DECONSTRUCTING THE TEENAGE PREGNANCY “EPIDEMIC:”
AN INFORMED APPROACH TO CARING FOR MARGINALIZED
ADOLESCENTS WHILE RESPECTING
REPRODUCTIVE AUTONOMY

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

by
Danielle Baurer
May 2017

Thesis Approvals:
Nora L. Jones, PhD, Thesis Advisor, Center for Bioethics, Urban Health, and Policy
Providenza Loera Rocco, MSW, MBE, JD, Center for Bioethics, Urban Health, and Policy
ABSTRACT

Teenage childbearing is considered a societal ill, despite the evidence failing to demonstrate a causative link between teenage childbearing and negative consequences for teens or their children. This thesis argues that the strongly held assertion that teenage childbearing is detrimental to teens and society is rooted in racist eugenics theories and histories of reproductive coercion. Today, social scientists, health care providers, and public health professionals develop and celebrate programs that reduce rates of teen pregnancy, particularly programs that provide Long Acting Reversible Contraceptives (LARCs) to teens in marginalized communities. While these efforts are well-intentioned, they fail to recognize their perpetuation of histories of reproductive coercion of young women of color. This paper recommends ways in which the medical community can be better informed and respect reproductive autonomy in caring for teens from marginalized communities.

Keywords: long acting reversible contraception, LARC, reproductive coercion, teenage pregnancy, IUD, urban bioethics
ACKNOWLEDGMENTS

First, I must thank my thesis advisor Dr. Nora Jones, whose teaching and mentorship throughout medical school has been instrumental to my and my peers’ development as compassionate, ethics-based clinicians. Her support and advising in the writing of this thesis made the seemingly insurmountable task of writing a thesis while completing my fourth year of medical school and interviewing for residency a reality. Second, to Providenza Rocco, who provided incredible insights and revisions, particularly for not having met me before reading my thesis.

Next I extend my gratitude to my sister Elana, who lets nothing inhibit her from supporting me to the fullest. Her extensive assistance in the development of the thesis as well as in its editing process were no exception to this rule, as she combed through my thesis draft while planning a 1000-person conference. Thank you to my sister Talia, whose fiery passion for sexual and reproductive justice inspires me to do this work by her side. And to my parents, who raised three radical feminist women and whose unwavering support we are so fortunate to have.

Lastly, I thank my partner Lev, who somehow keeps my head above water and holds me accountable to myself at the same time.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>II</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>III</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>VI</td>
</tr>
<tr>
<td>CHAPTER 1: THE CONSTRUCTION OF TEENAGE PREGNANCY AS SOCIO-MEDICAL DISEASE</td>
<td>1</td>
</tr>
<tr>
<td>History of Teenage Pregnancy as Socio-Medical Disease</td>
<td>3</td>
</tr>
<tr>
<td>1920s-1950s: Eugenics and Forced Sterilization in the United States</td>
<td>4</td>
</tr>
<tr>
<td>1960s-1990s: Welfare Policy and Women of Color: From Exclusion to Demonization</td>
<td>8</td>
</tr>
<tr>
<td>1960s-1980s: Birth Control As Population Control</td>
<td>12</td>
</tr>
<tr>
<td>1970s-2000s: Birth Control Advocacy: A New Focus on Teens</td>
<td>15</td>
</tr>
<tr>
<td>The Evidence Behind the Teenage Pregnancy “Epidemic”</td>
<td>16</td>
</tr>
<tr>
<td>Teenage Pregnancy and Poverty: Attempts at Drawing a Causative Link</td>
<td>17</td>
</tr>
<tr>
<td>A New Approach to Studying Teenage Pregnancy and Poverty</td>
<td>20</td>
</tr>
<tr>
<td>Teenage Pregnancy and Childhood Outcomes</td>
<td>22</td>
</tr>
<tr>
<td>CHAPTER 2: CURRENT AND FUTURE APPROACHES TO TEEN PREGNANCY AND CHILDBEARING</td>
<td>26</td>
</tr>
<tr>
<td>Modern Medical Approach to Teenage Pregnancy</td>
<td>26</td>
</tr>
<tr>
<td>Norplant: A Case Study in LARC and Reproductive Coercion</td>
<td>27</td>
</tr>
<tr>
<td>LARC Today: IUDs and Nexplanon</td>
<td>30</td>
</tr>
<tr>
<td>Barriers to LARC Removal as Coercive Inaction</td>
<td>33</td>
</tr>
</tbody>
</table>
Overcoming Clinician Bias By Considering the Voices of Teens........... 36

A Justice-Informed Approach to Providing LARCs.......................... 40

Contraceptive Counselling for Marginalized Teens......................... 40

Compassionate LARC Removal.................................................. 42

Facilitating Self-Removal...................................................... 43

Recognizing Unconscious Bias to Improve Care.............................. 44

An Urban Bioethics Analysis..................................................... 46

REFERENCES CITED........................................................................ 50
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Photo of diagram displaying an Aryan woman with five children and a woman of an ambiguous, non-Aryan race/ethnicity with eight children, stating “Inferior humans are reproducing faster than the healthy population.” Taken by author at Wannsee Museum, Wannsee, Germany</td>
<td>5</td>
</tr>
<tr>
<td>2. New York City Department of Public Health subway advertisement displaying panels of children with misleading teen pregnancy prevention quotes and statistics. Public health-led teen pregnancy prevention effort. (NYC Human Resources Administration, 2013)</td>
<td>17</td>
</tr>
</tbody>
</table>
CHAPTER 1: THE CONSTRUCTION OF TEENAGE PREGNANCY AS SOCIO-MEDICAL DISEASE

We've got to ask our community leaders and all kinds of organizations to help us stop our most serious social problem: the epidemic of teen pregnancies and births where there is no marriage... Tonight, I call on parents and leaders all across this country to join together in a national campaign against teen pregnancy...” (Clinton, 1995)

In his State of the Union Address, President William Clinton joined other politicians, public health officials, and health care providers in naming the physiologically normal occurrence of teenage pregnancy as a widespread medical disease (American College of Obstetricians and Gynecologists (ACOG), 2012; Farber, 2009; Finer and Zolna, 2011; Grogger and Bronars, 1993; Hofferth and Hayes, 1987). The belief in teenage pregnancy as disease has compelled policymakers and health care providers to build policies, programs, and public health campaigns with the goal of reducing rates of teenage pregnancy. Research has failed, however, to demonstrate a causal relationship between teenage pregnancy and poorer outcomes for parents or children (Boonstra, 2014; Roberts, 1997; Luker, 1996). The central argument of this thesis critically examines this question, arguing that the misconception that teenage childbearing is detrimental to the lives of teens and their children is actually founded on racist eugenics theories and policies.

Today, teen pregnancy prevention initiatives led by medical professionals focus on promoting long acting reversible contraceptives (LARCs) for teens (Committee on
Adolescent Health, 2012; Committee on Adolescents, 2014). There are two types of LARCs; the implant, a rod that is implanted under the skin of the arm, and the intrauterine device (IUD), a piece of metal that is inserted into the uterus. Both methods provide long term contraception without requiring a daily pill or putting on a condom before sex, and require a health care provider to remove them. Teens report both feeling pressured into receiving a LARC and encountering barriers to removal of LARCs (Roberts, 1997; Kavanaugh, Frohwirth, Jerman, Popkin, & Ethier, 2013). The experience of these teens represents a form of reproductive coercion, most commonly defined within romantic relationships, but for the purposes of this discussion defined best as an institution asserting control over a person’s reproductive decision-making.

Another concerning element of LARC programs is the fact that teen pregnancy prevention efforts focus on communities with higher rates of teen pregnancy, which in the United States means Latina/o and non-Hispanic Black communities (CDC, 2013). Thus, teen pregnancy prevention programs disproportionately target Black and Latina/o teens, many of whose communities have been the victims of coercive reproductive health practices for centuries. Such practices include example, example, and most recently being forcibly sterilized as recently as the 1960s (Luker, 1996; Nathanson, 1991). In caring for teens in communities that suffer from historical and current medical discrimination (Agency for Healthcare Research and Quality, 2015), health care providers bear a responsibility to be mindful of these and related coercive practices and work against their propagation.

To promote a more informed and anti-racist approach to reproductive health care for adolescents, I turn first to the recent history of teenage childbearing, and how
eugenics and racist ideologies are foundational to our understanding of teenage pregnancy. I then address research that has unsuccessfully attempted to show causation between teenage pregnancy and increased risk of poverty for parents and children. Finally, I will make recommendations for both clinical and policy level changes to caring for teens from marginalized communities. I advocate an approach that considers histories of reproductive coercion, and centers on the patient and the patient’s experience. I critique one-size-fits-all policies, and suggest that health care providers be careful in recommending LARCs broadly to all teens without being specific about risks and side effects, and without considering adolescent’s health care access for removal if they so choose.

Particularly in unstable political times, when reproductive rights are at great risk, I argue that it is not ethical to insert a contraceptive device into a person without considering how they will remove it. I advocate for offering free removal of IUDs and implants for any woman who cannot afford it and for teaching self-removal of IUDs. Ultimately, clinicians and policymakers can create programs that offer high quality contraceptives to teens while respecting their reproductive autonomy. And to be true advocates for patients’ reproductive autonomy, we need to take our work one step further to advocate for improved policies and . Before incorporating this informed approach to reproductive care, we must first understand how physicians, policymakers, and public health professionals arrived at the conclusion that teenage childbearing is a societal “epidemic.”

History of Teenage Pregnancy as Socio-Medical Disease
How did teenage pregnancy and childbearing become a socio-medical epidemic? When did policymakers, social scientists, and medical professionals agree to dedicate resources toward preventing this “disease?” More importantly, how did they come to this conclusion?

In this chapter, I explore the critical coalescence of a number of events that caused teenage pregnancy to be considered a socio-medical disease. First, the emergence of Social Darwinism and the consequent Eugenics movements in the United States propagated the theory that some races are inferior and do not have the right to reproduce (Sofair and Kaldjian, 2000). Second, the expansion of welfare to include Black women and the subsequent re-ignition of racist fervor toward Black women’s reproduction engaged the American public in the narrative of teenage pregnancy as disease. Lastly, the advent of the first oral contraceptive pill led to physicians being more intimately involved in fertility timing and birth control advocates targeting teenage pregnancy as a disease to treat with this new medication.

1920s-1950s: Eugenics and Forced Sterilization in the United States

Eugenics and Social Darwinist movements are foundational to understanding the history of birth control and its use as a tool in reproductive coercion. Kristin Luker (1996), in Dubious conceptions: the politics of teenage pregnancy, describes the emergence of eugenics:

As policies failed to reduce the overcrowdedness and delinquency of the emerging American cities, eugenics took hold as people began to evaluate who was fit to become a parent. The social ills of the time—crime, poverty, prostitution—were no longer a result of environment, but were inborn characteristics. The only way to curb the social ills of the time would be to stop the genetically inferior from reproducing. (p.32)
In Europe, social Darwinist and eugenics movements became the foundation of Nazi ideology surrounding racial purity (Sofair and Kaldjian, 2000). German psychiatrist Alfred Hoche described “the end of atomistic individualism and the transformation of the nation into a higher organism, the Volk” (Sofair and Kaldjian, 2000, p.312). Figure 1 is a photo from the House of the Wannsee Conference, where leaders of the Nazi party converged in 1942 to coordinate the mass extermination of Jews, or as they called it “The Final Solution to the Jewish Question.” This image describes the Social Darwinist belief that the health of society (or in Germany of the Volk) was at risk if inferior races reproduced at higher rates than the Aryan Race.

Figure 1. Photo of diagram displaying an Aryan woman with five children and a woman of an ambiguous, non-Aryan race/ethnicity with eight children, stating “Inferior humans are reproducing faster than the healthy population.” Taken by author at Wannsee Museum, Wannsee, Germany
This pseudoscientific theory of race underpinned the Nazis’ genocidal acts, including forced sterilization (Sofair and Kaldjian, 2000). The Nazi sterilization program targeted individuals with mental illnesses and others who were considered to be “feebleminded” (Sofair and Kaldjian, 2000). This program notably preceded the concentration camps and mass murders for which the Nazis are most well-known (Moskowitz and Jennings, 1996b, p. 29). Though the Nazis forcibly sterilized the largest number of people—300,000 to 400,000—they were not the first (Sofair and Kaldjian, 2000, p. 313). Nazi forced sterilizations began in 1934, while the United States government-sponsored eugenics movement began forcibly sterilizing in 1907 (Moskowitz and Jennings, 1996b, p. 30). Indiana passed the first law permitting forced sterilization of “criminals, idiots, imbeciles, rapists, and the feebleminded” in 1907 (Sofair and Kaldjian, 2000, p. 314). By 1931, 27 states had passed similar statutes (Luker, 1996). Most states restricted forced sterilization to inmates in public mental institutes, who were disproportionately poor and of minority groups (Sofair and Kaldjian, 2000).

At this time, the birth control pill did not exist; the medical community’s tool to control fertility was sterilization. The creation of Alfred Binet’s intelligence test, or today what is known as the IQ test, was used to assess for “feeblemindedness” (Nathanson, 1991). Binet’s test could not distinguish between those who were mentally impaired, did not speak English well, could not read, or did not want to cooperate with the examiners (Moskowitz and Jennings, 1996b). Those who were most likely to be tested—prostitutes, alcoholics, and immigrants—were also more likely to do poorly on this test (Luker, 1996). Thus, poverty and social deviance were conflated with “feeblemindedness.” Social deviance included not just prostitution but also sexual promiscuity among women. An
evaluation of the sterilization cases prior to 1938 in Virginia found that all of the women
recommended for sterilization were done so for “sexual license,” and in California, 75%
of women sterilized were done so for being “sexually delinquent” (Luker, 1996).
Sterilization policy was used to control the fertility of women who were deemed unfit for
reproduction for the very reason that they were having sex.

Though the US eugenics movement preceded Nazi forced sterilization and mass
murder, American eugenicists were inspired and rejuvenated by Nazi Germany’s wide-
scale implementation of forced sterilization. In 1934, Leon Whitney, executive secretary
of the American Eugenics Society, published The Case for Sterilization, stating: “while
we were pussy-footing around, reluctant to admit even that insanity of certain sorts runs
in families, the Germans were calling a spade a spade … by this action Germany is going
to make herself a stronger nation” (Whitney, 1934, p.136). The editors of The New
England Journal of Medicine published an editorial in support of involuntary sterilization
in 1935, drawing inspiration from Germany again, in stating that “Germany is perhaps
the most progressive nation in restricting fecundity among the unfit” (“Sterilization and
its possible accomplishments,” 1935).

Sterilization laws were challenged in United States courts, and often found to be
unconstitutional (Sofair and Kaldjian, 2000). Yet physicians were still able to recommend
eugenic sterilization, and many recommended sterilization for poor women, especially
poor women of color, to be sterilized into the 1970s (Sofair and Kaldjian, 2000). For
example, in 1974, Choktaw-Cherokee physician Dr. Connie Pinkerton-Uri found that
25% of Native American women of ages 14-44 were sterilized without consent during the
1960s and 1970s in the Indian Health Service (Lawrence, 2000). Despite US involvement
in World War II and condemnation of the Nazi Holocaust, eugenic sterilization in the US continued after World War II and the Nuremberg Trials (Moskowitz and Jennings, 1996b, p.30). In total, the United States forced sterilization program is estimated to have sterilized at least 60,000 individuals (Moskowitz and Jennings, 1996b).

Through much of the 20th century, physicians sterilized women without their consent, targeting poor women and women of color. The racist ideologies that underpinned these actions were not limited to forced sterilization, they compelled other policies that impacted poor women and women of color as well.

1960s-1990s: Welfare Policy and Women of Color: From Exclusion to Demonization

Welfare policy was also based in racist ideologies, and the politicization of welfare plays a significant role in the story of reproductive coercion and birth control. The first iteration of welfare was created in 1935 as part of the New Deal, and named Aid for Dependent Children (ADC). ADC was created to support single White women, with Black women specifically excluded from this law:

Northern Democrats struck a deal with their Southern brethren that systematically denied Blacks eligibility for social insurance benefits. Core programs… excluded agricultural workers and domestic servants in a deliberate effort to maintain a Black menial labor caste in the South. Whites feared that Social Security would make recipients… less willing to accept low wages… New deal public works programs blatantly discriminated against Blacks, offering them the most menial jobs and paying them sometimes half of what White workers earned (Roberts, 1997, p.206).

ADC was built on a foundation of mistrust and scrutiny of its recipients, primarily women. While Social Security benefits obligated the federal government to pay beneficiaries a set amount,
ADC clients faced caseworkers, supervisors, and administrators with discretion regarding who got aid and how much they got. These government bureaucrats required recipients to meet not only means standards but also degrading morals—tests that typically probed clients’ sexual behavior.” (Roberts, 1997, p. 206)

By the late 1950s, ADC had developed from a relatively uncontroversial program to a program under fire (Roberts, 1997). Mass migration to the cities increased need among families, and changing social norms resulted in more births out of marriage (Herrick and Stuart, 2005). ADC was still a policy designed to exclude women of color, but more women of color qualified for ADC benefits than before (Mink, 1994). The women of color who did receive welfare benefits were held up as examples of why eugenics-inspired policies were needed. In 1958, David H. Glass, Mississippi state representative, introduced a bill mandating sterilization for any unmarried mother who gave birth to another illegitimate child, stating:

During the calendar year 1957, there were born out-of-wedlock in Mississippi more than 7,000 negro children and about 200 White children. The negro woman, because of child welfare assistance, is making it a business, in some cases of giving birth to illegitimate children…the purpose of my bill was to try to stop, or slow down, such traffic at its source” (Roberts, 1997, p. 214).

To reduce welfare rolls, states implemented discriminatory and oppressive practices. State agents performed unannounced inspections and midnight raids on the homes of Aid for Families with Dependent Children (AFDC, previously called ADC) recipients to see if there was a man present in the homes of these single mothers (Herrick and Stuart, 2005). State officials justified these actions in stating that public funds should not support immoral relationships, and terminated AFDC benefits without right of repeal if they found “evidence of a man’s visit” or if the woman refused to allow the inspection
States also assigned people of color lower benefit levels and refused to accept their applications: “for 15 years Arizona and New Mexico illegally refused to accept public assistance applications from Native Americans residing on reservations” (Herrick and Stuart, 2005, p.28). Such discriminatory practices led welfare reform advocates to fight for safeguards specifically designed to protect the benefits of people of color. In many ways these efforts were successful.

Partially due to these new safeguards, AFDC rolls expanded rapidly in the 1960s, increasing from 3.1 million recipients in 1961 to 10.2 million recipients in 1971 (Herrick and Stuart, 2005). AFDC rolls also changed from being 86 percent White to 64 percent White (Roberts, 1997). Though AFDC recipients were still predominantly White, the expansion of the welfare rolls to include a large number of Black women fueled preexisting racist tropes of Black people as lazy and immoral: “the image of the welfare mother quickly changed from the worthy White widow to the immoral Black welfare queen” (Roberts, 1997, p.207).

The US government propagated this image. In 1965, Daniel Moynihan, aide to Lyndon B. Johnson, authored a White House memo titled *The Negro family; the case for national action*, in which he blamed Black families for their own plight and for the expansion of AFDC: “The steady expansion of the welfare program can be taken as a measure of the steady disintegration of the Negro family structure over the past generation in the US” (United States. Dept. of Labor. Office of Policy Planning and Research, 1965, p.14). The racism of the US government and US public in believing that Blacks were inherently inferior traces back to the founding fathers, whose belief in racial
hierarchy and race as an inheritable trait was necessary to justify slavery (Nathanson, 1991).

Public anti-welfare rhetoric became commonplace in the following decades. Some argued that the existence of welfare encouraged young women to have babies to receive federal funds, as Robert Moffit of the Heritage Foundation did: “we are the only society… that says to a teenage girl, ‘we’re going to give you a welfare check if you have a baby… if you want to reduce the rate of illegitimacy, you have to stop subsidizing it” (as cited in Roberts, 1997, p. 114). The narrative shifted from Black women reproducing irresponsibly to Black women reproducing to confer American taxpayers into paying them. A 1990 study found that 78 percent of White Americans thought that blacks preferred to live on welfare (Smith, 1990, p.9).

In the early 1990s, the image of the “welfare queen” pervaded American culture, and politicians targeted welfare for widespread cuts (Roberts, 1997). Bob Grant, a popular New York radio talk show host, appealed to racist stereotypes by imitating a welfare mother, using an exaggerated Black accent on his show:

'I don't have no job, how’m I gonna feed my family?’ I wonder if they’ve ever figured out how they multiply like that… it’s like maggots on a hot day. You look one minute and there are so many there, and you look again and, wow, they’ve tripled!’ (Roberts, 1997, p.18)

Grant called his welfare reform proposal the “Bob Grant mandatory sterilization act” (Roberts, 1997, p.18). Grant’s comparison of Black women to insects is deeply disturbing in its dehumanization of these individuals. And his statement neatly connected racism, eugenics, and welfare policy.
Shortly thereafter, in August 22, 1996, President Bill Clinton effectively ended the era of social welfare by creating so-called “Welfare for Work” (Herrick and Stuart, 2005). The former AFDC became Temporary Assistance for Needy Families (TANF), a lump sum federal grant program whereby states were given freedom to essentially cut the program (Roberts, 1997). Mothers had strict work requirements in order to receive benefits. Sociologist Dorothy Roberts (1997) described the destruction of welfare in her book *Killing the black body*:

> Welfare was stingy and humiliating, but at least it responded to the needs of poor children. In the new era of welfare, government has become a tool of social control, a means of improving the behavior of poor families… even the neediest children are cast deeper into poverty if their mothers do not conform. (p.209)

The destruction of AFDC represented a convergence of eugenics theory and public policy. US politicians, with the support of the American Public, decided that Black mothers were not worthy of receiving government assistance. The dehumanizing and racist rhetoric of US eugenicists and Nazis permeated the discussion of Black women and welfare.

While medical providers were not active participants in racist welfare policies in the same way as eugenics and forced sterilization, they were complicit as members of the American public with significant social clout. Some medical providers also harnessed widespread ire of welfare to support birth control policies, entangling reproductive coercion with reproductive rights.

1960s-1980s: Birth Control As Population Control

On May 9, 1960, the Food and Drug Administration (FDA) approved the first oral contraceptive pill (Luker, 1996). While some proponents of “the pill” celebrated it as a
victory for women’s liberation in decoupling sex and reproduction, many saw it as an opportunity for population control. By this time, many eugenicists had admitted that their attempts to destroy traits they considered to be hereditary, like alcoholism and “feeblemindedness,” had failed (Stern, 2005). Geneticists had demonstrated that most gene frequencies remained constant over generations, and changes in these frequencies could occur only over thousands of years (Stern, 2005). Thus, supporters of sterilization policies shifted their focus from eradicating “feeblemindedness” to reducing the burden of welfare and overpopulation.

Population control efforts stemmed from concerns that the post-World War II population boom, especially in developing countries, was exacerbating worldwide poverty, increasing political unrest, and weakening capitalism and democracy (May, 2010). “…Population controllers included conservatives who considered the children of poor people to be a burden on taxpayers, eugenicists who believed in curbing the fertility of the ‘unfit,’ and environmentalists who saw the nation’s growing population as… a drain on resources” (May, 2010, p.37). Thus, population control efforts focused on reducing the reproduction of the poor and marginalized.

In 1964, the American Medical Association’s (AMA) House of Delegates called for the involvement of physicians in population control, stating that “an intelligent recognition of... the need for population control... is a matter of responsible medical practice” (AMA renews anti-compulsion stand; revises policy on population control, 1964, p.31). James Z. Appel, then-President of the AMA, was quoted in The New York Times calling for “extra efforts to educate the lower economic and intellectual levels of society on birth control,” and was reported to have related the need for birth control to a
concern for overpopulation (Wehrwein, 1966, p.37). The AMA Committee on Human reproduction found that the birth control pill “has been proved to be highly acceptable and successful among welfare patients of very low socioeconomic and educational status who rejected or failed with all previous methods” (cited in Nathanson, 1991, p.37). Physicians of the 1960s, much like their predecessors and the Nazi doctors of Germany, hoped to restrict the fertility of poor women.

Also during the 1960s, mainstream feminist and reproductive rights movements successfully advocated for government-sponsored reproductive health services. The passing of the Family Planning Services and Population Research Act and the creation of the Office of Economic Opportunity (OEO), both in 1970, greatly increased access to family planning: “In 1965, about 450,000 women had access to family planning projects; by 1975, this number had jumped to 3.8 million” (Stern, 2005, p.1133). Population control had served as a successful argument in expanding much needed birth control services.

However, population control as the basis for birth control expansion quickly came under fire for its coercive nature. In 1973, the Southern Policy Law Center sued the Secretary of the U.S. Department of Health, Education and Welfare on behalf of the Reif sisters, who had been sterilized without consent at the ages of 12 and 14 at a federally-funded family planning clinic (Stern, 2005, p.1134). A number of Latina, Native American, and Black women came forward with their experiences of involuntary sterilization as a result of this case (Nathanson, 1991). When the Reif sisters’ case was heard in district court, Federal Judge Gerhard Gesell critiqued family planning programs for their involvement in forced sterilization: “the line between family planning and
eugenics is murky” (cited in Nathanson, 1991, p.56). Gesell’s statement elucidated the predicament that family planning, when not performed appropriately, could be a tool of racist ideologies.

**1970s-2000s: Birth Control Advocacy: A New Focus on Teens**

Birth control advocates recognized that population control also targeted marginalized communities and was no longer a winning tool for promoting birth control. They needed a new “face of the movement,” with which to promote birth control, and found this in teenagers. In 1974, Planned Parenthood of New York announced a campaign specifically targeting teenagers, and in 1976, the Alan Guttmacher Institute, the research and policy arm of Planned Parenthood, released a special issue of their *Family Planning Perspectives* journal entitled “11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States” (Lincoln, Jaffe, & Ambrose, 1976) Defining teen pregnancy as an epidemic, despite the fact that rates of teen pregnancy were actually decreasing (Vinovskis, 1988), demonstrates their commitment to politicizing teen pregnancy to advance their agenda of expanded birth control.

In 1978, Joseph Califano, then-Secretary of Health, Education, and Welfare, proclaimed adolescent pregnancy the top domestic priority of the Carter Administration (Vinovskis, 1988, p.xii). That same year, Congress followed in suit, as the House Committee on Population made the argument for birth control as disease prevention:

Let us suppose that there was an illness affecting one adolescent in ten each year, and that this illness had long lasting and sometimes crippling side effects. Suppose, also that it was expensive and difficult to avoid the
sequelae once the condition occurred, but that we possessed a reasonably safe and effective means of prevention. Would we emphasize a strategy of prevention or would we try merely to ameliorate the negative effects of the illness after it appeared? Of course, parenthood is not a disease, but when unplanned and unwanted, as is typically is for adolescents, pregnancy in some ways resembles an illness. (cited in Nathanson, 1991, p.49)

Birth control advocates shifted their focus from poor women to young women, using a disease model to describe what was once a social concern. In attempting to increase contraceptive access for all women, advocates further regulated young women’s bodies, especially those of young women of color. Ultimately birth control advocates propagated the perception of young women’s sexuality, under the label of teenage pregnancy, as a medical problem, with a solution of state intervention.

The Evidence Behind the Teenage Pregnancy “Epidemic”

As social and political forces coalesced to establish teenage pregnancy as a socio-medical epidemic, researchers attempted to support those efforts through research on the links between teenage pregnancy and worse outcomes for parents and children. In this chapter I describe how these efforts failed to demonstrate a causative link between teenage pregnancy and poverty, first exploring research on teenage parents’ educational and financial outcomes, and then research on children of teenage parents’ same comment outcomes. The lack of any conclusive evidence after years and millions of dollars of funding furthers my argument that teenage pregnancy and childbearing has been constructed as an epidemic not for altruistic reasons, but for social and political reasons.
Figure 2. New York City Department of Public Health subway advertisement displaying panels of children with misleading teen pregnancy prevention quotes and statistics. (NYC Human Resources Administration, 2013)

Teenage Pregnancy and Poverty: Attempts at Drawing a Causative Link

In the early 2000s, the New York City (NYC) subway displayed advertisements featuring images of sad children and alarmist statistics in attempts to reach teens and thus reduce rates of teenage pregnancy (NYC Human Resources Administration, 2013) (Figure 2). The quotes were not just alarmist, however; they were biased and misleading. The quote “if you finish high school, get a job, and get married before having children, you have a 98% of not being in poverty” points to a key misunderstanding and
miscommunication of data (NYC Human Resources Administration, 2013). Research has shown that those who live in poverty are most likely to have children as teens, but has failed to show that if they do not have children they will suddenly be lifted out of poverty.

In the 1970s and 1980s, researchers demonstrated an association between early childbearing and poverty: teens who lived in worse social and economic conditions were also more likely to have children at a younger age (Hoffman, 1998). However, these studies were unable to demonstrate that teenage childbearing caused worse social and economic outcomes. Causation between social phenomena is difficult to ‘prove’. In current research standards, causation can only be demonstrated definitively using multiple double-blind randomized control trials. This is not feasible in the relationship between teenage childbearing and poverty as it is not ethical to design a study with one arm requiring teens to have children.

The aforementioned researchers thus attempted to more closely approximate causation research by controlling for factors like parental education and income that might affect both likelihood of becoming a teen mother and socioeconomic success (Hoffman, 1998). They found that independent of parental education and income, teenage parenthood still resulted in worse socioeconomic outcomes for teen mothers (Hoffman, 1998). The National Research Council used this data to build the government report *Risking the Future*, which concluded that “women who become parents as teenagers are at greater risk of social and economic disadvantage throughout their lives than those who delay childbearing” (Hofferth and Hayes, 1987, p.138). This research is likely also the research that inspired the above-mentioned NYC subway ads.
However, in order for this analysis to be valid, “a woman’s status (teen mother or not a teen mother) must be uncorrelated with all remaining and unobservable factors that might influence the outcomes under consideration” (Hotz, McElroy, & Sanders, 2005, p.684). While objective measures like parental income and educational opportunity can be removed from statistical analysis, nonobjective measures like social environment and parental involvement cannot be measured, nor removed (Hoffman, 1998). Not only do these studies fail to prove causation by design, but they also fail to take into account unmeasurable factors that can have a significant impact on a person’s economic success.

To better control for social environment, Geronimus and Korenman (1992) compared pairs of sisters: one of whom had a child as a teen. They found that while teenage mothers were less likely than their sisters to have had postsecondary school or to be married, they had similar incomes in their late 20s through 30s (Geronimus and Korenman, 1992). This methodology is an improvement, though limited as family circumstances may change over time and thus conditions and parental inputs faced by sisters may be significantly different. Additionally, later replication of the study negated their findings, demonstrating worse outcomes for those who had children as teens (Hoffman, 1998).

Grogger and Bronars (1993) compared teenage women who had twins with those who had a singleton birth. They hoped that the difference between two children and one child was similar to the difference between one child and zero children. They found moderately negative effects of twin childbearing compared to singleton childbearing in measures of high school graduation, family income, and likelihood of living in poverty and on welfare, implying that there were negative effects from teenage childbearing
However, Grogger and Bronars (1993) themselves note the limitation of the assumption that a comparison of two to one is equivalent to one to zero, that if economies of scale exist in which caring for two children is less than double the work of caring for one child, they would underestimate the impact. If diseconomies of scale exist in which caring for two children is more than double the work of caring for one child, they would overestimate the effects. Ultimately, this study’s unique and complex design cannot be considered definitive in understanding the impact of teenage childbearing. The most notable conclusion one can draw from this study is that teenage childbearing’s relationship with poverty is highly challenging to study.

*A New Approach to Studying Teenage Pregnancy and Poverty*

In the early 2000s, a set of researchers used an innovative approach to address teen pregnancy and poverty, challenging previous studies and providing new insights into a previously inconclusive area of research. Hotz et al. (2005) compared teen mothers with those who had random miscarriages as teens, considering random teen miscarriage v. teen childbirth as the closest approximation of a randomized control trial. Additionally, their study examined outcomes teens until age 30, substantially longer than prior studies (Hotz et al., 2005).

This original and longitudinal approach to studying teenage childbearing bore important results. First, their findings countered previous studies regarding the effects of teenage childbearing on educational attainment, stating that there is “no statistically significant effect of early childbearing on the probability that teen mothers obtain a high school level education… relative to… if they had delayed their childbearing” (p.702). In their under 18 sample, Hotz et al. (2005) found that women who had children were less
likely to get a high school diploma, but were more likely to get a GED compared to teens who had miscarriages.

Regarding socioeconomic attainment, their longitudinal vantage point also provided new insights. While teenage mothers worked fewer hours at 18 or 19 than they would have if they had delayed childbearing, from age 20 on they worked more hours than they otherwise would have (Hotz et al., 2005). This increase in hours translated to earning “more in the labor market at older ages than they would have earned if they had delayed their births” (p.686). Teen mothers were more likely to use public assistance directly after the birth, but used less public aid in their late 20s, as their earnings rose and their children grew older (Hotz et al., 2005). This finding regarding public assistance is particularly salient as policymakers and physicians alike often tout teen pregnancy prevention as a public benefit in reducing reliance on government assistance. Hotz et al. (2005) demonstrated that with a long-term lens this assumption proves false.

Their findings strongly contradict prior findings, and they suggest a number of explanations. First, prior research had demonstrated that those who had children as teens were less likely to work in occupations that required higher education than women who postponed motherhood, likely due to their less socioeconomically advantaged backgrounds (Hotz et al., 2005). Thus, the authors postulated that women who had children as teens were likely to work in jobs that valued continuity of work and job-specific experience more than educational credentials. Having a child at a younger age may have caused less career disruption, allowing for more continuity and job-specific experience and thus more advancement and greater income.
Ultimately, Hotz et al. found that teenage mothers adapt over their life cycles—getting GEDs in place of high school diplomas, earning more than their counterparts over time, and relying less on public assistance as they get older. While their research cannot be viewed as conclusive, it calls into question previous assumptions that postponing childbearing will improve the socioeconomic attainment of teen mothers in any substantial way. (Hotz et al., 2005).

Considering the evidence in aggregate, one can draw only limited conclusions about teenage childbearing and poverty. Studies have established a significant correlation between teenage childbearing and poor socioeconomic trajectories, but have also demonstrated that those who have children as teens come from poorer backgrounds already. The current evidence does not support the assumption that teenage childbearing is the devastating life-changing event for mothers. Perhaps instead of stating “if you finish high school, get a job, and get married before having children, you have a 98% chance of not being in poverty,” NYC subway ads should have stated “if you finish high school, get a job, and get married before having children, your chance of being in poverty is likely unchanged” (NYC Human Resources Administration, 2013) (Figure 2).

**Teenage Pregnancy and Childhood Outcomes**

Another panel of the NYC subway ad speaks to another common misconception regarding teenage childbearing. This panel speaks in the voice of the child, stating: “I’m twice as likely not go graduate high school because you had me as a teen” (NYC Human Resources Administration, 2013). Similar to data regarding teen outcomes, data regarding childhood outcomes also failed to prove causation. And again, much of the research that
showed only correlation was cited in the influential 1987 government report *Risking the future: adolescent sexuality, pregnancy, and childbearing* (Hofferth and Hayes, 1987).

Again analogously to teen outcomes, some researchers attempted to control for confounding variables. A 1995 study published in *The New England Journal of Medicine* reported that teenage mothers were at increased risk of delivering low birth weight, premature, or small for gestational age infants even if they were married, had high quality education, and received adequate prenatal care (Fraser, Brockert, & Ward, 1995). Despite its publication in one of the most prestigious medical journals, this study suffered from a number of important limitations. Firstly, the study only controlled for marital status, education level, and prenatal care. The authors asserted that this controlled for sociodemographic effects, yet they did not control for income or psychosocial factors like stress and family support. Additionally, their sample was made up of White teenagers in Utah, who faced highly different life circumstances than the traditional populations targeted in teenage pregnancy interventions of urban Black or Latina young women. It is unclear, albeit highly unlikely, that data from these teens can be generalized to apply to young women living in America’s urban centers.

Fraser et al. (1995) also did not control for illicit substance use, including cigarettes. When later researchers limited their analysis to non-smoking mothers, they found that infants of women who had a first birth during their teenage years were not at increased risk of low birth weight, prematurity, or being small for gestational age (Smith and Pell, 2001).

Levine, Pollack, and Comfort (2001) used longitudinal data from the National Longitudinal Survey of Youth to examine long-term effects of teenage childbearing on
children born to teens. When looking solely at association, they found that children who engaged in early sexual activity, fighting at school or work, and truancy were more likely to have been born to a mother in her teens (Levine et al., 2001). Children born to teens also had lower standardized test scores and were more likely to have repeated a grade in school (Levine et al., 2001, p.361). However, when controlling for background effects (grandmother’s education, grandmother’s labor force status, mother’s standardized test scores, mother’s household structure and place of residence) they found no association between maternal age at first birth and standardized academic scores or grade retention in school. (Levine et al., 2001). This study included more extensive controlling for confounders than prior studies, yet researchers were still unable to remove unmeasurable factors like parenting style and parental involvement.

Social scientific research has failed to establish a causative link between teenage childbearing and poor outcomes in children born to teens or in teens themselves. So why is our understanding of teenage pregnancy and childbearing in the medical field so inconsistent with the evidence, when we consider evidence-based medicine to be the gold standard of clinical practice?

One element of this discrepancy is the historical, political, and social factors described above. Most medical providers (myself included) grew up in, and were thus socialized with the values of, White upper to middle-class communities (Castillo-Page, 2010). The belief in teenage childbearing as a social ill is not based on evidence, but rather on years of socialization. Unfortunately, the racist ideologies that underpin our understanding of teenage childbearing are impacting the way we provide medical care to already-marginalized teens.
CHAPTER 2: CURRENT AND FUTURE APPROACHES TO TEEN PREGNANCY AND CHILDBEARING

Modern Medical Approach to Teenage Pregnancy

Today, the medical community considers teenage pregnancy and childbearing a medical problem. Medical journals publish articles celebrating dropping rates of teenage pregnancy, applauding programs that target the most marginalized teens (Voelker, 2014; Secura et al., 2014; Blad, 2016; Boonstra, 2002). Programs that focus on teen pregnancy do so in many ways, from educational workshops to public health campaigns to contraceptive care. The most applauded strategy, however, is to encourage young women to get a LARC, as LARCs are considered the superior contraceptive option due to their “user-independent” structure and increased efficacy (Voelker, 2014; Secura et al., 2014; Blad, 2016).

However, when celebrated as a silver bullet to teen pregnancy and poverty, LARCs risk becoming part of the history of contraception as reproductive coercion. Unlike sterilization, LARCs are reversible. But unlike oral contraceptive pills, patches, or rings, they require a physician to restore fertility. When programs direct their efforts toward young women of color in high poverty settings, they risk encroaching upon reproductive autonomy, or “the power to decide when, if at all, to have children… [and] the choices related to reproduction” (Purdy, 2006, p.287).

To elucidate how LARC programs participate in coercive practices, I first describe a case study of LARCs and reproductive coercion in the development of Norplant in the 1990s. I then turn to current LARC programs and the extensive barriers to
Lastly, I introduce the perspective of teens themselves, contrasting it with the perspective of medical providers, to demonstrate the importance of the voices of those impacted in developing programs and policies that respect reproductive autonomy.

**Norplant: A Case Study in LARC and Reproductive Coercion**

In December 1990, the FDA approved Norplant, a novel contraceptive that consisted of six rods that were implanted under the skin of the arm that released a low dose of progestin, preventing pregnancy for up to five years. Policy makers and professionals touted Norplant as an amazing option for preventing pregnancy and as an anti-poverty measure (Roberts, 1997). Two days after Norplant’s approval, the *Philadelphia Inquirer* ran an editorial entitled “Poverty and Norplant: Can contraception reduce the underclass?” Donald Kimelman (1990), deputy editorial-page editor, wrote that “the main reason more black children are living in poverty is that people who have the most children are the ones least capable of supporting them.” He also suggested financial incentives for women on welfare to receive Norplant (Kimelman, 1990). A public outcry followed, relating this to histories of reproductive coercion, and the *Philadelphia Inquirer* published an apology (Roberts, 1997); however, others came to the newspaper’s defense. Marion Barry, the mayor of DC, notably a Black man, stated: “you can have as many babies as you want, but when you start asking the government to take care of them, the government now ought to have some control over you” (“Reflections of Marion Barry,” 1994).

Barry’s statement that if a person receives government benefits they are thus at the will of government control is fallacious and illogical. It harkens back to the creation of welfare in the New Deal. Social security was created as an entitlement program,
whereas welfare was created with a great deal of scrutiny built-in for young women, as described in Chapter 1. If Barry truly believed that receiving government benefits entitled the government to control you, he also should have scrutinized the behaviors of seniors receiving social security. Yet there is something unique about young women’s bodies and lives that open them to scrutiny and control. Barry’s statement is harsh and explicit in suggesting government control women’s bodies. Yet the foundations of his ideology are echoed in policies and practices: that young women receiving support from the same government that has disenfranchised them and their ancestors is a problem to be targeted, at times through coercive means.

All states made Norplant available to women on Medicaid for free, and over the next two years 25 different measures were proposed in 13 different states to implant poor women with Norplant (Gill, 1994, p.45). In 1991, Kansas state representatives proposed legislation that would grant welfare recipients $500 for using Norplant, giving a $50 bonus each year it stayed implanted, suggesting that this had “the potential to save the taxpayers millions of their hard-earned dollars” by reducing the number of women on welfare rolls (cited in Roberts, 1997, p.109). David Duke, Ku Klux Klan leader and Louisiana state representative (and supporter of Donald Trump), proposed paying women on welfare $100 per year to use Norplant (Gill, 1994, p.45). A North Carolina bill would have required that all women getting an abortion be implanted with Norplant unless it was deemed medically unsafe (Gill, 1994, p.45).

Norplant was not only directed towards women on welfare, but also specifically to teens. In a promotional video for Norplant, a Black teenager testified: “A lot of teenagers need Norplant. I’m about the only girl in my neighborhood who doesn’t have
kids… they need to get some [Norplant] so they can have fun and enjoy life while they be young” (cited in Roberts, 1997, p.113). In December 1992, Baltimore initiated a program to encourage inner-city girls to use Norplant, encouraging young women to get Norplant through aggressive programs in schools, clinics, and hospitals (Roberts, 1997, p.115).

Many Black leaders and others protested this city program as a form of reproductive control. A group of ministers representing over 200 Baltimore churches stated that the program “push[ed] the issue of social control of an ethnic minority by the majority population whose culture and values may be different.” (cited in Roberts, 1997, p.114). Members of the Nation of Islam packed a Baltimore City Council Meeting, cheering as a representative of Louis Farrakhan exclaimed “I'm not going to sit by and let my sisters and my children be destroyed by Norplant” (Valentine, 1993).

Others defended the program, including Joycelyn Elders, previously-ousted (Black) surgeon general: “Black people don’t want their children born to children… they do not want them growing up poor, ignorant slaves. And whoever goes around talking about genocide is someone who likes to see people in slavery” (Roberts, 1997, p.115).

Elders was known for taking controversial progressive stances, including promoting the legalization of drugs, comprehensive sexual health education, and contraception and abortion access (Stange, Oyster, & Sloan, 2013). However, in calling Black children of teens “poor, ignorant slaves,” Elders exposed the limits of her progressive stances in the face of racist eugenics-era ideologies. This limitation exists today as health care providers attempt to provide quality contraceptive care to teens, often without recognizing the coerciveness of their practices.
Today, the medical community considers LARCs a panacea for teenage pregnancy. The American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the Centers for Disease Control and Prevention (CDC) all recommend LARCs as first-line therapy (The American College of Obstetricians and Gynecologists, 2012; Committee on Adolescence, 2014; Centers for Disease Control and Prevention, 2014). The CDC and the AAP have both recommended a “tiered effectiveness” model of birth control counseling for teen patients, in which LARCs are offered before other methods of birth control (CDC, 2014, AAP, 2014).

Previously, IUDs had been offered only to women who had already given birth, as they were easier to place in the postpartum uterus due to a more elastic cervix (The American College of Obstetricians and Gynecologists, 2012). Additionally, IUDs were considered risky for young women at higher risk of contracting sexually transmitted infections, as the IUD strings which sit in the vagina were thought to carry disease up into the uterus with potentially worse outcomes (The American College of Obstetricians and Gynecologists, 2012). However, newer IUDs are easier to insert and studies have shown no increased risk of STI complications (The American College of Obstetricians and Gynecologists, 2012).

Some of the programs that have been touted as most successful are already engaging in troubling coercive rhetoric. For example, the Colorado Family Planning Initiative program provided over 30,000 low or no cost LARCs to low-income Colorado women between 2009 and 2014, and was considered a success for reducing teen birth rates by 40% during this time (Draper, 2014). Colorado Governor John Hickenlooper
boasted that the LARC initiative had reduced the infant caseload of the state’s WIC [women, infants, children] program by 23% (Hickenlooper, 2014). Both statistics beg the question of correlation versus causation; there could have been many other factors impacting teen birth rates and WIC numbers.

Another program, the Contraceptive CHOICE Project in St. Louis, studied the impact of free LARCs on unintended pregnancy rates in St. Louis. In their analysis, the authors addressed a number of concerns regarding LARCs, including adolescent discontinue rates, increased risk of sexually transmitted infections (STIs), and increased risk of risky sexual behaviors (McNicholas, 2014). However, the researchers did not address LARC removal or concerns for coercion. Additionally, they describe their recruitment strategy as seeking “women at the highest risk for unintended pregnancy…” particularly women “of less than 25, minority racial or ethnic background, and low socioeconomic status (SES)” (McNicholas, 2014, p.637). In targeting marginalized young women yet not addressing potential for reproductive coercion, the researchers missed an opportunity to provide justice-centered care.

The decrease in infant and child poverty rates boasted by LARC programs is unarguably a positive outcome. Yet the question needs to be asked whether this comes at the cost of compromising the reproductive autonomy of young Black and Latina women. Multiple studies have demonstrated that clinicians engage in contraceptive counseling techniques that encroach on reproductive autonomy. One questionnaire-based study in Los Angeles found that “low income Latinas and African American women had greater odds of being advised by health care providers to restrict their childbearing than did middle-class White women” (Downing, 2007, p.1806). A study by Dehlendorf et al.
(2010) examined race/ethnicity and socioeconomic status specifically in reference to IUDs. Researchers showed health care providers standardized videos of patients of differing backgrounds, then asked the providers for their contraceptive recommendation (Dehlendorf, 2010). They found that providers are more likely to recommend IUC [intrauterine contraception] to Black and Latina women than to White women (Dehlendorf, 2010, p. 4). This finding implies unconscious bias on the part of providers, or possibly a conscious belief that race and ethnicity should play a role in contraceptive counseling.

What makes LARCs so unique and effective relative to other forms of contraception is that once the device is inserted, the patient does not need to take any additional action to prevent pregnancy. This is often referred to as “user-independent contraception” (McNicholas, 2014). It is possible that health care providers suggest this contraceptive most to those who they trust the least. This practice has medical validity if a patient has demonstrated difficulty adhering to a daily medication regimen or articulates a desire to have contraception they do not have to think about. However, if providers are making these assumptions based on race, ethnicity, or socioeconomic status, they are then acting out of prejudice in caring for patients.

The flip side of the benefit of lack of patient involvement after insertion is physician control. What happens when a teen decides they want the device removed? LARCs prevent pregnancy. A teen who requests an IUD at age 15 may want to be pregnant at age 21, or 19.
Barriers to LARC Removal as Coercive Inaction

Not only do patients experience coercive practices in recommending LARCs, but providers also encroach on reproductive autonomy by refusing to remove LARC devices. During the Norplant era, the phenomenon of reluctant removal was documented in teens describing coercion and providers admitting to these practices. One teen, as cited by Roberts (1997), stated:

I’m going through all these changes and I’m trying to have it [Norplant] removed... then they tell me that it’s not putting me in bed, as if they know how I feel on the inside of my body… I feel like because I’m a social service mother that’s what’s keeping me from getting this Norplant out of me… I’ve known other people that has the Norplant that spent money to have it put in and spent money to have it put out with no problems... that’s how they make me feel, like “you got this Norplant you keep it. ” (p. 104)

This teen expressed the sentiment that underlies Norplant-related policies: that mothers receiving government benefits should be required to have physician-controlled contraception. Her concern for side effects was not taken seriously, and she was forced to continue to have a device in her body that she no longer desired.

Workers in a publicly funded clinic in Los Angeles admitted to feeling reluctant to remove Norplant due to costs: “we don’t want her to have it out after spending all that money,” explained a clinic worker at Planned Parenthood in Pasadena (Roberts, 1998, p. 133). An Oklahoma physician’s directive stated:

…it is not the intent of the department [of health] to cover removal of the Norplant system prior to the expiration of five years unless there is documented medical necessity. Payment is not intended to be made for the removal of the contraceptive for the convenience of the patient, minor menstrual irregularities, or for the purpose of conception. (cited in Roberts, 1998, p.131)
This physician explicitly stated that the intent of the Department of Health was contraception at the cost of reproductive autonomy. This unwillingness to remove a device even in the case of a patient wanting to conceive is coercive behavior.

While at times providers may appropriately encourage patients to continue to try a medication in the hopes that the side effects will subside, requiring a patient to continue a contraceptive that they have no control over is reproductive coercion. The fact that publicly funded clinics were those that felt this pressure only exacerbates racial and socioeconomic disparities in reproductive autonomy. The success of this device relied at least partly on providers forcing women to keep LARC devices against their will. The same trends exist today in the era of the implants and IUDs. Kavanaugh et al. (2013) examined providers’ perspectives on adolescents and LARCs, finding the same provider bias in reticence to remove an IUD from a young person: “if she takes it out in three months I’m crying. Even if the insurance company is paying for it that is a waste of a lot of money and provider time” (p.91).

While some providers openly admit to feeling reticence towards removing LARCs in adolescents, others unintentionally treat adolescents differently than older patients. Even providers who are dedicated to social justice and reproductive rights display unconscious bias in LARC removal practices. At a panel on reproductive care for marginalized communities at the Family Medicine Education Consortium in October 2015, one faculty member shared research findings that residents in an urban, social justice-oriented program were less likely to remove LARCs in adolescents than older patients on first request (Prine, Wang, McLendon, Baird & Ravi, 2015). Even in a program focused on reproductive justice, the residents had internalized that teens’
requests should be taken less seriously than those of older patients. Multiple studies have found that teens request LARC removal on average at similar rates and timing as older patients (McNicholas, 2014, p.640; Kavanaugh et al., 2013, p.93). These research findings demonstrate the unconscious bias that drives clinical practices of some health care providers.

ACOG, in their statement regarding adolescents and LARCs, asserts that “like all women seeking reproductive health services, adolescents have the right to decline the use of LARC as well as the right to discontinue LARC without barriers (ACOG, 2015, p.2). The Affordable Care Act requires insurers to cover all contraceptive methods approved by the food and drug administration without cost sharing, including LARC methods and the services necessary to support their use (National Women’s Law Center (NWLC), 2013, p.5), But because removal of an IUD or implant occurs at a different time from placement and is thus billed separately, women who lack or have inconsistent health insurance coverage may still face financial barriers to removal (Gomez, Fuentes, & Allina, 2014, p.172). Additionally, some insurance companies have refused to cover LARC-associated services despite the ACA mandate (NWLC, 2013). In response, the National Women’s Law Center released a toolkit in 2013, providing tools for patients and providers to advocate for coverage, as required by law (NWLC, 2013).

Some programs offer free LARC removal in addition to insertion, but not all do. Even if a program provides free LARC removal and is willing to remove a LARC upon first request, a teen might move away from that particular program, or the program’s funding might end before the teen gets their LARC removed. Considering the instability of reproductive health services in this country and the impending defunding of
reproductive health programs, it is likely that teens who have been implanted with reproductive devices may have no option for safe removal of their LARCs.

Additionally, those most affected by LARC removal issues are those who are already marginalized. Poor teens and teens of color are most at risk of having unstable insurance coverage as they turn 18 and no longer qualify for children’s health insurance programs. They may also feel less confident advocating for themselves in medical settings, particularly when providers tell them their costs are not covered. Lastly, marginalized teens may be less likely to have the time and ability to advocate for themselves in the face of insurance companies. Medical providers act neglectfully in inserting LARCs into teens without considering their options for removal.

*Overcoming Clinician Bias By Considering the Voices of Teens*

One fallacy in the discussion of teen pregnancy is the exclusion of the voices of those most implicated: teens themselves. Numerous studies have examined rates of teen pregnancy and outcomes of teen pregnancy, and have scrutinized the lives and decisions of young women (frequently young women of color). These studies operate under a number of assumptions that fail to recognize the realities of teens in different communities. Few have tried to understand why teens have children, preferring instead to attribute teen pregnancy to lack of access to contraception, lack of education, and sexual promiscuity. Those who have spoken to teens have found that pregnancy planning does not look the same in all communities, and that teens may choose to have children for many reasons.

The first assumption that underlies much of the research and guidelines regarding teen pregnancy is the dichotomy of unintended versus intended pregnancies. This
paradigm expects that all women “map out their intentions regarding whether and when to conceive, and… formulate specific plans to follow through on their intentions” (Aiken, 2016, p.147). Yet when researchers interviewed women regarding pregnancy intention, they found that pregnancy intention is better understood as a continuum, with multiple factors at play (Bachrach, 1999, p. 252). Women’s answers as to whether a pregnancy was “unintended” or not changed throughout a pregnancy and afterward (Bachrach, 1999). Bachrach et al. (1999) differentiated between “wanting” and “planning” a pregnancy, finding that “the idea of planning a pregnancy does not fit into the way some individuals see their lives” (p.252). The current paradigm erases the common occurrence of ambivalence, indifference, or changing desires regarding pregnancy.

This misconceived understanding of pregnancy intention and planning stems partially from internalized cultural norms. The professional class of clinicians, public health professionals, and social workers who develop programs to counter the presumed social disease of teenage pregnancy disproportionately grew up in White affluent or middle class communities (Castillo-Page, 2010). This group, myself included, were taught that having a child as a teenager is an antisocial act: that this will lead to loss of opportunity, social exclusion, and shame. This message is rooted in the reality of White, affluent or middle-class communities.

Youth in these communities grow up with a different set of expectations than youth growing up in poverty. Because they have access to more resources like high quality education (including advanced education), health care, and more career opportunities, they are encouraged to wait to have children until they are able to support them independently of their families (Zabin, 1994). Cultural norms in White, affluent
communities often expect young people to develop financial independence before starting a family, and social structures exist to support and encourage this (Zabin, 1994).

Adolescents living in marginalized communities grow up under different circumstances. Zabin (1994) describes the realities upon which poor adolescents base their choices:

First, that they have rarely seen a high-school graduate with a decent steady, paying job. Second, that men play no supportive role, financial or emotional, in the home. Third, that young women, as their mothers before them, have babies during their teens and drop out of school, and are no worse off at 30 than those who did not—women who live where they live and are visible to them. Fourth, that life is dangerous and often short, and delayed gratification an oxymoron. Fifth, that they have dreams of where they want to go and what they want to be, but little expectation that they will get there. And sixth, that no one seems to care much about whether they do. (p.96)

Zabin’s description offers a simplified and homogenous view of high poverty communities, but the picture she paints explains why the decision to have children early can be rational and smart under certain social circumstances.

Recent studies that have considered the voices of teens who become pregnant found that “a more positive orientation towards early motherhood was found among those with lower levels of maternal education or Black or Hispanic race/ethnicity, and these positive attitudes, in turn, were associated with teenage pregnancy” (Dehlendorf, Rodriguez, Levy, Borroto & Steinauer, 2010, p.5). This positive orientation in communities of color correlates with the norm, with the realities these teens experience, as described above.

Fertility timing can look different in two neighboring communities, yet be adaptive in both. Levine et al. (2001) describe “universal imperatives” in conceptualizing how
different cultures may differ in fertility timing norms. Universal imperatives develop in communities to promote economic security and health reproduction (Levine et al., 2001). Over time, they become cultural traditions that are passed down by generations and become “tested commonsense formulas that embody a folk wisdom greater than the parents can conceive or explain but which reduces or prevents their anxiety” (cited in Geronimus, 2004, p.884). Universal imperatives need not be based in a truth, but are nevertheless self-perpetuating, particularly in communities that hold social power.

Adults in these groups of power promulgate the conception of teenage pregnancy as an antisocial act through the means available to them: the media, advocacy organizations, legislation, public school curriculum, scientific research funding, and publishing. They are thus able to project certain cultural values as normative and, working from a set of assumptions that teenage pregnancy is maladaptive, develop studies that provide “scientific” backing for their universal imperatives. In high poverty communities of color next door, different realities lead to different norms that are dissonant with the moralistic imperatives of the dominant communities, confounding their “scientific” justifications and complicating their narratives.

However, before 1950, teen childbearing was a cultural norm across communities (Geronimus, 2004). When life expectancies lengthened in dominant communities and women in these communities gained educational and career opportunities, teen childbearing became less adaptive and thus less favored (Luker, 1996). Women in marginalized groups did not experience the same growth in opportunity, and thus the cultural norm of teen childbearing did not shift in the same way (Luker, 1996).
Most physicians grew up in dominant communities (Castillo-Page, 2010) and were thus socialized to believe that teenage childbearing has grave consequences before attending medical school and considering inconclusive socio-medical evidence to support this claim. Teenage childbearing as a societal disease is a deeply ingrained cultural truth for most professionals, and we operate from that understanding. Yet as clinicians it is our responsibility to treat our patients in a way that is culturally relevant to them and based in their reality, not our norms and biases.

A Justice-Informed Approach to Providing LARCs

To provide informed, respectful care to teens in marginalized communities, there are some concrete ways in which clinicians can adapt their practices. First, clinicians can engage in what is already a tenet of care: providing quality counseling on contraceptive options for teens. Second, clinicians can offer removal to teens regardless of ability to pay, and facilitate self-removal if need be. Lastly, but ultimately foundationally, clinicians must recognize their own unconscious bias toward teens of color to provide reproductive care rooted in justice.

Contraceptive Counselling for Marginalized Teens

As described above, many teens have described feeling pressure from medical providers to receive a LARC. While LARCs are the most effective contraceptive option, there are many reasons why a person may not want a LARC. These include pain of the insertion procedure, side effects, and requiring a physician for removal. Some believe that the tiered counseling approaches recommended by the CDC and ACOG are coercive in offering LARCs before other methods (Gomez, Fuentes, & Allina, 2014; Higgins, 2014). Others argue that offering all contraceptive options may overwhelm patients, and
that as medical professionals we hold a responsibility to provide guidance, particularly in the case of teens (ACOG, 2012; CDC, 2014). Some studies have actually found that teens prefer more directive approaches to contraceptive counseling (Moskowitz and Jennings, 1996a; Brown, Auerswald, Eyre, Deardorff, & Dehlendorf, 2013).

In all areas of medicine, clinicians use their judgment to offer diagnostic and treatment options to patients based on medical knowledge, practice guidelines, and an understanding of a patient’s preferences and values. A patient with high blood pressure will be offered the first line medications to treat high blood pressure, with consideration for the medical history of the patient and side effect profiles of different medicines. This basic paradigm applies in adolescent health care as well.

Reproductive health care, however, requires even greater concern for a patient's values and preferences than traditional medical treatment like blood pressure control. Reproduction and fertility hold greater cultural and social weight, and the risks of coercion are therefore also greater. In caring for patients from communities that have historically endured (and currently endure) mistreatment by the medical community in reproductive care, health care providers owe teens thoughtful and conscientious contraceptive counseling.

Quality contraceptive counseling thus entails a patient conversation that includes eliciting the teen’s priorities regarding contraception, education, and compassion in listening to their concerns. Only after considering the teen’s individual circumstances can a clinician offer a teen the “best” contraceptive option or options, including a full discussion of risks and benefits. Some clinicians may find that LARCs are frequently the
best option for their patient population, but all should recognize that LARCs are not a “one size fits all” solution.

**Compassionate LARC Removal**

LARC removal is another area in which health care providers can adapt practice to be more considerate of histories of reproductive coercion in communities of color. Even with the Affordable Care Act, reproductive health care access is not a guarantee, particularly for women of color (NWLC, 2014). In today’s political climate, reproductive health care access is worsening as the President and Congress enact laws reducing funding for contraceptive care (Hellman, 2017). Thus, in discussing LARC insertion with patients, clinicians must consider their removal.

Important points of conversation include when a patient foresees wanting to restore fertility, when they foresee their insurance status changing, if they are likely to return to the same clinic for removal, and if they plan to move in the near future. Given the long term coverage that LARCs offer, it is likely that a person may not know or misestimate when they would like to remove their LARC, or where they will be located at this time. Teens may have a greater challenge estimating these answers, as their lives may be in flux when they finish school, start working or school, or leave their parents’ home.

Considering that not all teens who receive a LARC will have the ability to pay for removal, I suggest that to truly respect reproductive autonomy, we as clinicians who implant LARC must offer free removal to all patients who cannot afford LARC removal. It is our responsibility to not only find funds to facilitate LARC insertion but also to respect the needs of our patients in offering free removal. The removal procedure is much
less costly than insertion as it requires fewer tools, less time, and the device itself is not a cost. Clinicians can also learn about local health centers that offer free LARC removal to those who cannot afford it and refer patients to these locations. We can also advocate among other providers to provide this service for free, and let patients know when they get their IUD inserted that they should be able to get it removed for free at these locations.

*Facilitating Self-Removal*

In an ideal world, all patients would have access to a health care provider to remove their LARC when they desire for free. However, in the United States, where many do not have adequate health care access and health care policy is moving toward reducing access to reproductive health care, many patients do not have access to a health care provider. Knowing this reality, providers have considered the potential for self-removal of IUDs.

At the Family Medicine Education Consortium conference forum on Reproductive Health care for Marginalized Populations in 2015, Dr. Sara Baird, a provider of reproductive care for women at Rikers Island, spoke about the challenges of women re-integrating into the health care system after leaving prison (Prine et al., 2015). She noted that in her practice they taught self-removal to their patients to ameliorate lack of health care access post-incarceration (Prine et al., 2015). Many teens receiving LARCs through LARC programs in marginalized communities likely face similar barriers to care and may benefit from learning self-removal techniques.

Foster et al. (2014) studied IUD self removal, finding that “African American women had four times greater odds of reporting that the feature of self-removability
makes them more likely to recommend the IUD to a friend” (p.58). Providers are likely uncomfortable with advertising IUDs as a self-removal device, but in special populations it may be worth discussing with patients to ensure their reproductive autonomy.

Additionally, Foster et al. (2014) found significantly higher success rates of IUD self removal with longer IUD strings (longer than 7 cm), and that having felt one’s own IUD threads made a person more comfortable with self removal. With this information, clinicians can offer patients to clip the strings longer than 7 cm and allow them to feel the strings in the office if they would like after the device has been implanted.

Discussion of self-removal and clipping of strings longer can facilitate safer removal if the patient so desires. Of note, this is not safe with Nexplanon as the implant is healed under the skin, often with scar tissue surrounding it that clinicians may have to gently cut away at in removing. Self-removal of Nexplanon would require patients to cut themselves and would come with high risk of infection, damage to local tissues, and scarring.

*Recognizing Unconscious Bias to Improve Care*

Clinicians have noted that teens tend to want their LARCs out more often and earlier than other patients (Prine et al., 2015). If clinicians are following guidelines and recommending LARCs to teens, more teens will receive LARCs, and thus more teens will also need their LARCs removed. Clinicians may anecdotally notice higher *numbers* of teens requesting LARC removal, and mentally extrapolate this to indicate higher rates of LARC removal requests in teens. Additionally, in encouraging teens to get LARCs more persuasively than other patients, clinicians risk engendering increased dissatisfaction and uncertainty among teens, which is likely to lead to increased requests
for LARC removal. This is yet another reason to provide high quality contraceptive counseling as discussed above.

Fortunately, multiple studies have demonstrated equivalent removal rates among teens and older adults (McNicholas, 2014, p.640; Kavanaugh, 2013, p.93). So why do clinicians’ intuitions contradict the evidence, and why are clinicians less likely to remove a teen’s LARC on first request than that of an older adult (Prine et al., 2015).

Researchers have not yet answered why clinicians misperceive teens in this way, yet there are a number of possible reasons. One of these reasons may be an unconscious bias clinicians have towards adolescents, and adolescents of color. Clinicians may have internalized ideas that young people, and people of color, are less reliable and less able to make decisions for themselves.

In medicine, we must recognize our responsibility to recognize our unconscious biases and work against them to provide quality, justice-based care. One, albeit limited, way of reducing bias is to rely on evidence as a more objective measure. One way clinicians can actively work against this unconscious bias is to track LARC insertion and removal in their own practice and evaluate the rate at which they are removing teens’ LARCs versus those of others. This data may be valuable to clinicians to evaluate objective trends, but also to evaluate their own decision-making in how they decide whether or not to remove a LARC, and who is at the center of this conversation.

When a patient comes to the office requesting their LARC removed, the clinician is in a position of great power over the patient. It is our responsibility to take great care to respect the autonomy of this patient and to not let our biases regarding LARCs, teens, and people of color inform harmful practices.
An Urban Bioethics Analysis

As clinicians in 2017, we have been steeped in both medical and social education that deems teenage pregnancy to be a problem for our patients and for society at large. However, when we examine the foundations of this so-called epidemic, we find them to be based in racist ideologies without scientific basis. While becoming pregnant may worsen outcomes for some of our patients, the evidence has failed to demonstrate that pregnancy in adolescence is necessarily worse for a teen, nor children of teens. Alternatively, some research has shown teenage childbearing to be beneficial to teens in certain social circumstances. Regardless, we know that teens from already-marginalized communities--often high poverty, Black and Latina/o communities--are more likely to become pregnant than those from more advantaged communities, and that these teens are not lifted out of poverty due to not becoming pregnant as a teen. Teens are not offered better education and job opportunities simply because they are not parents.

When politicians, news outlets, and medical professionals celebrate reductions in rates of teen pregnancy and link this to lower rates of children receiving government assistance, they imply that by choosing not to have children at a young age, teens themselves are reducing poverty rates. This puts the onus on young teens of color to reduce poverty, perpetuating problematic ideologies. If these young people of color can reduce poverty rates by not having children, they then are a cause of poverty when they have children as teens. This analysis overlooks the systems and policies that create and maintain a highly disparate society in favor of targeting individuals. This is a convenient
analysis for those who do not want to change these systems, who are also those who are in power and controlling the media, health care systems, insurance companies, and legislators.

If our understanding of poverty focuses on individuals, so do our solutions. As clinicians, programs that target teen reproduction are within our scope of practice. We know how to change practice guidelines to include teens in the populations that are appropriate to receive LARCs, and we can even go so far as to create guidelines that encourage tiered-effectiveness counseling in which LARCs are offered before other contraceptives. We can find government and grant funding to provide these services at low or no cost to teens in communities with high rates of pregnancy, most often urban communities of color.

At face value, offering effective contraception to teens who do not desire to become pregnant is respectful of their reproductive autonomy and well-intended medical practice. However, if we consider histories of reproductive coercion among the same populations we’re targeting with LARC programs, we can see how this can cause harm to individual patients and further distrust of the medical system in communities of color.

Firstly, we may be harming teens in our offices by pressuring them into receiving contraceptives they do not actually want. We may encroach on the reproductive autonomy of teen patients if we only offer them a contraceptive option that does not match their desires. We may cause trauma to our patients if we insert a device that they do not want to have or remove their control over their fertility if that is one of their concerns that is not alleviated. Additionally, as clinicians caring for teens we must realize that the interactions this teen has with us may impact the way a teen interacts with the
healthcare system for years to come. Teens who have negative experiences with healthcare professionals will be less likely to present for preventive health care visits and be more likely to present to health care with conditions that have progressed unnecessarily.

Not only can we cause harm to our individual patients, but we can also cause harm to communities and to our profession itself. We are already aware that our profession has wronged people of color in recent history and continues to do so with racial disparities in health care access and services. As providers dedicated to quality health care for all patients regardless of race or ethnicity, we can choose whether to be a part of a damaging history of reproductive coercion in communities of color, or we can choose to actively work to undo the impact of this history (and arguably present). To reverse this effect of mistrust of the health care system, we can start by building alliances with our patients of color. To provide great health care, we need our patients to trust us, and we need to trust our patients. We have a responsibility to ourselves and to the future of medicine--if we truly want to provide high quality care, we need to think in the larger scope of how we can ensure that our patients view the health care system as a system that does not exist to trample their autonomy, patronize them, and control their fertility.

The fact that teens cannot always evaluate risk/benefit ratios in the ways that adults can does not mean that they don’t deserve the ability to make decisions about their own reproduction. This does not indicate that a physician--likely a physician with an entirely different background, set of values, and reality from this teen—should determine their reproductive status. Considering the profound history of reproductive coercion that still haunts communities of color in the United States and abroad, we have a special
responsibility as medical professionals complicit in this history to take special care to honor reproductive autonomy, even if we are uncomfortable with our patients’ decisions.

With the election of Donald Trump in November 2016, many women feared that they would lose their contraceptive coverage, and were compelled to get IUDs. Physicians in some areas reported increased IUD insertion requests. The fears of these women are likely to be realized: the 115th congress has already moved towards repealing the Affordable Care Act, which would reduce contraceptive benefits for many women. The President has put forth an Executive Order encouraging Congress to disassemble the Affordable Care Act as much as possible, as well as defund Title X contraception services. Multiple state legislatures have passed anti-abortion bills, further restricting reproductive choice. In this political climate, we are more compelled as providers to act conscientiously in providing contraception to teens, knowing that their future coverage is highly uncertain. It is our responsibility to discuss LARC removal and consider how to ensure that an increase in LARC insertion right now does not mean many women with unwanted LARCs in the future.

As clinicians caring for teens who are already marginalized and are likely to be most affected by regressive policies targeting education, immigration, and healthcare, we are compelled to build alliances with our patients. Now is the time to come together to improve the health and wellbeing of our patients and communities. It is the time for us to use positions of social and political power not just to care for our patients using a reproductive justice approach, but also to fight for reproductive and social justice for all.
REFERENCES CITED


National Research Council (U.S.) Committee on Human Reproduction. (1953). *Pregnancy wastage; proceedings of a conference sponsored by the committee on human reproduction, national research council, in behalf of the national committee on maternal health, inc.* United States:

National Women’s Law Center (2013). *Getting the coverage you deserve: What to do if you are charged a co-payment, deductible, or co-insurance for a preventive service.* Retrieved from https://nwlc.org/resources/getting-coverage-you-deserve-what-do-if-you-are-charged-co-payment-deductible-or-co-insurance-preventive-service/


Success with teen pregnancy rate, but there is more work left to do. (2016). Contraceptive Technology Update, 37(7), 73.


