Incentivising contraceptive use: A helping hand or a push in the wrong direction?

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Contraception is essential to allow women control over their bodies and to fulfil their sexual and reproductive health rights. Despite this, in 2014 the WHO predicted that 222 million women and adolescent girls were living without modern contraception, mainly affecting vulnerable groups within society. A range of schemes have emerged to address this need for increased contraceptive access in marginalised groups of women, including incentivising programmes, where a reward is offered in return for use of a contraceptive. Enticing people into any medical intervention begs ethical analysis as the incentive may coerce the individual into a decision they may not have otherwise made. Coercion threatens informed consent by undermining voluntary decision-making. Thus,
using the four ethical principles I will determine whether the incentives used in
two high-income setting based contraceptive incentivising programmes today
disregard the autonomy of the women they are supposedly trying to help.

Outlining the incentivising schemes

US-based Project Prevention is a non-profit organisation that has garnered much
publicity since its founding by Barbara Harris in 1997, following her adoption of
four children born to a mother with crack cocaine addiction. The organisation
offers a substantial cash incentive ($300) to drug-addicted women in return for
use of a long-acting reversible contraceptive (LARC) or a sterilisation procedure².
Offering cash incentives to women fuelling a drug habit is an ethical minefield:
some would claim it introduces coercion and a failure of human rights.

On the other side of the Atlantic lies Pause, a UK-based programme that offers
help to women who have had children taken into care, and are at risk of future
custodial losses. One of the conditions of entering the programme is for women
to use a LARC. In stark contrast to the cash-in-hand mentality of Project Prevention, Pause appears a safer alternative, offering women a range of support during this ‘pause’ in their reproductive cycles, to help get their lives back on track\(^3\). However, the principle of increasing contraceptive use by the implementation of an incentive remains, regardless of its nature. Pause has its own ethical complications too, offering a woman the help she desperately wants and needs, solely under conditions set by the organisation, could be argued as forcing her hand into choosing to use LARC.

**Beneficence: For the vulnerable woman or the society she struggles in?**

Drug and alcohol use in pregnancy can have devastating effects. Children prenatally exposed to drugs and alcohol can face developmental and cognitive delays, behavioural disorders\(^4\) and are likely to be taken into care. Project Prevention emphasise this in their literature\(^2\). How society can tackle this issue is complex, after all the fetus has no rights before birth. Project Prevention’s proposal of preventing the woman from becoming pregnant logically allows her
time to seek help for addiction, whilst avoiding babies affected by substance misuse being born.

Pause also presents a bleak picture as the force behind its work. Within the pilot area Hackney, they estimated that for 49 women presenting with chronic social issues, 205 children were removed into care\(^3\). Pause prides itself on a dynamic approach, offering individualised programmes to target areas women most require support. Many women involved in the programme were in care themselves as children, many have substance abuse issues and the majority are in unsafe domestic environments\(^3\). Pause caseworkers remain steadfast, even when women routinely fail to attend appointments; this constant influence in their lives is surely a comfort to women previously ostracised and endangered. In this light both projects appear a kind alternative for the vulnerable woman, giving the opportunity to break a vicious cycle and rehabilitate without fear of becoming pregnant.
A question that should be asked when considering the beneficence of these schemes is whom the charity is helping most – the woman, or society. Project Prevention outlines four objectives for their work, in the following order:

1. Raising public awareness of the effects of drugs/alcohol on the fetus
2. Reducing tax-payer cost
3. Reducing social worker caseloads
4. Removing the burden on clients of having children taken into care

These suggest Project Prevention’s focus to be relieving the weight placed on society by substance abuse, rather than helping the women. Furthermore, it is likely that the financial incentive is used to fuel drug habits, and not all women passing through Project Prevention will enter rehabilitation programmes.

Although Pause also highlights societal cost, it exhibits how intervening helps the woman rehabilitate, alongside saving money. Beneficence, by definition, places the individual’s welfare at the centre of the scheme. On balance, Project
Prevention’s work, although cleverly disguised in the interest of the addicted woman, appears to swing more to the favour of society.

**Justice: A human rights approach**

The United Nations 2012 Population Fund report defined family planning interventions as a right for women\(^5\), implying contraceptive access should be universally obtainable. Yet with contraception uptake and availability lowest amongst those most vulnerable in society\(^1\); this right is not currently being collectively satisfied. Failure to fulfil this right can result in unintended pregnancy, which can deprive women of further human rights with devastating effect. For example, unintended adolescent pregnancy can cause women to drop out of education, which they have a right to, to care for the child, which can worsen the poverty and discrimination they endure\(^5\). Thus, increasing uptake of contraceptives by incentivising could help fulfil several human rights in the marginalised woman, alongside exercising her right to family planning.
In declaring access to family planning as a right, the UN also included one key word; voluntary. Does the use of incentives undermine this?

Project Prevention works solely with people suffering with substance addiction, and in Pauses’ pilot scheme, 98% of participating women abused drugs and/or alcohol. Impulsive, reward-seeking behavioural trends can precede addiction, making dependence more likely to manifest in certain individuals. Regardless of whether impulsivity is heightened by, or a predisposing factor to addiction, it could increase the likelihood of accepting a financial incentive by enabling more substance to be purchased. In this light, financially incentivising contraception use may not be branded ‘voluntary’ but as a bribe to fund addiction. This could repudiate further human rights, by denying the woman a right to freedom and liberty and to her own thoughts and beliefs, enticing her into a decision that suits the organisation rather than herself.

While Pause offers no money, their incentive of dedicated support could be construed as emotionally greater than that of Project Prevention. Women may
aim to regain custody of their children; for some this incentive may surpass any monetary value. Pause tries to combat this, specifying they will not assist any endeavour to resume custody of children, or assess parenting ability. However, the incentive remains, and with 51% of women in the pilot scheme homeless, the prospect of committed support could force a decision to take LARC, when without the incentive, the woman may not have voluntarily done so. Although the charity helps to fulfil contraceptive rights, incentivising healthcare may defy human rights themselves, the freedom to live and make their own decisions without influence.

**Non-maleficence: more harm than good?**

The difficult social situations faced by women working with Pause include street sex work, criminal proceedings, and domestic violence, which are potentially unsafe environments for pregnant women. Delaying pregnancy until in a safer
setting could be in the best interests for the woman. Can we defend the use of potentially coercive incentives for this reason? Quite possibly. Mill’s Harm Principle suggests preventing harm as the only circumstance that using power over another against their will could be justified⁷ and might be applied to incentivising contraception use today, to protect the vulnerable woman. Project Prevention implies this principle in their work; presenting their incentive as a kind preventative measure compared to the lifelong harm that substance abuse in pregnancy can force upon affected children.

Pause’s intervention may not directly cause physical harm, but it does have potential to cause distress in the future. Women may feel they were swayed into a decision by the emotional value of the incentive, and as such may feel manipulated in hindsight. Furthermore, although Pause clearly states they will not assist custody re-attempts, women may feel they have failed if despite getting their lives back on track through Pause, they did not manage to secure custody of their children, and this could negatively impact upon their wellbeing.
Although Pause only offers reversible contraceptive methods, Project Prevention also pays women to undergo sterilisation. Sterilisation in young women is controversial, with studies suggesting young childless women who undergo the procedure are likely to regret their decision\textsuperscript{8}. Of the 5,592 clients that had passed through Project Prevention by April 2016, 1,828 had undergone tubal ligation in exchange for cash\textsuperscript{2}. Offering large monetary sums to women funding a drug habit in exchange for a permanent medical procedure is morally dubious; in the future should the woman rehabilitate and wish to start a family, this will not be possible.

**Autonomy: free choice or forced coercion?**

It could be argued that incentivising contraceptive use in marginalised groups of women allows greater freedom of choice surrounding contraception. However, a $300 offer to women with drug addiction is surely one that some cannot afford to refuse; inability to fund their habit risks withdrawal. Undoubtedly true for some of the thousands of women passing through Project Prevention, this
involuntary response negates any validity of consent form signed and undermines autonomous decision-making.

Coercion by financial incentive is not the only concern for autonomy that rewarding contraceptive use raises. Both organisations target vulnerable groups of women, with Pause including those with learning difficulties and chronic mental health problems\(^3\). These groups have typically high incidence of unintended pregnancy\(^{34}\), and therefore healthcare professionals must not overlook their contraceptive needs. Aside from assessing capacity to make self-healthcare decisions, to ensure understanding of the schemes, there should be an educational exercise to minimise coercion\(^{10}\). Pause mandates this, although the literature available to the public about their education is scarce. Project Prevention does not publicise any such educational intervention, instead stating “if you cannot trust someone with their reproductive choices, how can you trust them with a child?” as a supposedly obvious argument for their incentive. In addition, Project Prevention lacks channels to signpost women to should they refuse LARC. In the UK, this should be discussed in the contraceptive
consultation, but as Project Prevention spreads into rural communities in Africa, this may not be guaranteed.

**Conclusion**

I find incentivising contraceptive use in marginalised groups of women a difficult ethical issue to wrestle with. On one hand, incentives increase contraception uptake and help fulfil reproductive health rights in women who previously may not have had their needs addressed. Conversely, by specifically targeting vulnerable women, the use of a desirable incentive could be construed as coercive. Pause offers a dynamic approach, individualising support to help the woman secure a safer future. Pause offers no permanent procedures, and no money exchanges hands. These factors combined reduce the chance of manipulation into the scheme, particularly for women funding drug habits, and reduce the chance of the woman regretting her decision in the future. I can understand the backlash and publicity garnered by Project Prevention. The cash incentive offered is substantial, and has been increased since the organisation’s
establishment, only intensifying its coercive power over women funding an addiction. Referrals to rehabilitation centres are not mandatory, and they do not publicise an educational intervention to suggest they ensure the woman understands her consent to a possibly permanent medical intervention. Besides avoiding the trauma of having a child removed, I question how the scheme helps the women at all.

I conclude that the nature of the incentive is key to determining if it can be morally justified. Pause’s considered approach to supporting women alongside their contraceptive intervention is a far more acceptable solution than the large cash incentive offered by Project Prevention, which although effective in increasing contraception uptake, is ethically condemnable for its accompanying coercive properties.

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References


