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ARHP Commentary — Thinking (Re)Productively

Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach☆,☆☆

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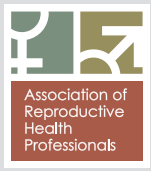

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Few developments have received as much attention or palpable enthusiasm in the reproductive field in recent decades as long-acting reversible contraception (LARC). Though the term may be changing, here LARC refers to intrauterine contraception (IUC), implants and other in-development methods that prevent pregnancy for extended time periods without user action. Reproductive health journals and conferences increasingly — and even overwhelmingly — feature articles, panels and clinical trainings on LARC, and for good reason. Rates of unintended pregnancy have actually *increased* among the most socially disadvantaged women in recent years [1], suggesting an inadequacy of current prevention approaches.

In this commentary, I first highlight the compelling advantages of LARC, including some aspects (such as sexual acceptability) less frequently highlighted among its benefits. I then consider three possible drawbacks about LARC that we may wish to consider as we move forward in our research and promotion efforts. The commentary concludes by advocating for the integration of a reproductive justice approach into our LARC promotion toolkit.

1. LARC's promise and potential

The reproductive health field's excitement about LARC is certainly understandable, especially along lines of efficacy. No reversible method of contraception is better at preventing pregnancy than IUC and implants [2]. Increased use of LARC could significantly reduce the rate of unintended pregnancy at the population level [3,4], particularly if LARC use were to increase among young women, who experience the lion's share of this health disparity [5,6]. LARC could thus reduce both the social and financial consequences of unintended pregnancies. Trussell and colleagues [7] estimated that if even 10% of US oral contraceptives users between the ages of 20 and 29 switched to LARC, total public expenditures would be reduced by $288 million per year.

Though the benefits of LARC to women themselves are often emphasized less frequently than the financial benefits, another of LARC's boons is its relatively strong acceptability

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among users [8,9] — as well as its comparatively high continuation rates [10]. LARC's efficacy is certainly valued by contraceptive users, though a significant number of other contraceptive attributes contribute to overall acceptability. For example, many LARC users enjoy not having to think about or attend to their device after insertion (barring side effects such as heavy bleeding and cramping, of course). Some women appreciate the suppression of menstrual bleeding that may occur on levonorgestrel IUC; many women report a reduction in menstrual bleeding as a major benefit of using Mirena [11]. Finally, though we have few systematic data on contraception and women's sexual functioning in general [12], LARC has the potential to improve some women's sexual enjoyment through at least two mechanisms: high efficacy, which could contribute to greater sexual dis-inhibition, and its allowance for sexual spontaneity. Two smaller studies report sexual functioning improvements in women using levonorgestrel IUC [13,14]. Strong overall user satisfaction with IUC [15–17] may be influenced at least in part by their facilitation of enjoyable sex, though few studies ask specifically about *sexual* satisfaction with LARC when assessing acceptability.

Given LARC's efficacy, acceptability, and both documented and potential benefits, one of our field's primary charters is to simply increase access to LARC — and, to the greatest extent possible, guarantee women easier access to these devices if and when they want them. Both anecdotal and investigative stories abound of the barriers women face in obtaining these methods, most of which relate to either provider or financial obstacles. (Several years ago, I finally traveled abroad and paid the equivalent of $15 to have an intrauterine device inserted, given my US insurance company's refusal to pay for — and later remove — the device in a nulliparous woman.) Increasing access to LARC is a vital aspect of a broader reproductive rights agenda in which women can avail themselves of basic preventive health care.

2. A moment for reflection and reassessment: considering LARC's possible drawbacks

Despite LARC's benefits and despite the need to reduce obstacles to obtaining these methods, now is the moment to consider at least three aspects of LARC to which we should devote care and consideration as we move forward with our research, programs and policies. Doing so may help us avoid repeating prior reproductive rights abuses, from eugenicist promotion of birth control in the early 20th century, to use of population "targets" in developing country settings, to US sterilization laws affecting the disabled and poor women of color. Reflecting on LARC's potential disadvantages would also help us better balance the goals between, for example, reduction of public expenditures resulting from unintended pregnancies, with the needs and desires of our reproductive health clients — the real-life women who use contraceptives. The goal here is not to discourage LARC access, but rather to contemplate at least a few issues that could help us further improve our client's health, well-being and bodily integrity — and not just their ability to prevent pregnancies.

2.1. The notion that LARC could single-handedly address unintended pregnancy

A first consideration pertains to the phenomenon of approaching LARC as the solution for unintended pregnancies and, in turn, as the best way to ameliorate the poverty and social disadvantage associated with many unintended pregnancies. Some have heralded LARC as a potential magic bullet, without larger consideration of the cultural and structural factors that may contribute to unintended pregnancies in this first place. Such tempting reasoning suggests that *lack of access to effective contraceptives* is the primary driver behind this health disparity — and that unintended pregnancies are a *cause* rather than a *consequence* of social inequality. Though use of LARC could surely diminish at least some number of unintended pregnancies, LARC cannot alone lead to changes in the educational and professional opportunities (or lack thereof), let alone the gender inequalities, that may strongly undermine consistent contraceptive use in the first place.

Alas, contraceptive knowledge and access do not single-handedly determine unintended pregnancy rates — even though we also need to continue fighting for contraceptive services, coverage and education. In Edin and Kefalas's [18] *Promises I Can Keep,* an acclaimed ethnography of socially disadvantaged women, few, if any, research participants described lack of contraceptive services or even lack of desirable contraceptive options as a reason behind their unintended pregnancies. In my own qualitative research on pregnancy ambivalence and contraceptive use, women and men rarely cited contraceptive service-related obstacles in why or how they experienced unintended pregnancies [19,20].

Even if LARCs were readily available and affordable, and even if clients and providers alike were well informed of LARC's benefits, women are unlikely to use these methods at the wished-for rates. LARC cannot single-handedly address the myriad relational, social and cultural factors that may undermine contraceptive use. It would be unwise to depend on any one method to accomplish these social goals; it would also be unfair to place the burden of such social change on women's bodies and contraceptive behaviors.

2.2. Clinical emphasis on LARC over all other methods

A second caution to keep in mind in our LARC efforts pertains to how we consider recommending contraceptive methods to clients. The field has witnessed a distinct shift from options-based counseling, in which a wide array of contraceptive methods are presented to potential contraceptives users, to directive and/or first-line counseling, in which one or two LARC methods are recommended over all others

[21]. Proponents of the latter argue that providers would be remiss if they did not suggest the most effective medication for other health issues (e.g., blood pressure medications), and pregnancy prevention counseling should follow suit. However, we should be cautious about equating pregnancy prevention with other types of health prevention such as heart disease, cancer and other illnesses. Though unintended pregnancy certainly can be a negative experience for many women, others report feeling happy about unintended pregnancies. Though few people unconsciously or secretly desire a chronic health condition or fatal disease, some women or couples may at times desire an "unintended" pregnancy, or they may want and not want a pregnancy at the same time.

As professionals, we may sometimes assume that efficacy is the only criterion that matters (or should matter) to women when choosing contraceptive methods. However, 50 years after the advent of hormonal birth control, we live in an era in which myriad characteristics affect contraceptive acceptability for women and their partners. For example, in some couples, men want to play a direct role in pregnancy prevention. A substantial number of women do not engage in regular penetrative sexual activity and thus do not want or need a long-acting method. Some women, for both cultural and personal reasons, do not like the idea of exogenous hormones or other items in their bodies — or they may have negative physiological reactions to synthetic hormones. Some women seek contraceptive methods that offer noncontraceptive benefits such as acne reduction or cancer protection [22]. Most contraceptive users want a method that enhances their sex lives — or at least does not detract from it. For all these reasons and others, let us celebrate that we *do* have an array of methods to recommend to women and their partners. LARC has been, and could be, a terrific option for many women. However, no one method will be perfect for *all* couples.

2.3. Inadvertent failure to acknowledge prior reproductive injustices to poor women of color

A third and final consideration to keep in mind is the ways in which our socially disadvantaged clients, particularly women of color, have endured legacies of social injustice that will affect the way they experience LARC promotion [23,24]. Historians have convincingly documented how well-intentioned contraceptive advocates in the early 20th century adopted popular eugenicist and racist arguments to further their cause — that is, suggesting that birth control could be used to control growing populations of poor and immigrant populations [25]. US compulsory sterilization programs targeted poor women of color, people with disabilities and people with mental illnesses [26]. At the height of Western concerns about "overpopulation" in developing countries, efforts to reduce birth rates often vanquished poor women's individual rights to use — or not use — contraception as they wished [27,28].

More recent decades have displayed subtler efforts to discourage poor women and women of color from becoming pregnant. For example, though few US citizens have been forcibly sterilized in recent years, rates of tubal ligation are enormously stratified by both education level and race [29]. Norplant serves as another recent example of such subtle tracking. In the 1990s, Norplant was aggressively marketed to poor women and women of color, especially to young, urban, African American and Latina girls [30].

Though the latest sociodemographic profiles of LARC do not suggest concentration of use among women of color [31] as documented with Norplant [32], LARC and Norplant's hype within the policy sphere otherwise share some concerning similarities. For example, as with Norplant, policy makers and professionals have exhibited more enthusiasm about LARC than contraceptive users themselves. As with Norplant, policy makers have suggested incentive programs in which poor women receive cash in exchange for having a LARC method inserted, and such programs may be in practice already. Evidence also exists that clinicians recommend LARC more to women of color than white women and more to socioeconomically disadvantaged women compared to socioeconomically advantaged [33].

Due to her social privilege, a white, middle class, fully insured, married woman will not have to wonder if her physician recommends LARC because of her race, her social class and/or the provider's concern about her potentially out-of-control fertility. In contrast, a poor woman of color may well feel sociodemographically targeted when a provider recommends LARC, especially given prior abuses such as coerced sterilizations, financial incentives for long-acting contraceptive use and other human rights abuses [34]. Directly acknowledging such racist and eugenicist legacies need not necessarily discourage LARC use, but it could help address suspicions of reproductive injustice among clients — and facilitate more possible openness to long-acting contraceptive services.

3. Integrating clinical and reproductive justice approaches to LARC

As we move forward with our LARC research, programs and policies, I encourage us to integrate a reproductive justice approach into our reproductive health toolkit. Loretta Ross defines reproductive justice framework as nothing short of "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls" [24]. Reproductive justice builds from the recognition that many communities, especially poor communities of color, have experienced historical reproductive abuses — from the breeding of slaves to forced sterilizations to cash incentives or welfare benefits in exchange for long-acting contraceptives.

Reproductive justice recognizes that the main reproductive challenge facing poor women of color is not unintended pregnancy by itself, but rather socioeconomic and cultural

inequalities that provide some people with easier access to self-determination and bodily autonomy than others [35]. For our purposes here, reproductive justice would enable women to access and use LARC *if they wish to,* but also to *dispense* with LARC and/or have LARC methods *removed* if they wish to. A reproductive justice framework would also allow and encourage us to directly acknowledge prior reproductive abuses to certain socially disadvantaged groups.

Reproductive justice suggests that our premiere responsibility as reproductive health professionals is not necessarily to reduce public expenditures, nor to ensure that all socially disadvantaged women use the most effective contraception possible. Rather, our ultimate reproductive justice endgame is to enhance the health, social well-being and bodily integrity of *all* our contraceptive clients. In that spirit, let us continue our efforts to make LARC affordable and easy to access, but let us also respect women's decisions not to use LARC, their ability to have LARC removed when they wish and their ability to have the children they want to have. Let us remember that women themselves know better than funders or practitioners do about where contraception fits into their lives, relationships and long-term goals at any particular moment.

I am delighted to be part of a professional field that engages in such debates and considers the tremendous complexity of many reproductive issues, including LARC. I encourage us to celebrate and promote a holistic reproductive health approach in which individual women and their partners have the ability to choose what method(s) they want and when they want them — as well as to continue our efforts to both counsel for and develop a wide array of contraceptive options and services for both women and men. I hope we can also continue to partner with other social justice movements in addressing the cultural and socioeconomic inequalities such as poverty, sexism and racism that can contribute to unintended pregnancy and reproductive ill-health in the first place.

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