VIEWPOINT

Women or LARC First? Reproductive Autonomy And the Promotion of Long-Acting Reversible Contraceptive Methods

By Anu Manchikanti Gomez, Liza Fuentes and Amy Allina

Anu Manchikanti Gomez is assistant professor, School of Social Welfare, University of California, Berkeley. Liza Fuentes is senior project manager, Ibis Reproductive Health, Oakland. Amy Allina is deputy director, National Women's Health Network, Washington, DC.

In recent years, enthusiasm about long-acting reversible contraceptive (LARC) methods has skyrocketed among U.S. reproductive health care providers because of these methods' potential to budge the rate of unintended pregnancy, which "stubbornly" persists at the same level despite efforts over many years to reduce it.[1] For too long, LARC methods—IUDs and implants—have not been an option that women could easily choose, because of a range of barriers: lack of knowledge,[2] providers' low familiarity and lack of training,[3–5] cost[6,7] and unavailability in clinics.[8] While we strongly believe that these barriers should be reduced so that LARC methods are an integral part of a comprehensive method mix, we also are concerned that unchecked enthusiasm for them can lead to the adoption of programs that, paradoxically, undermine women's reproductive autonomy. Our concern is that when efforts move beyond ensuring access for all women to promoting use among "high-risk" populations through programs and contraceptive counseling aimed at increasing uptake of LARC methods, the effect is that the most vulnerable women may have their options restricted. To avoid this pitfall, it is vital that programs designed to promote LARC methods put the priorities, needs and preferences of individual women—not the promotion of specific technologies—first.

While the possibility that LARC promotion efforts can undermine reproductive autonomy may seem remote in the face of the myriad barriers women face in using these methods, we believe that now is a pivotal time to engage in a critical discussion of this topic, given that use of LARC methods is on the rise,[9] new clinical models are showing success in reducing and eliminating barriers to using them[10,11] and many women have newfound access to contraceptives thanks to provisions of the Affordable Care Act.[12] Such a discussion may illuminate the ways in which narrowing the scope of possibilities for family planning program innovation to promoting a particular class of technologies allows the widespread social inequalities that underlie unintended pregnancy to become invisible. It also may show how prioritizing method effectiveness above other contraceptive features may deny some women reproductive control.

SOCIAL AND REPRODUCTIVE HEALTH INEQUALITIES

Clear disparities in levels of unintended pregnancy in the United States persist: Rates are disproportionately high among young, black, Latina and poor women.[1] In an effort to address such disparities, researchers and health care providers have not only devised interventions to reduce barriers women face in accessing LARC methods, but also developed targeted strategies to increase these methods' use among "high-risk" women.[13,14] Interventions targeting populations with the highest rates of unintended pregnancy may be seen as a sensible response to the fact that such women have an unmet need for family planning and as a sensible way to use limited resources to have a public health impact. Yet, targeted approaches to LARC promotion guided primarily by population-level statistical data risk imposing "statistical discrimination"—using epidemiologic data or previous clinical experiences to estimate a particular woman's risk, without consideration of her unique history, preferences and priorities.[15]

The notion that membership in high-risk populations may lead the least privileged women to receive contraceptive counseling that steers them toward a particular method is especially worrisome given the long-standing devaluation of the fertility and childbearing of young women, low-income women and women of color in the United States, and the perception that these women have too many children.[16,17] The history of such reproductive oppression is well documented, but the experience is not merely historical: Between 2006 and 2010, women in California prisons underwent coerced sterilizations,[18] and as recently as 2009, some 19 states denied additional cash benefits to families that had additional children while receiving assistance.[19]

Furthermore, women continue to perceive racial discrimination in family planning settings.[20–24] In a national study of black women, 67% of participants who had seen a health care provider for family planning services reported experiencing race-based discrimination when obtaining these services.[24] Other studies have found that black women may feel pressured to use contraceptives,[23] and black and Latina women are more likely than white women to be advised to restrict their childbearing.[21] Moreover, another study found that black and Latina women were more likely than white women to be counseled about birth control, but were no more likely to obtain a method, suggesting that increased counseling of minority women was not patient-initiated.[20] These concerns are all the more pressing because there is evidence that providers, consciously or not, consider race and socioeconomic status in making their recommendations about the most appropriate contraceptive for a patient. In a randomized trial of health care providers who watched

videos depicting 27-year-old women of varying racial, ethnic and socioeconomic backgrounds, providers were more likely to recommend IUD use for low-income black and Latina women than for low-income white women.[25]

These experiences, policies and studies underscore the reality that settings that serve the most vulnerable women seeking contraceptive care do not operate in a neutral context. Persistent racial and socioeconomic inequality colors the daily lives of both providers and patients, and is inextricably embedded in clinical encounters. Given this context, the family planning community must make particular efforts to ensure that women are able to freely choose LARC methods: It must take steps to make certain that use of these methods is driven by women's own expressed desires for them, and not by a programmatic attempt to reduce population-level unintended pregnancy rates by encouraging "risky" women to use them.

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Further, the increasing focus on LARC methods as the solution to unintended pregnancy in the United States neglects the role of social determinants of unintended pregnancy. Compared with other middle- and high-income countries, the United States has a disproportionately high rate of unintended pregnancy, especially among adolescents.[26] Arguably, macro-level factors—increasing economic inequality, lack of universal health care and stigma related to sexuality—play a larger role in this phenomenon than do low rates of LARC use.[27,28] For example, economists have noted that variation in state-level income inequality accounts for much of the geographic disparity in teenage childbearing in the United States, contending that policies specifically targeting teenage pregnancy (e.g., sex education, improved access to contraceptives) are unlikely to produce improved outcomes for the most disadvantaged young women.[28] These data on teenage pregnancy illustrate that overly relying on LARC methods as the solution to high levels of unintended pregnancy may hinder innovation and political will to envision and fund more integrated, structural efforts to improve family planning services and use.

Nationally recognized experts on poverty policy have suggested that increased access to LARC methods will reduce rates of nonmarital childbearing and poverty.[29] Using rigorous research methods with appropriate comparison groups to investigate whether use of these methods has any impact on poverty is important; however, any research of this kind must be designed with an understanding of how results could be used to inform policy—in both intended and unintended ways. If such research finds a causal association between LARC use and poverty reduction, could that finding be used to ask, encourage or even coerce women to use LARC methods simply because they are poor? On the other hand, what if LARC use does not bear on women's future income? Communicating such a null finding must not invalidate the much more important reasons for continuing to ensure women and their partners access to a full range of contraceptive options, including LARC methods: so that they can plan for and space births, and achieve their desired family size, no matter their wealth.

BEYOND EMPHASIZING EFFECTIVENESS ABOVE ALL

The framing of LARC methods as the first-line contraceptives that should be offered to all women focuses on the appeal of "forgettable" contraception,[14] the lack of user compliance required[13] and, most important, their high rates of effectiveness. However well-intended, such conceptualization implies that these methods offer women the most control over their reproduction—an implication that may not be reflected in the experiences of women who are currently the least likely to use LARC methods. For some women, optimal control may mean choosing a method that will almost never fail. For others, optimal control may mean choosing a method that can be started or discontinued as they choose, without the assistance of a health care provider.[30] For still others, control might relate to the effect of a method on the menstrual cycle. Further, many factors beyond method effectiveness—for example, side effects,[31] detectability by a partner or parent,[32,33] pregnancy ambivalence,[34] the experiences of family and friends,[35] and relationship context[36]—influence method selection and continuation. For a multitude of reasons, even with perfect knowledge and no barriers to access, many women still will not choose LARC methods. And as long as a woman's choice is based on accurate information and a good understanding of her own priorities, that decision should be supported as a positive outcome.

Moreover, the realities of the current health care and health insurance systems aggravate women's potential lack of control and may undermine the self-determination that LARC users can achieve. The Affordable Care Act requires insurers to cover all contraceptive methods approved by the Food and Drug Administration, including LARC methods and the services necessary to support their use. But because removal of an IUD or implant occurs at a different time from placement and is thus billed separately, women who lack or have inconsistent health insurance coverage may still face financial barriers to removal. In addition, even insured women may face resistance from health care providers if they are perceived as wanting to remove an IUD or implant too early. While the option of self-removal of IUDs may alleviate these barriers for some women, it is only a partial solution, as most women are not aware of it, and not all women will feel comfortable with it or will be able to successfully remove an IUD.[37,38]

The success of the Contraceptive CHOICE Project, which aims to promote the use of LARC methods[39]—and, in particular, its finding that when cost barriers are removed, women are much more likely to choose a LARC method and to continue using it[40,41]—has critical policy implications. While the high rates of LARC device uptake and continuation among CHOICE participants are noteworthy, it is important to acknowledge that the study is a demonstration project, modeling the kinds of outcomes

we might expect when widespread intertwined barriers to access, insurance coverage and funding are addressed.

In the CHOICE Project's counseling model, women are presented with information about contraceptive methods from most to least effective, meaning that LARC methods are presented first.[42] While the training materials confront head-on the very real problem of low familiarity with LARC methods by using evidence-based information and emphasize the importance of women's preferences, the principle that effectiveness is the most important aspect of a contraceptive technology is inherent in the model. While this may be the case from public health and technology development perspectives, privileging effectiveness in counseling may eclipse the range of concerns, preferences and priorities that individual women bring to their contraceptive decision making.

This focus on effectiveness points to the perceived tension between the public health goal of reducing unintended pregnancies and the individual and community goal of ensuring that women have the resources and knowledge to be able to effectively use a contraceptive method of their choice. Family planning care is not exceptional in requiring programs and providers to balance this tension. However, in family planning, this balance is particularly fraught because of programs and policies that are structured to prevent poor women and women of color from having children.[43–45] Given the historical legacy and ongoing reality of reproductive coercion in the United States—where low-income women, women of color and other marginalized women have been sterilized without their consent[46] and been provided with welfare benefits that are contingent upon contraceptive implant insertion[43]—it is imperative for LARC promotion programs operating in communities that have been the target of those policies to challenge this tension and prioritize women's reproductive autonomy.

An understanding of these realities and how they shape our behaviors and assumptions must be integrated into the design and delivery of family planning services. When it comes to LARC methods, is there a risk that efforts to increase uptake as a way to address the unintended pregnancy rate could come at the expense of individual women's preferences and, ultimately, autonomy? Or at the very least, might a clinical encounter in which a woman chooses a less effective method or no method at all be seen as a failure, particularly when LARC uptake is the "default outcome"[11,47] or a measure of clinical success or quality? When a woman is provided counseling to steer her toward the most effective methods, even if that is not her priority, the public health imperative plays a more significant role than it does when counseling starts with the woman and her concerns.

RECOMMENDATIONS

Our recommendations for improving the delivery of LARC services reflect our belief that woman-centered approaches to family planning promote reproductive autonomy and agency in ways that approaches focused on specific technologies or contraceptive features, such as effectiveness, cannot. These recommendations are intended not to inhibit LARC promotion efforts, but rather to focus them on increasing access for all women, rather than use among target populations. The goal should be that every woman has the opportunity to use a LARC method, meaning that she has a provider who can and will give her the method, without barriers like waiting periods; insurance that covers insertion and removal; and the knowledge to make an informed decision.

Family planning clinical practice and training should be developed with a woman-centered framework, which supports each woman in identifying her family planning priorities and in adopting the method that best meets her current needs. Approaches that show promise in increasing a woman's ability to effectively use her selected method, such as those used in the CHOICE Project, should be understood and advanced in ways that ensure that IUDs and implants are made accessible along with other components of a comprehensive method mix. Likewise, training should go beyond a "LARC first" counseling approach and support providers in responding respectfully to a woman's concerns and, ultimately, her choice not to use a LARC method, as legitimate and even successful. Given that many women lack accurate information about contraception yet still have preferences and priorities,[48] one possibility is that counseling scripts be structured around a ranking of women's priorities for a method (e.g., can be started and discontinued by women themselves; is highly effective; is "forgettable"), rather than around method effectiveness. Once a priority is identified, methods that meet it can be discussed. Some providers already use open-ended approaches,[49] and we believe that formalizing and testing such counseling techniques will offer more opportunities for providers to support all women in getting evidence-based information about the family planning methods in which they are most interested.

LARC promotion must expand—not restrict—contraceptive options for all women, particularly for women whose racial, ethnic or class identities have made them targets of forced sterilization[46,50] and of policies aiming to restrict their fertility.[44,51] Efforts to increase LARC use have historically been mired in racial and class biases about who is capable of managing the "hazard" of fertility and who is valued as a mother in American society.[52] When LARC use is the "default outcome"[11,47] specifically for women who tend to have the fewest choices in life, reproductive autonomy may be inadvertently restricted compared with the autonomy of women who are not perceived as being at high risk for unintended pregnancy. Looking at an individual woman through the lens of a statistical risk profile neglects her particular context, which is undoubtedly critical to every woman's decision making about family planning.

Policy barriers to both LARC insertion and removal must be eliminated. Programs promoting LARC use

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should ensure that the cost of device removal is automatically covered at the time of insertion, eliminate protocol and de facto barriers to removal (e.g., requirements that a woman keep an implant or IUD for a minimum amount of time before removal), and support clinicians in discussing the option of self-removal with women.

CONCLUSION

To fully realize the promise of LARC methods to support reproductive autonomy and health for women, we must also consider that the promotion and uptake of any contraceptive technology takes place in social and political contexts that historically and currently subjugate low-income women and women of color—those most likely to experience unintended pregnancy.[1] Such a discussion by no means diminishes the tremendous importance of continuing to eliminate structural and clinical barriers to LARC use; indeed, it can highlight issues, such as insurance coverage for IUD removal, that are not always recognized as concerns. We can increase women's ability to prevent and plan pregnancies by ensuring that as we devise solutions that eliminate barriers to LARC use for all women, we do not inadvertently diminish the reproductive autonomy of some women.

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Acknowledgments

The writing of this viewpoint was supported by grant K99HD070874 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health (NIH). The content is the responsibility solely of the authors and does not necessarily represent the official views of the NIH. The authors thank Lisa Harris, Daniel Grossman, Jessica Wolin, Laura Mamo, Sonja Mackenzie, Allen LeBlanc, Anoshua Chaudhuri and Susan Zieff for providing critical feedback on early drafts.

Author contact: *anugomez@berkeley.edu*

doi: *10.1363/46e1614*