

Guarding Against Coercion While Ensuring Access: A Delicate Balance

By Rachel Benson Gold

Widespread use of long-acting reversible contraceptive (LARC) methods—IUDs and hormonal implants—may be the next giant step forward for American women and couples seeking to determine whether and when to have children. These highly effective methods—which essentially can be forgotten once started—can dramatically reduce user error. And given that about four in 10 unintended pregnancies occur among women who had been using a contraceptive inconsistently or incorrectly, that is no small deal.¹ In practice, a couple relying on the pill is, on average, 45 times as likely as a couple relying on a hormonal IUD to have an unintended pregnancy in one year.²

Because of the potential significance of LARC methods, many family planning advocates are working to promote policies and practices that could reduce barriers to their widespread use. Reducing how much patients pay for these methods is critical: Starting an implant or IUD can cost a month's salary for a woman working full time at minimum wage.³ And other barriers to LARC use also need to be addressed, including insufficient provider training and experience, the need for improved patient education and the high cost of the devices themselves (which make it difficult for health care providers to have them on hand so they are readily available when women request them).

Yet, reducing these barriers to LARC provision and use would not be sufficient to make good on the promise of enabling women and couples to make childbearing decisions freely and for them-

selves. Supporters of reproductive rights caution that it is imperative to consider not just method effectiveness but also concerns about side effects, frequency of sexual activity and the ability of individuals to readily obtain the contraceptive method they choose.^{4,5} With unintended pregnancy highly concentrated among low-income women and women of color, it is also important to take into account the broader context of individuals' lives, including the range of economic, social and health-related pressures they may be facing.

As advocates of reproductive health and rights consider ways to increase access to and enable greater use of LARCs, they cannot ignore the historical context of coercive practices related to contraception, especially those targeting disadvantaged groups. These practices fall along a spectrum, ranging from extreme, overt and intentional instances of involuntary sterilization to more subtle attempts to influence women's contraceptive decision making by providing financial incentives or taking other steps to unduly encourage choice of a specific method, such as the experience with Norplant in the 1990s.

Understanding and acknowledging this dark history—some of which is recent—is important to today's conversations about increasing the use of LARC methods and, more broadly, to any discussions about individuals' contraceptive options. It should further sensitize providers about the paramount importance of providing care in a way that ensures their patients' choices are fully informed and completely voluntary. This, in turn, can help reassure patients that they are receiving unbiased and comprehensive information and

are empowered to choose freely from among the range of contraceptive options, including highly effective LARC methods.

Long History of Sterilization Abuse

Because it permanently robs individuals of any control over their future childbearing, coercive sterilization is particularly egregious. Yet, the practice—which was often aimed at women with limited mental capacity and low-income women of color, especially those receiving government benefits or who were dependent on the government for their health care—was distressingly common not too many decades ago.

The case of Mary Alice Relf, age 12, and her 14-year-old sister Minnie—two young African American girls sterilized in Montgomery, Alabama in 1973—is notorious.⁶ A nurse who had been administering injectable contraceptives under a program funded through the federal Office of Economic Opportunity brought the girls to a physician's office for their shots. Their mother, who was unable to read, accompanied them and put an "X" on a form, thinking that she was consenting to the contraceptive injections. The girls and their mother were then transferred to a hospital and their mother then escorted home; the girls were sterilized the next morning. According to the family's lawyer, the nurse returned for their 16-year-old sister Katie, but Katie evaded the nurse by locking herself in her room. Neither of the girls' parents knew the operations had taken place until after they were done.

However, what happened to the Relf sisters is hardly unique. In Aiken County Hospital in South Carolina, more than a third of the welfare recipients who gave birth during the first six months of 1973 were sterilized under a policy enforced by the county's three obstetricians.⁷ The physicians, who told patients they would refuse to continue to treat them after their third delivery unless they were sterilized, differed on their rationales. According to press accounts, one of the physicians attributed his motivation to cost: "I feel that if I'm paying for them as a taxpayer, I want to put an end to their reproduction." Another said: "It's not a matter of money at all. It's that the individual shouldn't have any more children." Neither

the hospital nor the state medical association objected; the hospital administrator described the policy as "well within accepted standards."

North Carolina has an especially long and disturbing history going back to the early decades of the 20th century, including the creation of the state Eugenics Board in 1933. Although the program was designed to provide sterilizations to individuals who were "feeble-minded, epileptic and mentally diseased,"⁸ the state Department of Public Welfare began promoting increased sterilization in the 1940s as a way to address poverty and childbearing outside of marriage.⁹ Public uproar about the program, which was not formally abolished until 1977, led to passage of a 2013 law offering compensation to the estimated 7,600 residents who had been sterilized under the program. The state believes that 40% of the program's victims were nonwhite, and that 2,000 of them were younger than 18, with the youngest only 10 years old.^{9,10}

In the mid-1970s, concern about abuse directed toward the Native American community led then-Sen. James G. Abourezk (D-SD) to ask the General Accounting Office to conduct an inquiry in four of the 12 Indian Health Service (IHS) areas across the country.¹¹ The agency's report, which covered FY 1973–1976, identified 13 violations of the agency's 1974 moratorium on sterilizing individuals younger than age 21. It also concluded that the informed consent procedures in place in the four areas "generally were not in compliance" with IHS regulations in effect at the time.

Allegations of abuse were also at the heart of a case filed by 10 low-income Latinas against Los Angeles County-USC Medical Center in the 1970s, who charged that they had been coerced into being sterilized before or during labor, or immediately after giving birth.¹² According to affidavits in the case, some of the women had not understood that the procedure was permanent. One indicated she had not been informed about the sterilization until a postpartum visit weeks later.¹³ Another obtained an IUD from a family planning clinic six weeks after the surgery, and according to her claim, did not find out that she had been sterilized until 1974, two years later.¹⁴

Although these kinds of blatant human rights abuses are no longer officially tolerated or sanctioned anywhere in the United States, instances of alleged abuse still arise. For example, the California state auditor recently reported that between 2005 and 2013, some inmates in California state prisons had been sterilized unlawfully, and without regard to informed consent procedures.¹⁵

The Norplant Controversy

By the 1990s, attention shifted away from sterilization toward Norplant, a contraceptive implant offering up to five year of protection against pregnancy that was approved by the Food and Drug Administration on December 10, 1990. Just two days after the method's approval, however, an editorial in the *Philadelphia Inquirer* argued that although no one should be compelled to use the method, "there could be incentives to do so. What if welfare mothers were offered an increased benefit for agreeing to use this new, safe, long-term contraceptive?"¹⁶ The piece unleashed an immediate firestorm, which led the newspaper to publish a formal apology less than two weeks later: "Great pain, anger and controversy have resulted from that editorial, and we deeply regret our decision to print it....In the previous editorial we said that women on welfare should be encouraged, but not compelled, to use Norplant. We suggested incentives, such as an additional benefit of some kind. Our critics countered that to dangle cash or some other benefit in front of a desperately poor woman is tantamount to coercion. They're right."¹⁷

These sentiments echoed those of Sheldon Segal, who led the team that created Norplant. He said that the method was developed to enhance reproductive freedom, not restrict it, and that anyone seeking to use it for purposes of coercion would find him "leading the opposition."¹⁸ Responding to a legislative proposal in Kansas, Segal added that "the line between incentive and coercion gets very fuzzy. The \$500 bonus can be a heavy government hand on the scales of choice for the poor....When you single out a welfare mother, wave a \$500 bill in front of her face and say the government is going to induce you not to have children, you've gotten into a risky area, ethically and morally."¹⁹

But it was too late. Employing incentives to induce low-income women to accept Norplant had taken on a life of its own.

Between 1991 and 1994, legislators in 13 states introduced measures to provide women receiving public assistance with financial incentives to obtain the implant.²⁰⁻²³ In 1991 in Texas, for example, legislators proposed an amendment to an appropriations measure that would have offered a woman \$300 if she agreed to receive the method and an additional \$200 if she retained it for five years. Although none of these measures ever became law, the many public debates they engendered sent a powerful message about where many policymakers wanted to go. And offering incentives was just the start.

During those same years, legislators in seven states introduced bills that actually would have mandated Norplant use for some women. Some of these measures, for example, would have required it for a woman who gave birth to a newborn showing signs of substance abuse during pregnancy. One bill introduced in Washington would have required the woman to keep the method in place until she was drug-free for six months. Another in North Carolina would have mandated the implant for women who had had a publicly funded abortion, unless medically contraindicated. A bill introduced in South Carolina in 1993 would have required a woman with two or more children to have a Norplant inserted as a condition of being able to start receiving welfare benefits, and still others—in Mississippi, Ohio and South Carolina—sought to require the method for women as a condition of continuing to receive benefits for their existing children.

(In the context of the fight over welfare reform in the mid-1990s, this approach paved the way for a debate over so-called family caps, which are policies aimed at limiting welfare payments to families with more than a designated number of children or who have additional children while receiving welfare payments. Family caps remain in effect in several states today.²⁴ California's family cap policy takes a unique approach—exempting a woman who has an additional birth due to contraceptive failure; specifically, the woman must

provide written verification that she was using a LARC method at the time, or that she or her partner had been sterilized.²⁵⁾

Finally, legislators in Colorado and Ohio introduced measures that would have offered women convicted of a crime reduced legal sentences if they obtained the implant or agreed to be steril-

ized. The question of reduced sentences gained more traction in the courts, however. During the mid-1990s, in states as diverse as California, Florida, Illinois, Nebraska and Texas, judges ruled that a woman must accept implant insertion as a sentencing requirement, usually as a condition of a reduced sentence. In the 1991 California case, *People v. Johnson*, Darlene Johnson was offered

A Global Challenge

In nations around the world, policymakers often have sacrificed the reproductive self-determination and human rights of individual women for a variety of reasons, including fears of a population explosion or implosion; the desire for more workers, soldiers or patriots; or to serve religious orthodoxies (see “Governmental Coercion in Reproductive Decision Making: See It Both Ways,” Fall 2012). In the latter half of the 20th century, reproductive and human rights activists focused global attention on the violations committed by governments curtailing what they view as “overpopulation.” For example, amid anxiety about the impact of high population growth rates on deepening poverty levels, India established population growth targets, condoned mandatory sterilization laws in several states and designed punitive disincentives for large families. Similarly, in the 1990s, under former President Alberto Fujimori’s regime, Peru sanctioned coercive and forced sterilizations of close to 350,000 poor and indigenous women, and almost 25,000 men, through intimidation and force.

Notably, it has been primarily reproductive rights advocates (as opposed to those simply opposed to government involvement in contraception or abortion altogether) who have condemned equally reprehensible governmental efforts to compel pregnancy and child-

birth. The height of such coercion in the modern era occurred under President Nicolae Ceausescu’s dictatorship in Romania from 1965 to 1989. Under that repressive regime, the state implemented a radical pronatalist policy that outlawed all forms of contraception and banned abortion, except for women older than 45 who had at least five children who were still minors. The state enforced these policies by carrying out mandatory monthly gynecologic exams and dispatching special state agents to health settings to investigate illegal abortions. This policy led to disastrous consequences. Maternal mortality—mostly the result of unsafe, illegal abortions—skyrocketed, as did infant mortality, while thousands of surviving children were abandoned in orphanages without basic food, health care and attention.

Formal U.S. policy governing international assistance efforts has consistently stood fast in opposition to coercion. The earliest U.S. Agency for International Development (USAID) guidelines from the 1960s outlined key principles under which population assistance would be provided. Under the early incarnation of these principles, assistance was conditioned on the voluntary participation of individuals free to choose among available methods that align with their own beliefs, culture and personal desires. In addition,

USAID would not promote any specific family planning policies or methods; instead, U.S. funds would support the ability of “people everywhere [to] enjoy the fundamental freedom of controlling their reproduction, health, and welfare as they desire.” These tenets were codified in the 1968 Foreign Assistance Act and then refined by USAID in simple and stark terms: “The underlying principles of U.S. assistance for family planning are voluntarism and informed choice.”

In 1998, Congress weighed in and further elaborated on the standards for voluntary family planning service delivery in all international family planning assistance programs funded by the U.S. government. The provision, known as the Tiahrt amendment, prohibits quotas and numerical targets related to births, clients or particular contraceptive methods. It also forbids using financial incentives to reach targets or to deny benefits or rights when an individual rejects family planning services. Finally, the amendment mandates the provision of comprehensible information on the health benefits and risks of the method chosen. This provision, which is renewed automatically each year as part of the annual appropriations process, remains in effect and stands as an important bulwark in support of voluntarism.

a reduced sentence for her child abuse conviction if she agreed to receive Norplant.²⁶ Although she agreed to the condition initially, her lawyers filed for a modification a week later. In denying her request, the judge noted that although the condition impinged on Johnson's right to procreate, that had to be balanced against the state's need to prevent child abuse. The saga came to an end when her probation was ultimately revoked after she tested positive for cocaine use and was sent to prison.

In a similar case, a judge in Illinois reduced the sentence for Lisa Ann Smith—who had pleaded guilty to child abuse in February 1993—with the stipulation that she receive the implant and obtain court approval to have it removed.²⁷ In rebuffing further motions to reconsider his order, the judge argued that mandating the contraceptive was a responsible option: “Almost anyone can have sex and have a baby, but there are far too many people having children who are not fit to be parents....Our jails are full of the offspring of such unions; our social welfare and health care systems reel under the strain of caring for such children and their eventual progeny.” Although Smith subsequently violated the terms of her probation and was sentenced to prison, uproar over the case led to Illinois' 1993 enactment of the only state law to block judges from requiring contraceptive use (specifically, requiring that the defendant be “implanted, injected with or to use any form of birth control”) as a condition of sentencing.²⁸

Although the tactic of linking reduced sentences to an agreement to use long-acting or permanent contraception receded as the decade wore on, linking sentencing to the ability to procreate has not disappeared entirely. Just this year, a Virginia man facing charges of child endangerment agreed to have a vasectomy as part of a plea deal. The prosecutor who offered the deal described the arrangement as “in the best interest of the Commonwealth.”²⁹

Instituting Safeguards

Disclosure of instances of coercion, both domestically and internationally (see box), have led to myriad safeguards that remain in effect today. The rules applying to sterilizations paid for by Medicaid are among the most stringent.

Although the program has stipulated since 1972 that family planning services are covered only for individuals “who desire such services and supplies,” subsequent regulations put additional specific requirements on Medicaid-funded sterilizations. These rules bar using Medicaid funds to sterilize anyone who is institutionalized or younger than age 21; they also require a 30-day waiting period between the time a woman consents and when the procedure is performed. The regulations lay out specific procedures designed to ensure that patients give their informed consent, including a requirement that they be told that receipt of any other benefits cannot be conditioned on agreeing to be sterilized.

From its inception in 1970, Title X also has incorporated important safeguards aimed at ensuring that all care received under the auspices of the program is obtained voluntarily; indeed, the very statute authorizing the program calls for “voluntary” family planning programs. Funded projects are bound by restrictions on sterilization services similar to those governing Medicaid. In addition, federal regulations require programs to offer services without “any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services.” Moreover, Title X regulations articulate the principle that grantees must provide services “in a manner which protects the dignity of the individual.”

Along similar lines, Title X regulations require that programs provide clients a choice of a broad range of contraceptive methods. Ensuring that individuals have access to the information they need to make informed choices—including information about the availability of alternatives—has long been a central principle of informed consent (see “State Abortion Counseling Policies and the Fundamental Principles of Informed Consent,” Fall 2007). The Institute of Medicine recently underscored the importance of giving patients “the necessary information and opportunity to exercise the degree of control they choose over health care decisions” as part of its effort to foster patient-centered medical care.³⁰

A Question of Balance

Although these safeguards were instrumental in stemming the worst of the abuse and will still clearly have value going forward, some reproductive health advocates are concerned that they can have the unintended effect of impeding people's access to care that they clearly want.^{31,32} For example, some argue that Medicaid's flat ban on sterilizations for individuals younger than 21 may block access to services for young people who freely and truly desire to terminate their childbearing ability. Moreover, the 30-day waiting period may have the effect of restricting access for women who want the procedure concurrent with either abortion or childbirth. In addition, some experts contend that the informed consent forms may be overly complex, and the requirement that the signed forms be available at the time of the procedure can be a logistical barrier for a woman wanting a sterilization concurrent with childbirth. Furthermore, it is noteworthy that these protections that apply to publicly funded procedures—or limitations, depending on one's point of view—do not apply to people who rely on private coverage.

The ability to make personal decisions about whether and when to have a child is a basic human right. Making good on that promise for all people—regardless of income, race or ethnicity—requires achieving the delicate balance between protecting unfettered access and preventing abuse, and finding that fine line between encouraging and coercing. Sometimes the line is plain to see. The U.S. history of sterilizing women without their informed consent—or in some cases without their knowledge at all—was clearly coercive. The Norplant controversies of the 1990s were equally stark, and rapidly led to a societal consensus to abandon its forced use. But although it may be less obvious, other cases, such as offering money to a low-income mother trying to provide for her children—or, for that matter, any low-income woman—still cross the fuzzy line between incentive and coercion.

In sharp contrast to events of past decades, today's conversation is motivated primarily by providers and advocates wanting individual women to have unfettered access to the extremely effective methods now available, as opposed to

servicing some perceived greater social good. The questions on the table now are much more nuanced and complex, and certainly no less important. Given the historical examples of women not having received the information they needed to make free and informed choices, what is the best way for practitioners to convey that some methods are more effective than others, while still ensuring that women are given the full information they need to make decisions about what is most appropriate for them? Because financial incentives have been inappropriately used to influence women's choices in the past, how can payment systems that financially reward providers when more women opt for the most effective methods, such as LARCs, be structured to avoid undermining the quality of the information and range of choices women receive?³³ This is a conversation that the reproductive health field—united as it is in its unshakeable commitment to the basic human right of individuals to make personal choices about childbearing freely and without coercion—should welcome. www.guttmacher.org

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