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Realizing Reproductive Health Equity Needs More than Long-Acting Reversible Contraception (LARC)

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Realizing Reproductive Health Equity Needs More than Long-Acting Reversible Contraception (LARC)

In a recent Editor's Choice column in *AJPH* ("Realizing Reproductive Health Equity for Adolescents and Young Adults"), authors Northridge and Coupey[1] advocate for increased use of long-acting reversible contraception (LARC), specifically the intrauterine device (IUD) and the implant, as a means to achieve reproductive health equity. They reference the American Academy of Pediatrics recommendation, which states that these methods should be considered "first-line contraceptive choices" for adolescents and young adults.[2] They also note "direct medical costs and increased public assistance expenditures" related to teen births and that unplanned births hinder young people's "opportunities to complete high school, graduate from college, secure meaningful employment with a living wage, and raise their children in a nurturing home within a safe community."

We agree that for some young women, access to LARC can be vital to their reproductive autonomy; however, we have concerns about how the authors recommend remedying health inequities through LARC. Below we discuss these concerns and advocate for an approach to LARC informed by reproductive justice and predicated on the equal value of all lives.

Conflating Cause and Context in LARC Recommendations

The U.S. has the highest, albeit declining, teen pregnancy rate among advanced industrialized countries; teen birth is strongly associated with greater inequality in this country.[3] Preventing teen pregnancy has long been framed as the solution to a variety of social problems, including poverty, school dropout, and criminal activity. However, it is now fairly well established that social inequality, especially poverty, is the context for teen birth, and not a result of it.[4-5] Put another way, if we imagine that all teenagers stopped having babies tomorrow, the opportunity and means to attend and graduate from college would still remain elusive for many. Stopping teen births would not remedy the decades-long decline in living wage jobs or result in safer communities for youth and others now or in the future. Deep structural inequalities would persist.

As with other teen pregnancy prevention efforts, the LARC recommendations attribute poor and working class young parents' lack of opportunities to their reproductive practices instead of focusing attention on structural inequalities, including lack of a living wage, housing insecurity, and profound histories of disenfranchisement and discrimination. This approach prioritizes individual level behavior interventions and further perpetuates inequity by not addressing broader systemic injustices.

Prioritizing the Bottom Line Contradicts Reproductive Autonomy

While Northridge and Coupey are clearly committed to principles shared by the contributors to this editorial, namely that "[a]ll young people deserve every opportunity we can afford them as a society to pursue healthy and meaningful lives," we are concerned by what appears to be the uncritical promotion of LARC among young people deemed especially "at-risk" – in part because their fertility is regarded as a burden on taxpayers. Focusing on decreasing public costs through the promotion of LARC, in lieu of identifying and eradicating

the systemic inequities responsible for young people's limited opportunities, puts us on a path to the bottom line and perpetuates inequality.

No one form of contraception should be *the* first-line method for everyone. The choice of a contraceptive method is a personal decision and therefore highly contextual.[6] Positioning any method as "the first-line" choice invites a lack of regard for the preferences of people who have the capacity to become pregnant. The authors write that the reasons for low usage of LARC are primarily due to "knowledge gaps, access issues, and confidentiality," but do not appear to consider other factors in decisions around usage. Yet the "first-line" argument, using only a rationale of effectiveness, minimizes options by presenting LARC as the best (and possibly only) approach for all. This may actually limit young people's reproductive autonomy, especially in programs that provide resources for device insertion, but do not make explicit provisions for device removal when desired.

Racial and Class Bias

Talk of "teen pregnancy," and more specifically teen birth, serves as a signifier of morally or socially acceptable ("fit") parenthood. Furthermore, births among adolescents occur disproportionately in low-income communities and communities of color. When teen pregnancy is automatically understood to be socially inappropriate, without recognizing the structural realities that give rise to, and may sometimes even confer benefit to, early childbearing,[5] racial and class bias can flourish. This also encourages medical professionals to assess the appropriateness of a patient's childbearing, without requiring that they attend to the underlying class and racial bias that may inform both their own perceptions of appropriate parenthood and their care practices. Well-meaning health care providers might feel that, through LARC provision to poor or young people, they are helping to transform the inequalities that inform the statistics. However, through unquestioned assumptions about whose reproduction is valued and whose is not, they may be contributing to social inequality.

Promotion of LARC methods above all others is particularly disconcerting given the long-standing devaluation of reproduction among a range of socially marginalized groups, including poor people, young people, and people of color. From their inception, LARC methods have been employed in abusive and unconstitutional ways; our nation's history of eugenics can be traced through their use.[7] Norplant, a long-acting, hormonal contraceptive implanted in the arm, was first introduced in the early 1990s; many young people were given free access and then subsequently faced difficulties in getting clinicians to remove it. Judges also used this LARC method in the criminal justice system when sentencing young women: in lieu of a prison sentence they would receive Norplant. We encourage healthcare providers and other advocates of LARC to consider this history vis-à-vis the documented success of family planning programs that offer women the *range* of contraceptive methods in their practice.

Re-Envisioning Health Equity through Reproductive Justice

Over the past twenty years, the reproductive justice movement has articulated a clear vision: all people deserve the right to not have children, to have children, and further, to parent the children they do have in safe, healthy, and supportive environments.[8] When fully realized, this vision offers people access to non-coercive, patient-centered reproductive health counseling and a range of contraceptive methods, and it offers, *crucially*, the right to have children free of stigma and shame. This is of particular importance for young parents, whose pregnancies and childbearing are so commonly denigrated and devalued.

A reproductive justice approach means reducing barriers to accessing LARC and making them readily available to all *fully informed* people who want them.[5] However, it also mean respecting the decision *not* to use these methods and/or to have these methods removed when they wish. The quality of contraceptive programs should be based not on how many LARC methods they distribute, how many teen pregnancies they prevent, or on how much money taxpayers save, but by how many people feel truly respected and cared for when it comes to childbearing and family formation.

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