Long-acting reversible contraception: Targeting those judged to be unfit for parenthood in the United States and the United Kingdom

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Abstract

There is a long history of regarding marginalised groups as unfit to parent and of eugenic policies targeting those with 'undesirable' bodily conditions or behaviours. This is part of a broader pattern of stratified reproduction – structural conditions that enable or discourage certain groups from reproducing – that often brings about and exacerbates injustices. This paper critically assesses the US and UK social and medical literature on applying pressure to marginalised groups, or those who have behaved 'irresponsibly', to use long-acting reversible contraception (LARC). Targeting young people for LARC fails to recognise that social inequality is the context for teenage pregnancy, not the result of it. Provider pressure on women of colour to use LARC is linked to institutional racism, whilst policy for those with physical and intellectual disabilities is shaped by disability discrimination. Other groups to be targeted include so-called 'welfare mothers', substance users, those who have had children put into care and offenders. Particularly controversial are cases in which LARC has been ordered by courts. LARC policy incorporating these kind of discriminatory practices needs to stop; future policy should focus on person-centred care that bolsters reproductive justice.

Keywords: long-acting reversible contraception; LARC; motherhood; parenting; intersectionality

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Background

The development of long-acting reversible contraceptive (LARC) technologies has increased fertility control options. Here, we define LARC as including subdermal implants, intrauterine devices and injectables (Wale & Rowlands, 2021) – most US and Scottish literature excludes injectables from the definition. LARC are highly-effective contraceptive methods for those who do not desire a pregnancy in the near future, and can be used at all stages of a reproductive life-course. Many have welcomed the efficacy and lack of need for day-to-day considerations. Yet, at the same time, the promotion of LARC has drawn attention to problematic trends in public health. Reproduction has many social and cultural complexities (Ginsburg & Rapp, 1991) and needs to be understood as being structured across social categories. It encompasses individual desires over fertility control as well as being an outcome of the social inequalities that structure social lives. This latter element is known as 'stratified reproduction': a social environment which empowers, encourages and resources reproduction for privileged women and consequently disempowers reproduction for others (Agigian, 2019; McCormack, 2005).

The initiation of LARC methods often appeals to policymakers for two reasons: they reduce pregnancy risk more than other methods, and they are not user-controlled (Rowlands & Ingham, 2017). This latter provider-dependency is important as, although it is recognised that all contraception has a failure rate, in practice at an individual level, irresponsibility rather than method failure is often assumed (Beynon-Jones, 2013). Provider-dependency is also the basis of state-sponsored promotion of LARC (Wale & Rowlands, 2021).

In the UK, the National Health Service (NHS) provides free access to contraception, including LARC, which can be obtained in different healthcare settings including general

(family) practice and community sexual and reproductive health clinics. Access is not, however, always good, with intense pressures on all parts of the NHS. In the past, there have been various schemes with the stated aim of increasing LARC use which included additional payment for fitting, and, more recently, financial incentives for giving LARC advice. In contrast, the pattern of policy in the United States varies, with some State policies not consistently supporting LARC use (Bogan & Marthey, 2021). Some policies are based on co-payment, there are difficulties with reimbursement for in-patient LARC insertion, young people may be subject to parental notification, and non-citizen immigrants are often excluded from reimbursement or insurance schemes.

This paper draws on the concept of reproductive justice (Sister Song, 2019). Reproductive justice was developed in the United States by women of colour in opposition to specific understandings of reproductive choice which ignored the structural conditions that enable or constrain individuals from making decisions (L. J. Ross & Solinger, 2017). It highlights the need to pay attention to the social context, including the ways in which different social identities intersect and lead to complexity in understanding discrimination and privilege. Reproductive justice seeks to draw attention to the ways in which stratified reproduction in the global north is intertwined with the construct of 'ideal' parents being considered to be White, heterosexually-coupled and middle-class. This social norm is used to police women's bodies and behaviour and is often used to discourage those who do not fit this norm from having children (L. Ross, 2017). Reproductive justice seeks to uncover and challenge intersectional oppressions such as white supremacy, misogyny and neoliberalism, by drawing attention to the multiple meanings and subject positions of diverse people who experience reproductive injustices (L. Ross, 2017). It draws attention to and challenges the norms associated with 'appropriate' reproduction which shape who is encouraged or coerced into

specific reproductive decisions, including the material conditions in which people are situated.

We will argue that LARC has become a pivotal technology with which to discipline bodies that are not considered fit to reproduce. The social norms of reproduction are entwined with essentialist understandings of women *as* mothers (Letherby, 1999; Lowe, 2016). Women are responsibilised through the concept of maternal sacrifice (Lowe, 2016). Maternal sacrifice requires women to put the perceived needs of actual or future children first, including making the 'responsible' choice of using fertility control to prevent the birth of children unless they can conform to the 'ideals' of parenting, based on existing social stratifications (Lowe, 2016). At a time of 'intensive motherhood' (Hays, 1996), when women are expected to maximise child development through child-centred parenthood, views about suitability for and timing of becoming a mother have exacerbated judgements about 'good' and 'bad' motherhood (Saunders, 2021).

This paper will consider the ideology of motherhood on which assumptions rest about parental fitness, examining the impact that this ideology has on the bodies of people who are considering use of LARC. We recognise that not all those who may use or consider using LARC identify as women. However, as LARC policy and practice has developed from essentialist understandings about women, motherhood and heterosexuality, we are using this language as it is from these ideas that policy and practice has developed. The paper will begin by setting out the broader context of stratified reproduction in the global north, before presenting in detail the ways in which LARC has been utilised within marginalised populations to 'discourage' births to those positioned as potential 'bad' parents.

Unfit to Parent?

There is a long history of judging certain women as potentially 'undesirable' mothers (Lowe, 2016). Historically, it is well-documented that, in England, unmarried mothers were subject to shame, stigma and punishment as a way of discouraging sexual activity outside marriage. During the 16th and 17th centuries, laws were passed on bastardy which sought to punish unwed mothers. Under a law passed in 1624, concealing a pregnancy or birth was key evidence when considering whether the death of a child born to a 'lewd woman' was murder. The concern behind this statute was that unmarried women would commit infanticide to avoid stigma and punishment (Kilday, 2013). Those drafting these statutes were particularly exercised about the financial burden that unmarried mothers and their children would place on parish funds. Echoes of these concerns are still prevalent today in policymaking agendas centred around ideas about the undeserving poor and welfare dependency (Sawhill, 2014) – these contribute to reproductive injustices by a refusal to provide adequate living standards for family formation.

During the 19th and 20th centuries, concerns began to broaden from a narrow focus on individual circumstances to ideas about the desirability or need to control groups or populations, through the development of eugenic thinking. During the 19th century, eugenics became a pseudo-scientific ideology popularised in many countries across North America and Europe (J.-J. Amy & S. Rowlands, 2018; J. J. Amy & S. Rowlands, 2018). Arising from Darwinian ideas about natural selection, it was suggested that encouraging or discouraging certain hereditary traits would enhance the population. Most of the targeted constitutional ('feeblemindedness', epilepsy, schizophrenia) or behavioural (criminality, alcoholism, prostitution) characteristics deemed at the time to be detrimental to the population, were later shown *not* to be primarily genetically-determined. The development of eugenics is

inseparable from colonialism. White European Western nations justified their occupation and domination of other countries as a 'civilising mission' based on a presumption of 'natural' superiority of White Europeans as more 'developed' than the populations they were subjugating (Levine, 2010). Post-colonial legacies include continuing poverty of citizens and racialised, hierarchical and oppressive societies that are more likely to try to deter pregnancies in marginalised groups.

Eugenic ideas led to the development of mass sterilisation policies in many countries, including both colonised and colonising nations (J.-J. Amy & S. Rowlands, 2018). For example, between 1909 and 1964, California sterilised more citizens than any other US State in numerous large State Hospitals, institutions in which these people were detained. In some cases, sterilisation was forced against a person's will; in others, pressure and coercion was used to get agreement for sterilisation. Policies varied but they often included those deemed to suffer from the type of physical or mental conditions mentioned earlier. Some policies also covered 'behavioural' / 'moral' issues, including sterilisation on grounds of sex offending, sex-working, promiscuity, vagrancy or alcoholism (J.-J. Amy & S. Rowlands, 2018; J. J. Amy & S. Rowlands, 2018). Whilst both men and women were targeted, the vast majority of sterilisations were forced on women.

There are other historical examples of coercive fertility control. There were concerns that Depo-Provera (DP) was being disproportionately administered to working class and minority-ethnic women in major British cities. The Campaign Against Depo-Provera (CAPD) was active in the UK between 1978 and 1983 (Lambert, 2020). Also, the UK Organisation of Women of African and Asian Descent (OWAAD) launched 'Ban the Jab' in 1979, a campaign against indiscriminate provision of DP to Black and Asian women. White and

Black women fought together for reproductive justice. A CADP document stated that “DP is doctor controlled, not woman controlled”.

This history of policing the bodies and behaviour of women in order to prevent the birth of specific children because of assumptions about individual risk or a wider burden on society is the legacy on which current LARC policy rests (Brown & Moskowitz, 1997; Lowe, 2016). Moreover, it includes individualised ideas about ‘good’ and ‘bad’ motherhood, and the responsibilisation of women to prevent births if they potentially fall into the ‘bad’ mother category. By focusing on individuals, rather than the social conditions in which they live, the categories of ‘bad’ motherhood can be used to justify coercive policy rather than seeking to facilitate societal changes that would enable better parenting to occur.

Women are the bearers of the collective, that is, without them, families, groups and communities would cease to exist. This has led to a wide range of norms and controls over their bodies and behaviour (Lowe, 2016; Yuval-Davis, 1997). Whilst what ‘good mothering’ actually means varies over time and between places, it is always seen as opposite to the ‘bad mother’ whose behaviour threatens her children’s wellbeing and, through them, wider society. The idea of maternal sacrifice, the norm that women should always consider the wellbeing of children first, is a key element of policing behaviour (Lowe, 2016). This includes the idea that marginalised women, who may struggle to fulfil ‘good motherhood’ standards, should refrain from having children until, when, or if, they are judged to be in a position to do so. In short, women have an embodied obligation to regulate their fertility, in line with society’s ideas about fitness to parent, regardless of their own desire to have children. This often ignores the injustices, discrimination and inequalities that produce marginalisation.

In this paper, we are focusing on some specific criticisms about women's motherhood capacity in relation to LARC; but we acknowledge that judgements about parenting ability is a broader issue that also affects others.

Marginalised Women and LARC

This section considers different issues of marginalisation that have been the subject of LARC policy or practice beyond individual decision-making. In the following examples, we have differentiated between specific bodies or behaviours as having either been targeted in one way or another as prime 'beneficiaries' of LARC or as having a clear potential for this. There are examples of combinations of bodies and behaviours, for instance substance abuse in teenagers (Won et al., 2017). We acknowledge that the distinction between these two is not straightforward, but we are using this conceptual divide to draw attention to the range of issues. Moreover, all ways of categorising social lives are problematic, as they ignore the tenet of intersectionality that recognises how individual lives are complex and are structured by numerous factors that intertwine and overlap (Crenshaw, 1989). By using these categories, we acknowledge that this is, to an extent, contrary to the essence of intersectionality, namely that different identities interact with each other and are not just singular or the sum of the parts of two or more identity positions (Cooper, 2016; L. Ross, 2017). However, there is insufficient space in this paper to consider fully issues such as the complexity of racialised poverty within LARC policy and practice.

Embodied Unfitness

In this subsection, we are focusing on areas of LARC policy and practice in which certain people's bodies have been deemed unsuitable or less able to become a 'good parent'. In some

instances, such as young age, the unsuitability might be a temporary state, whereas in others, such as intellectual disability, the status is unlikely to change. Indeed, the targets for LARC will vary from place to place depending on prevailing social norms and current policy agendas, and it is thus important to recognise that this is a constantly changing picture. However, in the examples we use, it is worth remembering that little regard is given to the potential adverse outcomes beyond pregnancy, such as the side-effects of LARC that women may have to endure (Hoggart et al., 2013) or recognised complications (Wale & Rowlands, 2021). The risk of pregnancy is the sole or main consideration within LARC promotion.

Teenage and younger motherhood has been problematised and subject to policy interventions such as the UK Teenage Pregnancy Strategy in 1997 and the US Teen Pregnancy Prevention Program in 2010. Teenage pregnancy is perceived to disrupt an idealised life trajectory that requires young women to be productive and self-investing by extending time in education and work before having children, based on middle-class norms (Saunders, 2021). These ideas run alongside a perception of youth as naturally innocent and a desire, amongst some, to restrict sexual knowledge out of fear of corruption (Lowe, 2016). The targeting of LARC to young people often ignores how social inequality is the context for teenage pregnancy, not the result of it (Gubrium et al., 2016). Rather than LARC being the solution for such teenagers, structural inequalities and injustices need to be addressed, for example by ensuring a living wage and secure housing (Gubrium et al., 2016), as well as recognising the need to support young people who do continue with pregnancies. Although the UK NICE guideline on contraception for those aged under 25 does mention choice as well as effectiveness as a key consideration (NICE, 2014), the overwhelming emphasis within English public health guidance on teenage pregnancy is on its prevention (Hadley, 2020).

Those with long-term health issues are also often deemed to have unfit bodies for good motherhood. Physical conditions have the potential for being targeted for LARC use. The parenting capacity of those with disability due to neurological conditions such as multiple sclerosis has been called into question and LARC put forward as a 'particularly appropriate' solution for such individuals (Coyle et al., 2019). Women living with HIV have been pressured, too, into having DP injections after childbirth (Towriss et al., 2019). Those with sickle cell (SC) disease have been the subject of reproductive injustices (P. T. Ross, 2015). It is known that DP reduces the incidence of SC crises (Manchikanti et al., 2007). Pressure on those with homozygous SC disease to use injectable contraception has a certain logic but can undermine women's autonomy. Women with eating disorders are advised in the UK that their first-line contraceptives are implants or intrauterine contraception (FSRH, 2018). This is despite there being potential difficulties with insertion of implants and IUDs in such individuals. In these examples we can see how a need to maximise the prevention of pregnancy can assume more importance than the implications for the individual women's health and her personal choice.

Women with intellectual disabilities (ID) are often not told about choices, side-effects or health implications, as the dominant discourse is around their unsuitability to become mothers (Wiseman & Ferrie, 2020). A woman's impaired decision-making should not justify coercion or manipulation in relation to contraception by clinicians caring for her (Coverdale et al., 2018). Yet, this is often the case for those with ID. Assessing mental capacity is complex, and those with ID will vary in their ability to consent to sexual activities, understand fertility control and the implications of any desire to be a parent. It is in line with this complexity that individuals with ID can, on occasions, be found by judges to have capacity to consent to sex with a regular partner but not to make contraception decisions

(England and Wales Court of Protection, 2018). It appears that even women with milder ID still largely have decisions about contraception made for them (Ledger et al., 2016; Wiseman & Ferrie, 2020). Qualitative work done a decade ago, which likely is still applicable, showed that women with ID in the UK were disproportionately prescribed DP, mainly due to fears among prescribers that such women would not be reliable users of shorter-term methods (McCarthy, 2010). There may also be pressure from carers for use of DP, as the amenorrhoea induced by the hormone means little or no menstrual health measures are needed. Quantitative evidence from the United States confirms this phenomenon; those with ID are three times more likely to be using DP than those without ID (Wu et al., 2018).

In England and Wales, the Court of Protection has responsibility under the Mental Capacity Act 2005 to assess cases about proposed enforced treatment on grounds of a lack of mental capacity. Whist the process is rigorous, it is worth considering how LARC is viewed against what is usually deemed to be the 'distress' caused by an unintended pregnancy or child removal. In recent years, the Court has preferred LARC to sterilisation in all but the most extreme cases. The Court has ordered intrauterine devices to be inserted in the best interests of individuals with ID (England and Wales Court of Protection, 2019, 2020). In one case, the judge determined that women with ID do not need to be asked about bringing up a child or for this to be taken into account when prescribing contraception (Thompson, 2018). It has been noted in decisions taken in the Court of Protection that LARC methods are all more 'restrictive' options in terms of a person's rights and freedoms than methods such as contraceptive pills or patches. In the United States, such cases are dealt with by adult guardianship/conservatorship legislation. This system, which controls around 1.3 million US citizens, has powers to order LARC and to prohibit its removal (Powell, 2021).

Structural discrimination against people of colour and other minority-ethnic groups is a systemic problem. The impact of racialised poverty, combined with differential access to healthcare is the context for reproductive lives (Roberts, 1997). It is unsurprising that healthcare professionals may filter their perceptions of individual patients through a racial frame and interpret the needs of individual women with reference to racist controlling images (Volscho, 2011). Racialised ideologies include hypersexuality and hyperfecundity (Jones, 2013); there are negative stereotypes about 'fatherless' Black male children raised by irresponsible, unmarried, welfare-dependent mothers in both the United States and the UK (Hancock, 2004; Jones, 2013). Although it is hard to pin down prescriber bias for LARC and racial discrimination, we believe that these may have been and may continue to be operative. A study based on US National Surveys of Family Growth data found similar patterns of LARC (IUD or implant) use between different ethnic groups (Kramer et al., 2018). A US study showed that African American and Native American women are more likely to use DP than European American women; it could not be determined if this was through choice or coercion (Volscho, 2011). However, other evidence shows that racism is a factor in contraceptive prescribing. Studies show that low-income women of colour in the United States were more likely to report being advised to limit their childbearing by healthcare providers than were middle-class White women (Downing et al., 2007), and among low-income women, Black women were more likely than White women to report ever having been pressured by a clinician to use contraceptives (Becker & Tsui, 2008). Qualitative research also suggests that, compared to White women, women of colour may perceive more provider pressure to use LARC (Higgins et al., 2016). Moreover, in a US study of simulated patients shown to clinicians on videos, low socioeconomic status Latina and Black women were more likely to have intrauterine contraception recommended than low socioeconomic status White women (Dehlendorf et al., 2010). There is a lack of comparable studies in the

UK, although in the 1980s, trials of DP focused on Black and poor women without explaining the risks (Jones, 2013).

Demonised behaviours

In this subsection, we focus on LARC policies that apply to certain types of behaviour. As outlined above, concerns about irresponsible or immoral behaviour that would lead to additional costs to society are not new, nor are these necessarily separate from the categories of marginalised people that may be targeted for LARC. Nevertheless, we suggest it is worth considering these issues separately, not least because an assumption of irresponsibility rather than an intrinsic embodied issue may be the key to understanding the rationale. Moreover, the concept of irresponsibility is based upon an assumption of planning and (self) control that has little relationship to actual reproductive lives in which both unruly biological bodies and social structures govern conception (Barrett & Wellings, 2002; Lowe, 2016; Ruhl, 2002).

The ideas of fertility irresponsibility from unplanned pregnancy is a central element in abortion stigma, and this understanding is sometimes seen amongst abortion care providers (Lipp, 2010). Even in Britain, where abortion is generally accepted and free within the NHS, there remains a preoccupation with reducing abortions, by minimising the number of unintended pregnancies through the promotion of LARC (Ma et al., 2020). In England, the Standard Operating Procedures for abortion services not only specify that contraception be offered by providers, but stress the importance of LARC as an effective method, thereby implicitly promoting LARC above other methods (DHSC, 2020). In other words, seeking abortion is a marker of questionable behaviour which automatically positions women as needing to be relieved of control over their fertility.

Concerns about fertility are raised in relation to those reliant on welfare benefits. In the United States, racialised concerns about so-called 'welfare mothers' mythologised them as irresponsible, promiscuous, morally-weak and undeserving (McCormack, 2005; Thomas, 1997). In the 1990s, women on public assistance were provided with financial incentives to obtain contraceptive implants in 13 US States (Meier et al., 2019). More recently, initiatives like Upstream have been set up to increase the availability of fertility control methods, with a particular emphasis on removing the barriers to LARC (https://upstream.org/about). Increased access is clearly important, especially given the private healthcare system in the United States, but there should be more emphasis on ensuring individual fertility choices. Yet, claims made about LARC promotion include that these methods can reduce poverty and health inequalities (Parks & Peipert, 2016; Sawhill, 2014). Interviews with homeless women found perceptions of biased counselling from healthcare professionals, who played down potential side-effects of LARC (Dasari et al., 2016). However, there is no evidence that promotion of LARC will reduce the problem of poverty (Foster, 2020). In the UK, universal no-cost access to contraception has been available for decades and use of LARC is not necessarily promoted as an anti-poverty strategy. However, welfare caps that restrict payments to families with more than two children, plus the generalised othering and devaluing of working-class women could influence local LARC prescribing practices, especially as these women are much less likely than middle-class women to be automatically deemed good mothers (O'Brien, 2019; Saunders, 2021). Moreover, as poverty is more likely amongst minority-ethnic communities and people with disabilities, these groups are likely to be disproportionately impacted.

Good motherhood is often viewed as irreconcilable with substance use, as the immature desire for drugs is often considered to lead to neglect of children in chaotic homes (Lowe, 2016). There are risks to children's wellbeing from parental alcohol, tobacco and recreational drug use (Kuppens et al., 2020). Yet, draconian policies tend to overlook the structural factors that often accompany addiction, such as domestic abuse, poverty and homelessness, which are often a significant cause of harm, and require public support to alleviate them (Knight, 2015). Ascribing maternal unfitness to women merely on the basis of their using substances has been shown to be contrary to scientific evidence (Terplan et al., 2015). The individualisation of responsibility is contained within the US Federal Unborn Victims of Violence Act 2004 which defines drug users as illegitimate mothers (L. J. Ross & Solinger, 2017). Substance abuse during pregnancy is considered by 23 US States to be child abuse under civil child welfare statutes (Guttmacher Institute, 2020). The targeting for LARC is thus legally endorsed. An example of this is Project Prevention (https://www.projectprevention.org) which has connections with the criminal justice system and links punishment and rehabilitation with reproductive coercion (Lowe, 2016). It provides cash payments for women who sign up to sterilisation or use of LARC. However, cash incentivisation for women agreeing to use LARC undermines women's autonomy (Lucke & Hall, 2012; Wale & Rowlands, 2021). There is evidence that women who inject drugs are capable of organising LARC for themselves and do not need to be paid to limit or end their fertility (Olsen et al., 2014). In the UK, Pause (https://www.pause.org.uk), a support programme for women who have had children removed, has for some years made LARC use a condition of attendance. Whilst attending Pause is nominally optional, as some attendees recognise, their dependency on the programme to improve their lives and increase their chances of seeing existing or keeping future children, means that LARC acceptance is not a choice but an imperative (Boddy & Wheeler, 2020). Although, recently, this condition has

been expanded to include use of non-LARC methods of contraception (BPAS, 2021), the change was made only after criticism of their approach.

The practice of designating some types of behaviour as a marker of 'bad motherhood' also has an impact on women offenders. Incarcerated women in the United States are living in an environment in which an idealised version of maternal identity is advocated but is in practice unattainable (Sufrin, 2018). The use of LARC in return for reduced sentences, as a condition of probation or as part of plea bargaining with child welfare authorities has been condemned by the American Medical Association (Board of Trustees, 1992) and heavily criticised by legal scholars (Albiston, 1994). However, this practice by the judiciary has not ceased. Between May and July 2017, in the jurisdiction of Tennessee, 32 women received a contraceptive implant in return for reduced sentences (Winters & McLaughlin, 2019). In the UK, Public Health England recommends that LARC be offered to women leaving prison in preference to other fertility control methods (Peden et al., 2018). Offending behaviour is thus seen as being incompatible with 'good motherhood', and those involved should be prevented from having (more) children. Moreover, the chances of imprisonment after offending behaviour is disproportionate. Poor women and women of colour are more likely to receive prison sentences and be dependent on welfare payments after release (Sudbury, 2002). This adds to the discursive positioning of them as potentially bad parents.

Discussion

Research clearly demonstrates that LARC is specifically promoted to groups of women whose bodies and behaviours fall outside cultural assumptions about ideal motherhood. As the historical evidence shows, there have long been mechanisms in place which seek to

reduce births from those deemed to be immoral or perceived as a potential burden on society. These ideas persist, despite some changes over time as to the boundaries of the categories of potentially unfit parents. The ideology of maternal sacrifice calls on women deemed to be at risk of being 'bad mothers' to be responsible for preventing conceptions, yet at the same time, because these women are positioned as irresponsible, their natural choice should be LARC. LARC use is promoted specifically because it removes control from the user. Whilst the move towards LARC from a previous emphasis on sterilisation is clearly to be welcomed, the rationale remains the same. However, the emphasis on LARC and the prevention of pregnancy ignores the structural conditions, such as poverty and racism, that often create marginalisation. By ignoring the structural causes, and instead focusing on individuals and behaviours, targeted LARC policy reinforces rather than reduces inequality. More research is needed into LARC provision, ranging from policymakers to clinicians, to ascertain and challenge the complex values that are behind these trends in LARC promotion.

Reproductive justice demands that mothering is a human right that cannot be withheld by the state or society (L. J. Ross & Solinger, 2017). But commonly in US and UK society, those who are not able to adhere to constructions of 'readiness' or an appropriate trajectory are expected to delay or forgo having children, despite the centrality of motherhood to traditional conceptions of femininity (Lowe, 2016; Saunders, 2021). Women should have the right to parent with dignity (Browner, 2016). Yet, this right has been eroded by a societal model of childrearing that has shifted the locus of legitimate parental authority away from parents' experiential knowledge to that of expert 'authoritative knowledge' that promulgates an increasingly time-consuming, supervised and regimented form of childrearing based on a standard that is unattainable by many (Browner, 2016). Marginalised mothers are often overwhelmed by adverse circumstances with limited access to the resources that are now seen

as culturally important for childcare (Saunders, 2021). However, rather than an emphasis being placed on ensuring that structural inequalities are reduced and/or support is given to enable the care of any children, all too often the solution put forward is LARC.

We do recognise the sincere attempts made by many clinicians, programme managers and policymakers to assist women in achieving their reproductive wishes. Evidence shows, for example, that some healthcare professionals do offer a full choice of methods to substance-using women, even when they feel LARC are the most appropriate methods for them (Charron et al., 2020). However, we believe that policies that pick groups to be targeted or differentially promote LARC are problematic. Undue emphasis on LARC reduces reproductive autonomy and has implications for trust in the healthcare system. There needs to be acute awareness of the tension between what is 'good' for public health and what is 'good' for individuals (Wale & Rowlands, 2021). Women want their preferences taken into account when seeking contraception. There may be racial or other differences in the degree to which women wish providers to be involved in the decision-making process (Dehlendorf et al., 2013) and in a desire for stopping the method to be under a woman's control (Jackson et al., 2016). Women are more satisfied with shared decision-making than provider-driven or patient-driven decision-making (Dehlendorf et al., 2017). Adhering to a person-centred contraceptive care framework helps to ensure high quality, equitable contraceptive services (Holt et al., 2020).

'Fitness to parent' may seem at first blush a somewhat intangible concept to be underlying policy and decisions about LARC. However, we believe that the evidence put forward in this paper shows clearly that it is an important concept with widespread ramifications. Even though the harmful effects of being judged according to this concept may be attenuated

nowadays from a previous emphasis on sterilisation, decisions about fitness to parent are still being made in many contexts. These judgements pervade multiple disciplines including policymaking, social work, probation, the law, clinical medicine, public health and the research agenda. Promotion of LARC use can be directed according to physical characteristics such as age or possession of a medical condition, social circumstances or types of behaviour deemed to be 'irresponsible'. Often, underlying all of this are disturbing undertones of racism and poverty. LARC policy incorporating these kind of discriminatory practices needs to stop; future policy should focus on person-centred care that bolsters reproductive justice.

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