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Quality Care for Women's Health

Time to Stop Offering Incentives for Contraception Use

Ruth A. Woroch

Incentives for receiving a COVID-19 vaccination have made the news recently. Inducements range from a free beer to airline tickets, even a chance at a million-dollar lottery. Incentivizing individual healthy behaviors is not a new concept; it has been used for decades to influence family planning. In 1956, India, as a means of population control, offered 30 rupees (\$7 US) to anyone who underwent sterilization.¹ I am aware of a social service agency that serves young adults with mental illness that offers \$50 for each dose of long-acting progesterone an individual receives. Even people who are not sexually active may receive the injection and quarterly payment.

Project Prevention, a nonprofit organization started in 1997, offers \$300 to men and women with drug and/or alcohol addiction who undergo sterilization or use long-acting reversible contraception (LARC).² According to its website, as of May 2021, 2,845 people have received compensation for undergoing sterilization (2,444 tubal ligations and 401 vasectomies), 2,785 have received payment for intrauterine device (IUD) placement, and 996 for receiving a contraception implant. According to the Project Prevention website, the program has prevented the birth of at least 3,600 children. The organization surmises that it has saved the US taxpayers more than half a billion dollars. Included in this calculation were costs of foster care for children born to addicted parents and long neonatal intensive care unit stays by premature, low-weight infants.

More than a quarter century has passed since the Programme of Action of the International Conference on Population and Development was signed in Cairo in 1994.³ This landmark document, adopted by 179 countries, emphasizes “rights-based” family planning and the empowerment of people of child-bearing age as the best method to achieve an improved quality of life for all as well as sustainable population growth. Principle 8 of the document declares:

States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive healthcare programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so.^{3(p27)}

Newman and Feldman-Jacobs⁴ delineated the necessary elements of an informed contraception decision. The family planning decision must be based on full, free, and informed choice. Full choice

means that the individual has access to the complete range of contraceptive options (long-acting, short-acting, permanent, hormonal, nonhormonal, client controlled, provider controlled, etc). Free choice indicates that the choice of whether to use any contraception is made voluntarily, without barrier or coercion. Finally, informed choice means that the decision is made after receiving complete information on all options: side effects, risks, benefits, cost, and removal as well as the risks associated with nonuse.

Building on these concepts of full choice, free choice, and informed choice, Senderowicz⁵ introduced the concept of *contraceptive autonomy*. This is defined as “the factors necessary for a person to decide for themselves what they want in relation to contraception and then to realize that decision.”^(p161) Rather than measuring family planning by a simple user/nonuser formula, this schema considers whether a person needs or desires the particular method of contraception. It recognizes that an individual may be a user of contraception for reasons other than pregnancy prevention. For example, a teenager may be receiving a quarterly injection of progesterone to receive \$50. Although the injection may be used to decrease menstrual flow, this is not the reason the individual is receiving the quarterly payment. Has this person been informed of the risks associated with the injection (pain, irregular spotting, potential for decrease in bone mass, etc)? Are these issues concerning to teen, or would she rather receive the spending money, no matter the consequences? Project Prevention participants may undergo sterilization to receive the promised \$300, which they may also use however they wish, including to finance an addiction.

These 2 examples of incentivizing contraception carry the nefarious undertones of authoritarian oversight. The implied message is one of patriarchal control over a person's body. The financial reward for choosing a LARC or sterilization may tip the decision-making process toward a choice deemed acceptable to those in authority but may not be the best choice for the individual or couple.

Many nurse practitioners have received the waiver to prescribe medication-assisted treatment (MAT) for substance use disorder (SUD). This means that both family planning services and SUD can be addressed in 1 clinic, by 1 provider, who has a rapport with the person. Providing this care in 1 clinic by 1 provider will reduce barriers such as the logistics of transportation and childcare involved in attending multiple appointments. Many people who use MAT for SUD have had successful pregnancies and parenting experiences. The same is true for mental health care. In an integrated primary care/behavioral health care clinic, the choice of contraception (if any) should be thoroughly discussed by a health care provider who has a rapport with the individual. Perhaps an

IUD or implant (or no contraception) would be appropriate choices for a young person with mental illness. Regardless, all options should be thoroughly explained, offered, and covered by health insurance or available at low cost. With this information and choice of options, people can be better prepared to make an informed decision as to the best method for them at this time in their lives.

Any form of payment for contraception or sterilization could be considered coercive because it risks interfering with free choice. It is time to end all programs that offer financial incentives to people for contraception use or sterilization.

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