INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

Differences in Counseling for Long-Acting Reversible Contraceptive (LARC) Methods Based on Race, Ethnicity, and Socioeconomic Status

Contraceptive Counseling & LARCs

- Long Acting Reversible Contraceptive (LARC) methods refer to intrauterine devices (IUDs) and implants. These methods of birth control provide highly effective birth control, without the patient needing to remember to take a daily pill, schedule a monthly appointment for a shot, or consistently use condoms.
- Healthcare providers regularly counsel patients on contraceptive options, thereby playing a role in steering them toward or away from LARCs as a method of contraception.
- Studies have shown that providers vary their contraceptive recommendations to individuals based on race, ethnicity, and socioeconomic status (SES), even when clinical factors between individuals are identical (Dehlendorf et al. 2010).
- Unchecked enthusiasm for LARC methods may lead to promoting their use among populations perceived as "high risk," which may paradoxically undermine reproductive autonomy, particularly in non-white, low-SES patients.

Historical Roots

- There is a long-standing history of reproductive oppression in the U.S. targeted at low-income people and people of color. Efforts to reduce fertility and childbearing in these groups are well documented, even in recent years. These groups continue to experience racial discrimination in family planning settings.
- Perhaps the most egregious example of this has been a history of coerced and forced sterilizations which have been targeted towards people of color and those of lower SES (Stern, 2005; Stern, 2020). As recently as 2013, the Center for Investigating Reporting discovered that women continued to be sterilized without consent in the California prison system (Johnson, 2013).
- U.S. federal policy continues to allow individual states to cap welfare benefits based on family size, leveraging restriction of public benefits as a means of discouraging fertility amongst people of lower SES (National Conference of State Legislatures, 2011). Some states have taken this as far as trying to incentivize or require LARC as a prerequisite for obtaining welfare assistance (Jekanowski, 2018).
- Previous research has shown that family planning discrimination extends to the prescribing practices of individual physicians. Black and Latinx patients are more likely than white women to be advised to restrict their childbearing (Downing et al., 2007). Clinicians are more likely to recommend IUDs to low-SES black and Latinx patients than low-SES white patients (Dehlendorf et al., 2010).

Frequent Misconceptions

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"LARCs are the best form of birth control, so should be offered as first line treatment to all patients"

- "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 healthcare provider. For still others, control might relate to the effect of a method on the menstrual cycle…For a multitude of reasons, even with perfect knowledge and no barriers to access, many women will still 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, htat decision should be supported as a positive outcome" (Gomez et al., 2014).

"High risk" patients should all be counseled to receive LARCs, since they are most likely to benefit from long-term contraception.

- Targeted approaches to LARC promotion, guided by population-level statistical data, runs the risk of imposing statistical discrimination, where epidemiologic data replaces consideration of a patient's unique history, preferences, and priorities (Gomez et al., 2014).

"LARCs are easily reversible so there is no downside to implanting them".

- Insurance does not always cover *removal* of LARCs, particularly if the patient seeks removal prior to the lifespan of the contraceptive device.
- For some patients, needing to return to a healthcare provider, who may not be a trusted figure, can serve as a barrier to removal. Patients may also receive pressure from a provider to keep their LARC, even if they have expressed that they no longer want it (Higgins, et al., 2016).

How Contraceptive Counseling Differences Contribute to Health Inequity

- The goal of contraception should be to *increase* autonomy and choice for patients. By promoting LARCs at increased rates to non-white, low-SES patients, healthcare providers may paradoxially *restrict* options and limit autonomy in these patients (Gomez et al., 2014).
- Differences in contraceptive counseling may serve to further undermine trust between providers and patients, which contributes to patient disengagement from the medical system. This may, in turn, have negative implications for patients in other aspects of their healthcare (Higgins, et al., 2016).

Possible Solutions

- Patient-centered care should be prioritized above all else. Health care providers should determine the patient's priorities for contraceptive methods before recommending a specific method.
- Investment in strategies to train and support health care providers from lower SES backgrounds and health care providers of color can reduce the risk of bias in healthcare delivery. Patients report higher levels of trust and communication when there is racial concordance between providers and patients.
- Removal of cost barriers to LARC implantation and removal should be prioritized. Individual autonomy in contraceptive decisions is optimized when patients feel confident that they can both implant *and* remove their contraceptive method without financial barriers.

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Takeaway Points

- Studies have shown that providers vary their contraceptive recommendations to individuals who differ on no clinically relevant variables, but only on race, ethnicity, and socioeconomic status (SES).
- There is a long-standing history of reproductive oppression targeted at low-income people and people of color. Health care providers must be educated and aware of this history in order to appropriately promote LARC methods when counseling their patients.
- All contraceptive counseling– but especially that aimed at providing care for historically oppressed groups– should center patient preferences and concerns above all else.

References

1. Dehlendorf, C., Ruskin, R., Grumbach, K., Vittinghoff, E., Bibbins-Domingo, K., Schillinger, D., Steinauer, J. (2010). Recommendations for Intrauterine Contraception: A Randomized Trial of the Effects of Patients' Race/Ethnicity and Socioeconomic Status. *American Journal of Obstetrics and Gynecology, 203*(4), 319.e1-319.e8. https://doi.org/10.1016/j.ajog.2010.05.009.
2. Downing, R.A., LaVeist, T.A., Bullock, H.E. (2007). Intersections of Ethnicity and Social Class in Provider Advice Regarding Reproductive Health. *American Journal of Public Health, 97*(10), 1803–1807. https://doi.org/10.2105/AJPH.2006.092585
3. Gomez, A.M., Fuentes, L., Allina, A. (2014). Women or LARC First? Reproductive Autonomy And the Promotion of Long-Acting Reversible Contraceptive Methods. *Perspectives on Sexual and Reproductive Health 46*(3), 171–75. https://doi.org/10.1363/46e1614.
4. Higgins, J.A., Kramer R.D., Ryder, K.M. (2016). Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Adult Women. *American Journal of Public Health, 106*(11), 1932–37. https://doi.org/10.2105/AJPH.2016.303393.
5. Jekanowski, E. (2018). Voluntarily, for the Good of Society: Norplant, Coercive Policy, and Reproductive Justice. Berkeley Public Policy Journal. Spring 2018, 74-85. Retrieved August 17, 2022, from https://bppj.berkeley.edu/2018/08/23/norplant-coercive-policy-and-reproductive-justice/.
6. Johnson, C.G. (2013). *Female inmates sterilized in California prisons without approval.* Reveal. Retrieved September 24, 2022, from https://revealnews.org/article/female-inmates-sterilized-in-california-prisons-without-approval/.
7. National Conference of State Legislatures. (2011). *Welfare Reform: Family Cap Policies*. Retrieved August 17, 2022, from https://www.ncsl.org/research/human-services/welfare-reform-family-cap-policies.aspx.
8. Stern, A.M. (2005). STERILIZED in the Name of Public Health: Race, Immigration, and Reproductive Control in Modern California. *American Journal of Public Health, 95*(7), 1128–38. https://doi.org/10.2105/AJPH.2004.041608.
9. Stern, A. (2020). *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st century.* University of Michigan Institute for Healthcare Policy and Innovation. Retrieved September 24, 2022, from https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st.

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