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The Potentially Problematic Ethics of Long-Acting Birth Control for Marginalized Women

Introduction

With the passage of the Affordable Care Act in 2010, insurance coverage of contraceptives increased dramatically, particularly for Medicaid patients. Many states have sought to maximize this newfound coverage by promoting contraceptive use in several different ways. The development driving this capstone project is the implementation of Medicaid reimbursement for immediate postpartum long-acting reversible contraceptives (LARCs); thirty-five states and the District of Columbia currently approve this practice (The American College of Obstetricians and Gynecologists 2017). States that offer Medicaid reimbursement for this practice offer women on Medicaid either an IUD or a contraceptive implant at no-cost, both of which can guarantee five or more years of pregnancy prevention. The reason that this policy is considered inventive and, in some ways, controversial, however, is because this practice involves placing the implant or IUD while the woman is still in the hospital following the birth of a child.

This practice makes sense on a number of levels, particularly for state budget offices. Pregnant women who would not otherwise be covered by Medicaid are temporarily covered for the birth of their child; this means that immediate postpartum LARC policies utilize insurance coverage that will soon cease to exist. LARCs can cost well over \$1000 if not covered by insurance, so, for many women, receiving one as part of Medicaid coverage is their only option. Medicaid-covered pregnancies and births are huge expenditures, so preventing these pregnancies in the first place makes the upfront cost of an IUD well worth it for states, from a financial perspective. Finally, unplanned pregnancies have well-documented negative effects on women,

particularly impoverished women, so it seems morally responsible to offer these highly-effective options to Medicaid patients.

Policies approving Medicaid reimbursement for immediate postpartum LARCs also have their critics, though. For many minority and women's advocacy groups, it reads as a reinvention of the American Eugenics Movement. To offer poor and, often, minority women a contraceptive device that ultimately requires removal by a medical professional can be easily interpreted as morally questionable; if a woman cannot afford to return to the hospital several weeks postpartum to get the contraceptive, how could she afford to get it removed if she changed her mind? Furthermore, given the goal of the programs to utilize fleeting insurance coverage, it can be assumed that the recipient of an immediate postpartum LARC will not have coverage should she want to have the LARC removed at any point after having it placed. Additionally, critics of the practice fear that minority and poor women are particularly susceptible to the power dynamic present in a physician-patient relationship and thus may accept an immediate postpartum LARC without fully understanding or considering the decision and its implications. Furthermore, on a structural level, critics fear that this practice is a thin guise for population control and that states are aiming to prevent poor Americans from reproducing.

Similar debates haunt other forms of contraceptives, as well. For example, Nurx, a telemedicine company that delivers oral contraceptives ("the pill") to women's homes without a need for doctors' appointments or pharmacy trips has met high levels of resistance from pro-life advocates, who cite a fear that, by getting the contraceptive without physician interaction, women may be at higher risk for complications. In 2013, a student organization at Boston College was banned from distributing free condoms on campus, as the Catholic University cited fears of validating hookup culture. On the other end of the spectrum lies America's dark history

with compulsory sterilization, which poses the ultimate fear for critics of immediate postpartum LARC.

It is impossible to research contraception in America, in any form, without finding divergent opinions. The purpose of this capstone is to wade through the multitudinous opinions, criticisms, and fears, using the implementation of immediate postpartum LARC policies as a case study, and break down the provision of free birth control for Medicaid patients into its morally-variable components. There are ethical arguments to be made for both sides: numerous studies have found that *birth control reduces poverty*, but do current birth control practices take away impoverished women's choices? Where is the line between the ethical demand to reduce poverty when possible, and the moral responsibility to allow women to think for themselves and create the families they desire, even when their choices are costly to state Medicaid programs?

Methods

The intention of this capstone is to explore the existing literature on no-cost LARC programs, as well as the literature on the role of birth-control in the reduction of poverty. The literature on no-cost LARC programs (the largest of which is called 'The Contraceptive CHOICE Project') is largely published in biological sciences journals, while literature on birth-control and poverty exists mainly within economics and sociology. Following a comprehensive literature, I plan to utilize anthropological methods in the analysis section to discuss the narrative control presented in scientific literature, in addition to a historical perspective on the American Eugenics Movement. Following this analysis, I will present Martha Nussbaum's Capability Approach to explain how no-cost LARC programs, particularly for Medicaid beneficiaries, have the potential to both secure and stifle central capabilities for impoverished women, thus leaving

their ethical validity up to implementation. In the conclusion, I present my recommendations, based upon Nussbaum's normative argument, for Medicaid contraceptive programs going forward.

Literature Review

Influence of the Medical Community

In the largest study of its kind, The Contraceptive CHOICE Project provided no-cost contraception to over 9,000 women living in the St. Louis, Missouri, area. As part of their admission into the program, women received counseling that heavily emphasized the benefits of long-acting reversible contraceptives: IUDS and implants. While 11.6% of American contraceptive users opt for IUDS or implants, 75% of women in the CHOICE program who received the aforementioned counseling chose an IUD or implant for contraception (Guttmacher Institute 2016; Birgisson et al 2015). This seems to indicate that the influence of a medical professional (who has been instructed to promote specific options) significantly affects the choices of patients, thus affirming the assertion that the information healthcare providers receive significantly affects patient outcomes.

Medicaid and the Cost-Effectiveness of No-Cost LARC Programs

Unintended pregnancies are estimated to cost American taxpayers between \$9.6 and \$12.6 billion dollars per year (Trussell et al 2013). In fact, 68% of unplanned births are publicly funded (Guttmacher Institute 2015). An examination of policies that extended Medicaid coverage for postpartum women and women living at up to 200% of the Federal Poverty Line (thus allowing the women to receive no-cost contraception) found that these policies resulted in

an 8.9% reduction in overall births (Kearney and Levine 2009). The same study estimates that each prevented birth costs approximately \$6,800 (not including the lifetime cost if the baby ultimately becomes a Medicaid or CHIP beneficiary, or receives other assistance), which the authors believe makes Medicaid expansion an extremely cost-effective option (Kearney and Levine 2009).

A New York Times feature on the implementation of immediate postpartum no-cost long-acting reversible contraception for South Carolina's Medicaid patients reports that from 2012-2016, the state's Medicaid program saved \$1.7 million by reducing the number of births occurring in its low-income population (Tavernise 2016).

The Groups Targeted by No-Cost LARC Programs

The Contraceptive CHOICE Project (the same study that generated 75% usage rates for LARCs), the largest source of data on the results of no-cost contraception, included 9,256 women. Of these women, 58.2% belonged to racial minorities, 23.2% held a college degree, 37.2% received public assistance, and 39.4% reported struggling to pay basic expenses (Peipert, Madden, Allsworth, and Secura 2012). The regional cohort from which these women were drawn has 36% racial minority representation and less than 14% of residents living below the federal poverty line, showing that the CHOICE study (from which most data about no-cost long-acting reversible contraception is drawn) contains an overrepresentation of impoverished and minority populations.

Immediate postpartum long-acting reversible contraception is now covered under thirty-five states and the District of Columbia's Medicaid programs (The American College of Obstetricians and Gynecologists 2017). In the United States, 57% of Medicaid recipients belong

to racial minorities (Kaiser Family Foundation 2018), so any policies directed at Medicaid beneficiaries will disproportionately affect minority populations.

Side Effects of LARCS

A 2017 study found that women who received a no-cost long-acting reversible contraceptive were about half as likely as women utilizing other contraceptive forms to use condoms; the women utilizing long-acting reversible contraception were therefore about twice as likely to acquire a sexually transmitted infection than their counterparts, thus showing a potential downside to long-acting reversible contraception usage, particularly for populations at high-risk of HIV transmission (McNicholas, Klugman, Zhao, and Peipert 2017).

Potential issues with implant contraception include a high rate of provider error; one study found that, of 218 women who began pregnant while utilizing a contraceptive implant, 84 of the women did not actually have an implant inserted (Stoddard, McNicholas, and Peipert 2011). Complications from implants occur in less than 1% of patients and are usually not serious; however, FDA trials for contraceptive implants excluded overweight women, and the efficacy of implants in overweight women is unknown (Stoddard, McNicholas, and Peipert 2011). Additionally, while it is possible (although not recommended) to remove one's own IUD, a provider visit is required to remove an implant.

In a report comparing the continuation rates for IUD and implant users following immediate postpartum insertion, almost 10% of IUD users experienced IUD expulsion within 6 months, which is a much higher rate than is typically broadcasted; there were no reported issues for the women who chose implants (Woo et al 2015). Because it is believed that up to 10% of IUD users experience spontaneous expulsion within the first 12 months following insertion; if

programs providing no-cost long-acting reversible contraceptives are designed to avoid issues with patient noncompliance, the expulsion and need for replacement of the IUD would pose a serious problem (Stoddard, McNicholas, and Peipert 2011). IUD insertion also carries a very low risk of uterine perforation, which can result in infertility.

A Brazilian study found that the immediate postpartum insertion of the entogestrel implant does not negatively impact a woman's ability to breastfeed (Braga et al 2015). This conclusion bolsters arguments in favor of immediate postpartum long-acting reversible contraceptive provision.

Birth Control and the Reduction of Poverty

When major indicators of poverty are controlled for, just having legal access to birth control reduces female poverty by .5% (Brown and LaLumia 2014). Interestingly, the ability to procure birth control does not appear to prevent women from having children but instead grants them the ability to delay pregnancy (Brown and LaLumia 2014). It is widely hypothesized that the delay of pregnancy thus allows women to attain higher levels of education and increases the chances of women having children at more financially optimal times; this delay drastically decreases the likelihood of the children receiving government assistance, which further increases the financial benefits of policies for immediate postpartum LARCs for both state and federal programs.

Timing of LARC Provision

A 2012 Colorado study sought out pregnant adolescent women who cited a desire to prevent pregnancy for at least 12 months following delivery. The study offered the women an

etonogestral implant, which is a form of long-acting reversible contraception. The women were only eligible for the study if they had the implant inserted within four weeks of delivery; the vast majority had it inserted immediately postpartum. Within 12 months, 18.6% of control participants were pregnant, while 2.6% of implant recipients were pregnant (Tocce, Sheeder, and Teal 2012). The authors appear confident that the timing of the implant insertion was critical to the reduction in repeat pregnancies. 75% of pregnancies for the implant recipients occurred following the removal of the implant (Tocce, Sheeder, and Teal 2012). Numerous studies have found no significant difference in IUD complication rates for immediate postpartum insertion or insertion at a later date (Prescott and Matthews 2014).

Successes of LARC Programs

The Contraceptive CHOICE Project recruited many of its participants from abortion facilities, in an attempt to target women that have previously experienced undesired pregnancy. A study found that this project, which provided reversible contraceptive at no-cost, led to a rate of teenage birth of 6.3 per 1,000, while the U.S holds a rate of 34.1 per 1,000 (Peipert, Madden, Allsworth, and Secura 2012). However, this study contains a couple of significant weak points: teenage pregnancy is utilized as a proxy for unintended pregnancy, and the study does not break down pregnancy rates by the contraceptive method chosen. Furthermore, this is the same previously cited study that had a rate of 75% LARC usage, which means that the reduction in the teenage birth rate is likely overstated, when compared to just providing reversible contraceptive at no-cost, without counseling that specifically emphasized the use LARCs.

A study utilizing women seeking services at a New Zealand abortion provider found that women who opted for long-acting reversible contraception when all contraceptive methods were

offered at no-cost were less than half as likely to have had a repeat abortion within two years (Rose, Garrett, and Stanley 2015). Repeat abortion is a much stronger proxy for unintended pregnancy than teenage pregnancy, so the results of this study do strongly support an argument for no-cost long-acting reversible contraception preventing unwanted pregnancies.

When follow-up care is provided at no-cost for a year, women receiving long-acting reversible contraception immediately postpartum had an 82% rate of continuation at 12 months, which does indicate a high level of patient satisfaction (Woo et al 2015). Another study on the CHOICE cohort data found that more than 80% of women receiving long-acting reversible contraception were satisfied, as opposed to a satisfaction rating of 54% for oral contraception (Peipert et al 2011).

Analysis

Compulsory Sterilization in America

The American Eugenics Movement led to the coerced or forced sterilization of thousands of poor, non-white, disabled, or otherwise “undesirable” Americans in the 20th Century. This practice was said to prevent the general population from the offspring of these “undesirable” people; the “undesirable” was a category that included “the poor, the disabled, the mentally ill, criminals, and people of color” (Ko 2016). In the 1930s, federally-funded eugenic sterilizations were legal in thirty-two states (Ko 2016). These programs persisted into many states in both legal and illegal forms well into the 1980s. There are a number of accounts of Native American women receiving “incidental” sterilizations during an appendectomy procedure in the 1970s (Rutecki 2010). The same report finds that physicians employed by Indian Health Services coerced Indian women into consenting to sterilization procedures by threatening to withhold

future healthcare or to revoke custody of existing children (Rutecki 2010). North Carolina, home to one of the largest sterilization regimes in the United States, sterilized over 7,600 individuals between 1930 and 1980; of these 7,600 sterilizations, 65% were performed on black women; black women make up 13% of the state's population (Krase 2014).

In 20th century America, compulsory or coerced sterilization became a scientifically-backed method of perpetuating a racist ideology, in addition to a number of other prejudices. As shown above, states were able to clearly denote the populations that it believed to be unsuitable for reproduction, and these populations were always either non-white, impoverished, disabled, or a combination of the three. What is perhaps most concerning though, is an examination of who exactly both backed and promoted compulsory sterilization and eugenics. Phillip Reilly traces the beginnings of the American Eugenics Movement to an 1899 publication advocating for the sterilization of criminals (Reilly 1983, 646). Reilly further explains how, in the early 20th century, the number of physicians taking on an advocacy role and promoting the use of sterilization for social benefit expanded tremendously (Reilly 1983). In addition to publishing a significant literature (thirty-eight articles in thirteen years) on the benefits of forced sterilization, physicians were highly active in the lobbying process for the legalization of compulsory sterilization (Reilly 1983).

The American Eugenics Movement was a fad constructed and driven by the American Upper Class, who feared the demise of American society as it stood at the turn of the twentieth century. The men who wrote the aforementioned literature and performed the aforementioned procedures were unilaterally white and educated. The patients they targeted were, often in more than one way, deemed inferior to these doctors, whether it be on the basis of race, mental status, gender, or socioeconomic status.

It is a mistake to believe that the structural pitfalls that led to the rise of the American Eugenics Movement are forgone or antiquated. As detailed in the literature review, the largest and by far most respected study on the provision of no-cost long-acting reversible contraceptives (no-cost LARCs) disproportionately utilized participants belonging to a racial minority or living below the Federal Poverty Line. Furthermore, all of the scientific literature on the use of LARCs in disadvantaged or underserved populations is written and published by people possessing, at minimum, a master's level degree. This is an inherent flaw in scientific or medical research involving the poor or otherwise underserved; the people who publish this research possess a high level of education and, thus, do not fall into the same categories as the people that they serve. However, the literature on no-cost LARCs (which is almost entirely based upon a study that disproportionately utilized poor and minority women) and the implementation of Medicaid policies on LARC use targets poor and minority women, in a way that is not dissimilar to the targeting of sterilization policies.

Language in LARC Literature

Stoddard, McNicholas, and Peipert 2011, one of the most heavily cited studies on LARC use, utilizes the phrase "LARC method failure rates rival that of tubal sterilization" on four separate occasions (Stoddard, McNicholas, and Peipert 2011). The entire article is written in the context of preventing pregnancy among poor and, often, minority women. Therefore, this statement can be reinterpreted as "LARC methods are as effective at preventing pregnancy among poor and minority women as sterilization procedures." Furthermore, the term 'rival' can be read as placing the prevention of pregnancy into a competitive framework, as if the scientific exploration of contraceptive methods has been a competition, and sterilization and LARCs have

been equally successful at preventing pregnancy among the impoverished. While it is highly unlikely that this paper was published with an awareness of this language usage, this phrasing could potentially hint at implicit biases held by the authors who, as I explained above, are inherently privileged in a power dynamic with the people who are affected by their research. Essentially, all of the papers published on the use of LARCs in low-income populations are arguing for the most effective and most cost-saving methods for preventing pregnancy among groups of people that have previously been labeled ‘undesirable’ in eugenic policies; this is conveyed in both the language used and the conclusions drawn.

Patient-Provider Dynamics

A 2013 study found that healthcare providers were essential in preserving or even expanding health disparities; when a provider perceived a patient to be of low socioeconomic status, he or she was less likely to recommend supplements that he or she perceived as expensive, despite the health benefits of these supplements (Hernandez 2013). This resulted in pregnant women who were perceived as poor being less likely to utilize omega-3 fatty acids during pregnancy than their counterparts who were perceived as wealthy (Hernandez 2013). A 2011 study found that black women received less comprehensive information about breast cancer treatment options than their white counterparts, and that this informational disparity resulted in a disparity in outcomes (Sheppard, Adams, Lamdan, and Taylor 2011). Both studies found that the information given by the provider significantly influenced the patient’s decision-making and understanding of her condition.

There are two key takeaways here: providers significantly influence patient decisions and providers tailor their interactions to the perceived socioeconomic status of their patients. As

shown in the literature review, the information published about LARCs for low-income women in scientific and medical journals is incredibly favorable. Given that healthcare providers are likely to get their information on best practices from these sources, it seems that the entirely one-sided narrative which promotes LARC usage would result in physicians and other practitioners favoring this practice as well. Additionally, the LARC literature is generally critical of single-parenthood, teenage pregnancy, and rapid repeat births, all of which are typically associated with low socioeconomic status and may thus further invoke providers' implicit biases. If a provider perceives a woman to be of low socioeconomic status (or otherwise belonging to an 'undesirable' group), he or she is inclined to promote a LARC to the patient, because the available literature overwhelmingly favors this practice for low-income women. However, this also means that a provider may be less likely to promote LARCs to women of perceived high-socioeconomic status, which would make it more likely that women belonging to 'desirable' groups will reproduce.

Opposition Opinions on LARC Policies

A statement published by Sister Song: Women of Color Reproductive Justice Collective and the National Women's Health Network states:

Many of the same communities now aggressively targeted by public health officials for LARCs have also been subjected to a long history of sterilization abuse, particularly people of color, low-income, and uninsured women, Indigenous women, immigrant women, women with disabilities, and people whose sexual expression was not respected. (2018)

The statement continues by endorsing LARCs as an option for women, but strongly discourages providers from coercing or otherwise directing women toward LARCs, particularly on the basis of assumptions about socioeconomic status or other characteristics (Sister Song 2018). In a

journalistic piece, reproductive justice experts warn that the aggressive marketing and targeting of LARC policies border on population control (Sausser 2017).

It is nearly impossible to find authoritative pieces online that oppose LARC usage in poor or minority women; however, there is a healthy selection of journalistic debate. An overview published by the Guttmacher Institute cites several previous uproars as cause for hesitation in the implementation of LARC policies (Gold 2014). For example, in the early 1990s, thirteen states introduced legislation to monetarily incentivize women receiving public assistance to consent to having a birth control implant placed (Gold 2014). Other bills introduced suggested requiring mothers suffering from substance abuse to have an implant placed until they could pass a drug test; another proposed that mothers of more than two children could not receive public benefits until having an implant placed (Gold 2014). Finally, a string of legal decisions occurred in 1993 that resulted in women who had been convicted of crimes receiving reduced sentences in exchange for consenting to receiving a birth control implant (Gold 2014).

As previously stated, there has been an utter lack of commentary on potential drawbacks of LARC programs from the scientific or medical community. This is deeply problematic, because, as explained earlier, medical and scientific literature is not published by women who receive no-cost LARCs through Medicaid benefits. The academic narrative on these programs is entirely one-sided, and that poses a complicated problem regarding the true nature of informed consent. There are parties that are concerned about the rapid increase in policies approving and marketing the usage of LARCs, particularly to poor and minority women, but these voices are not granted merit within the medical community. Medical providers (who receive all of their information from the medical community's literature) are critical to the treatment decisions that their patients make, and they are not receiving a comprehensive view of the issue.

Normative Argument

Martha Nussbaum bases her arguments upon the belief that society should work to ensure every human a life of dignity. Nussbaum states, “What does a life worthy of human dignity require? At a bare minimum, an ample threshold level of ten Central Capabilities is required” (Nussbaum 2011, 32). She goes on to list ten Central Capabilities: life, bodily health, bodily integrity, senses, imagination and thought, emotions, practical reason, affiliation, other species, play, and control over one’s environment (Nussbaum 2011, 33-34). This does not mean that humans must possess all ten of these items, but instead must possess the ability to gain these ten items if they so choose. Of relevance to the LARC conversation are the Central Capabilities of bodily health, bodily integrity, emotions, and affiliation.

The Capability of bodily health is defined as: “Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter” (Nussbaum 2011, 33). In theory, the alleviation of poverty should institute all ten Central Capabilities; in the case of bodily health, the alleviation of poverty allows for adequate medical care, adequate nutrition, and shelter. To this end, the alleviation of poverty by providing access to birth control would support the notion that no-cost birth control for Medicaid clients helps American society to provide the capability of bodily health. However, programs that involve coercion would clearly violate this capability, by preventing a woman from making her own reproductive health choices freely.

Next, bodily integrity is “Being able to move freely from place to place, to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choices in matters of reproduction” (Nussbaum 2011, 33). In the case of immediate postpartum LARCs for Medicaid clients, pressure of any variety from a provider

would seriously infringe upon ‘choices in matters of reproduction’ as would coercion to either use or abstain from birth control of any form.

Nussbaum describes the Capability of emotions as “Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one’s emotional development blighted by fear and anxiety” (Nussbaum 2011, 33-34). To prevent a woman from having a desired pregnancy is to ultimately prevent her from having a loving relationship with and attachment to a child. Coercive birth control programs, particularly for LARCs which require medical attention to reverse, have the potential to reduce a woman’s capability to have emotional attachments, thus reducing her human capability and, ultimately, dignity.

Finally, in a similar vein to emotions, the Capability of affiliation is “Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction” (Nussbaum 2011, 34). To an extent, to limit a woman’s ability to reproduce is to constrain her social interactions, because it ultimately limits the people that will be present in her life. On the simplest level, contraception that is not freely chosen changes the relationship of a women’s landscape in ways that are impossible to fully predict.

In addition to limiting the capability of the women themselves, it is also feasible that the women who are targeted in LARC programs have their own intricate social networks, which can include romantic partners, other children, and extended families. The limiting of a woman’s reproductive capability, then, can also affect the Central Capabilities of her social network; specifically, these restrictive practices can limit the association and emotional capability of a large group of people.

Conclusions and Recommendations

When Nussbaum wrote *Creating Capabilities*, it's reasonable to assume that, in discussing the imperative for reproductive choice, she was arguing for an increase in access to birth control. This is a commonly argued-for expansion of rights, and, in line with poverty studies literature, it makes sense. Women who can freely choose their own contraceptive methods are less likely to live in poverty, which means that their children are less likely to live their lives in poverty. It's a simple concept: more birth control equals less poverty. But is the reduction of monetary poverty the only thing that matters, and do programs promoting LARCs to underserved populations go too far?

In taking Nussbaum's approach that the preservation of capabilities is the most important factor in ensuring human dignity, we accept the notion that agency is a human right, for which society is responsible. So, yes, women should have the agency to decide when and if they want to have children, and they certainly should not be denied this right simply because they are poor or otherwise underserved. LARCs have risen to such a high level of popularity within the medical community because they are incredibly effective at preventing pregnancy, so they are a fantastic option for a woman who does not want a pregnancy in the near future.

Recently, it seems that academia has become fixated on the detrimental effects of unplanned pregnancies, and this fixation is not without reason. Unplanned pregnancies are tied to a whole array of negative life outcomes, and they are, as LARCs prove, relatively easy to prevent. The problem, though, comes in when unplanned pregnancies are equated with all pregnancies occurring in impoverished or minority women. Many of the studies cited in this capstone utilize teen pregnancy, rapid repeat pregnancy, and unwed pregnancy as proxies for

unwanted pregnancies, because these factors typically correlate with low-income and similar negative outcomes. This means that healthcare providers who stay current on scientific literature have repeatedly exposed to the notion that these pregnancies are unwanted, even though they may be very much wanted.

As discussed in both the Literature Review and Analysis sections, healthcare providers have tremendous influence over the healthcare decisions made by their patients. Therefore, the messages that healthcare providers receive are extremely important. The approval of Medicaid reimbursement for immediate postpartum LARCs has been billed as good for patients, because it is extremely convenient for the patient, who will not have to return for a number of years. There is no mention anywhere of immediate postpartum LARCs for privately-insured women. The advent of immediate postpartum LARC policies is still recent, so it's hard to say exactly how it will affect America's underserved communities, but it seems plausible to posit that it will ultimately shrink these populations.

In reconciling Nussbaum's normative ideas with the realities of policies regarding no-cost contraceptives for impoverished Americans, it becomes clear that the moral success or failure of these programs lies entirely in execution. To prevent robbing impoverished women of their agency and, therefore, human dignity, literature about contraception for Medicaid patients should be reframed to emphasize patient choice. Furthermore, healthcare providers (and researchers) should refrain from assumptions about which pregnancies are unwanted, and about what is best for their patients, vowing instead to only provide comprehensive information and to allow patients to make truly free decisions. It is not ethically allowable to coerce patients into decisions about their reproductive futures based only upon cost-saving measures.

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