=9.797, p=0.044$.

In March 2023, we used Prolific, a national panel of thousands of vetted participants, to survey 1,400 reproductive-aged people in the United States who were assigned female at birth. We oversampled racial/ethnic (37%), gender (5%), and sexual minorities (36%).

We assessed contraceptive coercion using 5 items:

- **Downward coercion** (pressure to NOT use birth control)
  - (1) Refused their desired method
  - (2) Made to feel they should not use contraception

- **Upward coercion** (pressure TO use birth control)
  - (3) Made to keep using a method they wanted to stop
  - (4) Made to feel they had to use contraception
  - (5) Made to use a specific method

Few studies have quantitatively assessed patient experiences of coercion in contraceptive care, especially among groups facing structural oppression. Understanding inequities in people’s experiences of contraceptive coercion is a critical step in combating such practices. We set out to document inequities in contraceptive coercion among a large, diverse sample.

We used chi-square tests and logistic regression to examine demographic differences in contraceptive coercion among people who had ever talked to a provider about contraception ($N=1,199$).

We observed no significant differences in downward coercion by sexual orientation or race/ethnicity, nor significant differences in upward or downward coercion by gender identity.

**Results**

Gay/lesbian participants were more likely than bisexual, heterosexual, and other participants to report experiencing upward coercion at their last contraceptive counseling: $X^2(3)=8.761, p=0.033$.

<table>
<thead>
<tr>
<th></th>
<th>Coercion</th>
<th>No coercion</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH Asian</td>
<td>17%</td>
<td>83%</td>
</tr>
<tr>
<td>NH Black</td>
<td>23%</td>
<td>77%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td>Mixed/other</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>NH White</td>
<td>14%</td>
<td>86%</td>
</tr>
</tbody>
</table>

In logistic regression, while controlling for age and education, NH Black participants had an increased risk of experiencing upward contraceptive coercion relative to NH White participants ($OR=1.71, SE=0.36, p=0.011$). Gay/lesbian participants had a marginally significant increased risk of experiencing upward contraceptive coercion relative to heterosexual participants ($OR=1.82, SE=0.64, p=0.089$). We observed no significant differences in downward coercion by sexual orientation or race/ethnicity, nor significant differences in upward or downward coercion by gender identity.

**Conclusions**

Compared to NH White, heterosexual people, those from groups facing structural oppression reported more experiences of upward contraceptive coercion— that is, pressure TO use birth control.

These experiences reduce reproductive autonomy and likely both reflect and perpetuate stratified reproduction and healthcare distrust.