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Under what conditions is it ethical to offer incentives to encourage drug-using women to use long-acting forms of contraception?

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ABSTRACT

Aims To stimulate debate by examining ethical issues raised by Project Prevention, a US-based organization that offers $US300 to addicted individuals who agree to either undergo surgical sterilization or use long-acting forms of contraception. **Method** An analysis of key ethical questions raised by Project Prevention. **Results** The important issues for debate are: (i) what are the reproductive rights of drug-using women; (ii) does a substantial cash incentive undermine the ability of addicted women to make free and informed decisions about long-term contraception; and (iii) how can we best assist addicted women to access good reproductive health care and obtain treatment for their addiction? **Conclusions** We need more research on ways in which small non-cash incentives for reversible methods of contraception could be used in a morally acceptable and effective way to promote the sexual, reproductive and general health of addicted women.

Keywords Coercion, contraception, drug treatment, informed consent, reproductive health, reproductive rights, substance abuse.

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Project Prevention is a US-based organization that aims to reduce the number of infants who are exposed to illicit drugs by providing $US300 to addicted individuals who agree to undergo surgical sterilization or to use long-acting forms of contraception. According to the organization's website, 3600 addicted clients have been paid to: undergo tubal ligation (permanent sterilization for women; 1319 procedures), receive Depo-Provera (an injectible contraceptive lasting 3 months; 1059 procedures), insert intrauterine devices (IUD, lasting up to 5 years; 963 procedures), use Implanon or Norplant (contraceptive implant lasting up to 3 years; 167 and 38, respectively) and undergo a vasectomy (permanent sterilization for men; 54 procedures) [1]. Project Prevention is not a medical service and does not supply the contraceptives or perform the sterilizations directly. Rather, individuals, most often women, access contraceptive procedures through other medical services and then obtain payment from Project Prevention.

Project Prevention has been criticized for its eugenicist language, for targeting poor women from minority groups, for violating the reproductive rights of addicted individuals, for offering a large cash incentive and for portraying attempts to treat addiction as futile [2–10]. It has been argued that the cash incentives offered by Project Prevention are legally and morally unacceptable because they undermine individual freedom and autonomy and invalidate consent [11,12]. Project Prevention has expanded recently into the United Kingdom [13] and Africa [14] and is planning to expand into Australia [15].

In this paper we examine three questions that are raised by using financial incentives to encourage addicted women to use long-acting contraceptives: (i) what are the reproductive rights of drug-using women; (ii) does a substantial cash incentive undermine the ability of addicted women to make free and informed decisions about long-term contraception; and (iii) how can we best assist

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addicted women to access good reproductive health care and treatment for their addiction? We focus on addicted women because they have taken up these programmes at a higher rate than addicted men. We examine these questions using the widely recognized ethical principles of autonomy, non-maleficence, beneficence and distributive justice [16].

WHAT ARE THE REPRODUCTIVE RIGHTS OF DRUG-USING WOMEN?

Unintended pregnancies are common among drug-using women [17,18]. In the United States almost 50% of all pregnancies are unplanned; almost half of these end in abortion [19] and more than half occur in women who are using contraception [19,20]. Given the overall high rate of unplanned pregnancy, it is not surprising that socially disadvantaged and addicted women have higher rates of unplanned pregnancies [21]. Approximately 90% of women who abuse substances are of reproductive age [22]. In the 2009 US National Survey on Drug Use and Health [23] 4.5% of pregnant women reported using illicit drugs in the past month, 10% reported alcohol use and 15.3% reported smoking cigarettes. Claims are sometimes made that maternal drug use directly harms the fetus without good evidence [24]. None the less, drug use in pregnancy and the associated social disadvantage can have potentially serious adverse effects on the mother, the fetus and developing child [25,26]. Low to moderate maternal smoking, drinking and heavy cannabis use may contribute to neurobehavioural and cognitive deficits in offspring [27,28].

In these studies it is difficult to disentangle the reproductive harms arising from illicit drug use in pregnancy from those attributable to maternal tobacco and alcohol use, violence, poverty and environmental risks [29]. Many addicted women want to provide the best care that they can for their children [30,31], while struggling to overcome their addiction [32]. Children of addicted women are at significant risk for biological, developmental and behavioural problems even if we cannot attribute these outcomes confidently to different types of drug use, poor nutrition, poverty, social disadvantage and lack of access to antenatal care [33].

It is interesting to contrast discussions of the reproductive risks of addicted women with those of another vulnerable group; namely, adolescents. Unintended pregnancies among adolescents are common [34] and adversely affect maternal and child health outcomes. Children born to adolescent mothers are more likely to have low birth weight and to be physically neglected and abused [35]. Attempts to reduce the rate of unplanned pregnancy among adolescents have not, however, attracted the same criticisms as efforts to do so in addicted women. It is accepted that adolescents often become pregnant because of unsafe sexual behaviour and it is considered ethical to intervene to reduce the number of such pregnancies.

Efforts to encourage contraception among drug users could be viewed as a responsible attempt to improve public health provided that they respect the rights of addicted individuals. Ideally, women planning a pregnancy should have access to good preconception care [36,37]. Assisting drug-using women to prepare for pregnancy and avoid unplanned pregnancy is important for the health of both mothers and babies. We need more research about how best to help drug-using women plan for, or avoid, pregnancy, if that is what they wish. This approach would enhance the autonomy of addicted women in their reproductive decision-making.

A core idea in public health ethics is to use cost-effective ways of removing potential health problems before they cause significant harm [38]. Public health interventions can become ethically problematic when motivated by the needs of people other than the recipients of the intervention [39]. The intervention may not be wanted, or in fact be harmful to the recipients, thus breaching individual liberty and violating respect for their autonomy. The ethical standards of beneficence and non-maleficence require that drug-using women who become pregnant should be provided with appropriate care and support during and after the pregnancy and assisted to manage their drug use. It is ethically unacceptable to provide inadequate care because the woman has a stigmatized condition such as an addiction.

Reproductive health services for substance users also need to address sexually transmitted infections (STIs). Substance-using women report low rates of condom use and high rates of partner change [40,41], which places them at high risk of sexually transmissible infections. Long-acting contraception does not appear to increase the rate of STIs among human immunodeficiency virus (HIV)-infected women [42], although findings are more equivocal in sex workers [43]. The provision of contraceptives is an ideal opportunity to provide advice about the prevention of STIs.

Reproductive rights include access to information and education, reproductive health and health care, including access to contraception and abortion in order to enable women to decide on the number, timing and spacing of their children. Providing women with access to reversible forms of contraception enhances their autonomy and minimizes potential adverse health outcomes for women and their children while still acknowledging that drug-using women may want to have children [32].

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DOES A SUBSTANTIAL CASH INCENTIVE UNDERMINE THE ABILITY OF ADDICTED WOMEN TO MAKE FREE AND INFORMED DECISIONS ABOUT LONG-TERM CONTRACEPTION?

The offer of a substantial incentive may undermine the ability of addicted individuals to provide informed and autonomous consent [44]. If the payment is provided in cash, recipients are free to spend the money as they choose, including to purchase drugs. We address three questions raised by this use of financial incentives: (i) are financial incentives ever acceptable motivators for changing health behaviour; (ii) is it acceptable to use financial incentives to influence family planning decisions; and (iii) if the answers to the first two questions are affirmative, can guidelines be developed about how to use financial incentives in an ethically acceptable way to encourage addicted women to use long-acting forms of contraception?

Are financial incentives acceptable motivators for changing health behaviour?

Financial incentives are being used increasingly to motivate people to engage in healthier behaviour [45], including, quitting smoking, better managing chronic health conditions, losing weight and eating more healthily [46]. Incentives are designed to capitalize on 'present bias', a tendency for most humans to prefer smaller, more immediate rewards over larger rewards that occur later in time. Personal payments appear to be more effective than information in changing behaviour and they are less restrictive than legislation that compels change or punishes people for failing to act in a healthy way.

Meta-analyses show that making vouchers (that can be exchanged for goods and services) contingent upon evidence of abstinence (e.g. urine tests) reduces drug use in people who are being treated for addiction; these effects increase with the monetary value and proximity of the incentive to the targeted behaviour [47,48]. Financial incentive strategies have been used successfully in the United States to decrease drug use among people in addiction treatment [49]. These results are promising but we need more empirical evidence on the effectiveness of incentives to ensure that this potentially powerful therapeutic tool is used appropriately to encourage and sustain healthy behaviour [45]. From an ethical perspective, incentives should be used in ways that preserve the autonomy of the individual while minimizing the potential for harm and enhancing the potential for benefit [16].

Is it acceptable to use financial incentives to influence family planning decisions?

Incentives have been used in developing countries to increase access to, and use of, reproductive health services. Clients are provided with vouchers to purchase family planning advice, prevention and management of STIs, care for sexual assault and safe abortions. The vouchers (either given free or provided at an affordable price) can be redeemed when using an accredited health service provider. When well implemented, these programmes reduce inequities in access to health services and improve the quality of these services [50]. This evidence suggests that it is possible for financial incentives to be used in acceptable ways to influence family planning decisions.

Can guidelines be developed about the ethical use of financial incentives for addicted women to use long-acting forms of contraception?

What are the risks and benefits of using long-acting forms of contraception?

Use of long-acting contraceptives reduces the risks of an unplanned pregnancy. If surgical sterilization is used, the associated gains must be balanced against the small risks involved in any medical procedure and the very much reduced chance of having children at a later date. Any risks are very small for non-surgical, long-acting forms of contraception and there are a number of benefits [51]. Long-acting methods of contraception allow women to be protected from unwanted pregnancy without needing to remember to take a daily contraceptive pill or use barrier methods, and are also reversible. However, there are also contraindications for all long-acting methods of contraception [52] and women need to have access to good medical advice in choosing the method that is best for them.

Is the incentive large enough to undermine informed decisions about contraception?

An incentive of $US300 is considerably more than any addicted woman would be able to pay to access contraception or sterilization, if they are unable to access a publicly funded programme. It is not a sum that an unskilled, addicted woman could earn readily by legitimate means. Conversely, it is not a large amount in the context of the time and effort required to undergo the contraceptive procedure. An incentive provides undue inducement when it distorts judgement by encouraging people to underestimate the risks and overestimate the benefits of participation [53]. Large payments are problematic if they compromise the validity of a woman's consent. Incentives for reproductive health promotion in other settings have typically been much more modest. For example, a pilot programme in Australia offers $AUD10 for young people to undergo STI testing [46]. The sum of $US300 is large for someone with a low income, and in a research

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study the sum would probably be too high to be acceptable to an ethics committee. The use of lesser incentives may be less ethically objectionable.

Is payment likely to exacerbate existing harms or create additional risks?

Large cash payments could exacerbate harms by enabling participants to purchase larger than usual quantities of their drug of choice; but the same argument also applies to other non-addicted participants who may use a cash incentive for harmful purposes. The argument also applies to paying addicted research participants, a practice that is used widely [44]. If, as Jaffe suggests, medical research ethics provides a useful framework for assessing the ethics of public health interventions [39], then empirical studies have found that incentives of $70 [54] and $100 [55] in cash are not associated with increased drug use. Participants who received cash payments were also more likely to attend follow-up appointments than those who received gift vouchers [54]. Payment in the form of vouchers or goods and services (e.g. food, clothing, health care) may be less likely to exacerbate harm immediately, but they may be worth less than cash and thus be less attractive. They can also be exchanged for cash.

Does a more modest cash incentive necessarily impair an addicted individual's ability to give free and autonomous consent [56]? The answer will be 'yes' for those who believe that addiction is a 'brain disease' that abolishes the capacity for autonomous decisions. A more nuanced view would acknowledge that although an addicted person's capacity to give informed consent can be impaired, steps can be taken to minimize the effects of this impairment and support an addicted person to give informed consent [57]. Thus, an addicted person's decision-making capacity would be impaired if they were intoxicated and in acute withdrawal, but this would not necessarily be true of addicted people who are not in either of these states. Carter & Hall have argued that we should act as if addicted individuals possess decision-making capacity and aim to maximize it by seeking their consent for treatment or research participation in ways that encourage them to make considered decisions [57].

It could be argued, using this analysis, that there are circumstances in which an addicted woman could give informed consent to contraceptive choices when offered financial incentives to do so. These could include, for example: only seeking consent for the procedure after a clinical consultation with an independent health-care provider; giving addicted women time to reflect on their choice (e.g. by requiring a cooling-off period, the usual practice for surgical sterilization); not offering a financial incentive that is large or immediate; offering reversible forms of long-acting contraception instead of surgical procedures; and providing addicted women with adequate independent information about their contraception options. This approach would respect the autonomy of addicted women while increasing their access to methods of contraception.

HOW CAN WE BEST ASSIST ADDICTED WOMEN TO ACCESS REPRODUCTIVE HEALTH CARE AND TREATMENT FOR THEIR ADDICTION?

As we have argued, there are ways in which financial incentives can be used appropriately to encourage healthy behaviour and influence family planning decisions. They can also potentially be used ethically with addicted individuals after adaptation along the lines proposed above. For example, regular, small non-cash incentives could be paid for ongoing use of long-acting reversible contraception. This would be ethically preferable to offering a single large cash payment. With such adjustments, the use of incentives could potentially provide a useful and ethically acceptable way to improve the sexual and reproductive health of addicted individuals [13]. However, it is important to ensure that any incentives are attractive to the recipients and successful in achieving the desired outcomes. Further research is needed about the best way to use incentives to enhance the sexual and reproductive health of addicted women.

An important question for future research is: what are effective and ethical ways of using incentives to improve the reproductive health of all addicted people, both men and women? Reducing the size and the immediacy of the incentives would reduce the possibility that addicted people would be induced to undergo medical procedures that they would not otherwise undergo. Research could evaluate the effects of using smaller and staggered incentives, e.g. for an initial consultation, and for continued use of long-term reversible contraception methods. It may also be ethically preferable to make the initial incentive contingent upon receiving counselling and advice rather than upon agreeing to undergo a contraceptive procedure.

It is important to give greater priority to the use of reversible forms of long-acting contraception and to providing addicted women with adequate information about their options. Different methods will suit different women depending on their age, their tolerance for hormonal methods, whether they have already had children and their future aspirations for children [58]. With the availability of safe and effective long-acting reversible contraceptives, permanent sterilization should not be the first and certainly not the only contraceptive option offered to addicted women.

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CONCLUSION

It is socially and ethically desirable to provide all women, including those with an addiction, with the resources needed to prevent unplanned pregnancies. Financial incentives are becoming increasingly acceptable for encouraging health promotion in general, and there is evidence that they can be used successfully to influence reproductive decision-making. The use of moderate cash or non-cash incentives for reversible forms of contraception could prove to be an ethical and effective approach to promoting sexual and reproductive health and drug treatment among addicted individuals. Further research is needed to examine how incentives could be used in a morally acceptable and effective way to promote the sexual and reproductive health of addicted individuals.

Declarations of interest

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