SOGC STATEMENT ON COERCIVE CONTRACEPTION PROVISION AND PATIENT AUTONOMY IN FAMILY PLANNING DECISIONS

The United Nations and the World Health Organization (WHO) state that access to safe, voluntary family planning is a human right because it is essential for promoting gender equality, advancing the autonomy of women, and reducing poverty.(1, 2) Key elements of quality in family planning care include: having choice among a wide range of methods; patient-provider relationships based on respect for informed choice, privacy, and confidentiality as well as the cultural and religious beliefs of the individual; providing evidence-based information on the effectiveness, risks, and benefits of the different contraceptive methods; having technically competent trained health care workers; and having convenient access to voluntary, coercionfree contraceptive services. (1)

Health-care providers are responsible for conveying accurate, clear information, using language and methods that can be readily understood by the individual, together with noncoercive counselling, in order to facilitate full, free, and informed decision-making.(3) In a rightsbased family planning framework, the choice of contraception should be made by the woman herself based on information regarding safety, effectiveness, accessibility, and affordability. A woman's personal beliefs, culture, preferences and ability to use the chosen method, must be respected.

The use of highly effective methods of contraception is one of the pillars of unintended pregnancy prevention. Research indicates that women cite effectiveness as one of the most important factors when choosing a contraceptive method.(4) This has led to the development of a tieredeffectiveness approach to family planning counselling in which health care providers counsel about the most effective contraceptive methods first and present less effective contraceptive methods thereafter.(5) The most effective methods are long acting reversible contraceptives (LARCs), such as intrauterine contraceptives (IUCs) or implants, and permanent contraception procedures, such as tubal ligation/bilateral salpingectomy or male vasectomy, for individuals who are certain that they do not desire a future pregnancy. Effectiveness is part of a larger framework of counselling that addresses a woman's needs and goals as well as the benefits, risks, and side effects of various contraceptive methods. The tiered effectiveness approach is not meant to be directive or to assume that a woman should or will choose a particular contraceptive, but only to ensure that a woman puts all of the method characteristics, including contraceptive effectiveness, into perspective when making her choice.(6)

Respecting an individual's autonomy requires that health care workers provide nondirective, non-judgemental counselling, advice, and information to enable individuals to make decisions that are best for them. People should be able to choose their preferred method of contraception, taking into consideration their own health and social needs. Similarly, they must be able to refuse contraception if they choose to do so.(3) Policies and practices related to contraceptive information and services should aim to eliminate stereotypes and discriminatory attitudes that would support or could be perceived as supporting coercive practices which may target disadvantaged groups or vulnerable populations.(7)

Permanent contraception, also known as sterilization, is one of the most effective methods of contraception. This may be performed by means of tubal ligation, bilateral salpingectomy, or male vasectomy. The choice of permanent contraception has personal, social, and medical implications; sterilization is complex from a historical, sociological, and ethical perspective and has been associated with reproductive injustice in Canada. Historically, Indigenous women and other vulnerable populations, including women with mental illness or intellectual disabilities, have been sterilized involuntarily(8, 9) and there are continued concerns that coercive contraception counselling targeting specific groups is ongoing.(10) Conversely, women requesting permanent contraception report have been denied the procedure based on age or nulliparity. Ethically, permanent contraception provision should promote access for individuals who wish to use sterilization as a contraceptive method but at the same time it is imperative to safeguard against coercive or discriminatory uses.(11) Adequate counselling that explores a patient's reproductive plans and places their wishes at the center of care is essential for informed choice. Counselling should emphasize the permanent nature of the procedure and provide information regarding alternatives including LARCs and male partner vasectomy. If there is any doubt that an individual is able to fully understand the permanence of the procedure and provide informed consent, sterilization procedures should not be performed.

The decision to have a procedure for permanent contraception should be made without pressure or coercion, as failure to ensure this would represent a human rights violation.(3, 12) Coercive or forcible sterilization procedures are unethical and should never be performed.(11) This would include withholding health care as an incentive for having a permanent contraception procedure, threatening to involve child protection services if an individual doesn't agree to permanent contraception, or performing a sterilization procedure during the course of another surgical procedure without the woman's knowledge or consent. In Canada, the Supreme Court has ruled that only individuals who have the capacity to give consent can agree to have a permanent contraception procedure; a proxy decision-maker cannot consent to a permanent contraception procedure for another individual. (13) This 1986 ruling states that: "*Sterilization should never be authorized for nontherapeutic purposes under the parens patriae jurisdiction. In*

the absence of the affected person's consent, it can never be safely determined that it is for the benefit of that person. The grave intrusion on a person's rights and the ensuing physical damage outweigh the highly questionable advantages that can result from it." (10) Similarly, health care providers should be sensitive to possible biases about race, ethnicity, socioeconomic status, mental health and parenthood,(8) that may,be overly paternalistic and negatively affect contraceptive care.

Provided that contraception counselling has followed the principles of patient autonomy and voluntary informed consent, it would be ethically acceptable to perform a permanent contraception procedure at the same time as delivery/birth/abortion.(11) Women planning to deliver by caesarean section may choose to have a permanent contraceptive procedure performed at the same time. Providing an effective and permanent method of contraception at the time of caesarean section has advantages including avoiding a subsequent operative procedure and its inherent risks. Adequate, unbiased, and non-directive contraceptive counselling should occur in the antepartum period and the woman should understand the permanent nature of the procedure and be certain that her family is complete. This ensures that decision-making includes adequate consideration of risks and benefits of the procedure, alternative contraceptive methods, and contingency plans if there are unanticipated obstetrical or neonatal complications. The decision for a permanent contraception procedure in the event of an elective or emergency caesarean section should be clearly documented in the patient's antenatal chart, consent should be obtained antenatally, and their decision respected when possible. Patients also have the right to change their minds. Thus, it is important to reconfirm the patient's decision shortly before the operation.

Health care providers may encounter instances where a woman who was planning to deliver vaginally requires an emergency caesarean section and requests that a permanent contraception procedure be performed at the same time. Although there may be exceptional circumstances where permanent contraception may be appropriate, permanent contraception procedures should generally be avoided when this decision is being considered/made during labour. In these scenarios, LARCs can be offered instead and permanent contraception can be delayed and discussed later in the postpartum period when adequate counselling can occur.

The provision of LARC or permanent contraception at the time of pregnancy termination shares some of the characteristics of sterilization in the context of caesarean section. Health care providers who provide abortion services are uniquely positioned to counsel and provide contraceptive services; however, counselling should also acknowledge that contraception may not be a priority for all patients at the time of consultation. The process of obtaining abortion services and overcoming barriers may be overwhelming and tiring for a patient, and increase their vulnerability on the day of the abortion procedure.(14) Some women report feeling pressure from

providers to choose a birth control method at the time of abortion.(15) While LARC and permanent contraception may be suitable options in these instances, patient autonomy must be respected, including the choice to *not* use contraception or to use a less-effective method.(16, 17) Specifically, fully informed choice prior to the termination procedure provided without pressure and in the context of information about alternatives is required for ethical practice.

The promotion of LARC use to prevent unintended pregnancy should focus on increasing accessibility of LARC; individual autonomy and choice should not be undermined as this would ultimately restrict contraceptive options, particularly for the most vulnerable populations.(17) Individuals who choose to use a LARC method must also be able to freely choose to discontinue that method which will require the assistance of a health care provider.

Conclusion:

The foundation of quality contraceptive services is informed decision-making about contraception within a rights based framework in a system that ensures access to all contraceptive methods, including highly effective ones. Contraceptive services should be culturally sensitive and delivered in a way that ensures fully informed, voluntary, and coercionfree decision-making, respects dignity, autonomy, privacy and confidentiality, and is sensitive to individuals' needs and perspectives. Counselling and services should not be discriminatory or target disadvantaged populations in an adverse fashion and health care providers should avoid biases about race, ethnicity, socioeconomic status, mental capacity, mental health, personal characteristics and parenthood that may influence contraceptive care provision. While permanent contraceptive procedures can be scheduled and performed at the time of caesarean section, counselling and consent should be completed prior to the scheduled procedure or the onset of labour. Intrapartum decisions regarding permanent contraception at the time of emergency cesarean section should generally be avoided and deferred until the postpartum period. Efforts to promote LARC use should focus on enhancing LARC awareness and access (to both insertion and removal) while refraining from actions that may be perceived as coercive or limiting informed contraceptive choice.

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