Published in final edited form as:

Qual Health Res. 2013 August ; 23(8): 1114–1124. doi:10.1177/1049732313494483.

Control and Constraint for Low-Income Women Choosing Outpatient Sterilization

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Abstract

Little is known about Hispanics and their contraceptive choices in general, with some past studies detailing non-consensual sterilization. This article is based on interviews with a mostly Hispanic sample of 44 women being sterilized at a public clinic in southeast Texas with the Essure device, which entails a new outpatient sterilization procedure. These women cited relationship factors, wanting to better their and their children's lives, and past reproductive histories as reasons for deciding on sterilization. They specifically chose Essure as a result of an apprehension of surgery and potential side effects from tubal ligation. Their choices, however, were limited by larger structural factors of work, family, the political economy, and the health care system. We conclude that this new sterilization technique provided more contraceptive choices for these women, yet more contraceptive decision making autonomy, as well as more equitable social structures, are still needed.

Keywords

contraception; decision making; interviews; semistructured; Latino/ Hispanic people; sociology

The history of sterilization in the United States is embroiled with sexism, racism, classism, and eugenics (Badagliacco & Ruiz, 2006; Carey, 1998; Shapiro, Fisher, & Diana, 1983), which some claim is ongoing because poorer women on government funded insurance have proportionally higher rates of tubal ligation (Bass & Warehime, 2009). Moreover, sterilization rates are rising in the United States (Godecker, Thompson, & Bumpass, 2001; Piccinino & Mosher, 1998), especially among women of lower socioeconomic status (SES). Sterilization rates are highest for Black women, followed by Hispanic, then White women (Borrero et al., 2010). Hispanic women, however, have the fastest growing rates of female sterilization, which rose 15% between 1982 and 1995 (Piccinino & Mosher, 1998). Questions still remain as to why women from more disadvantaged backgrounds choose sterilization over other methods of contraception (Metoyer, 2009).

Despite the many past instances of forced sterilization, there were also cases of women using sterilization policies for their own benefit (Metoyer, 2009). Currently, some women

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

might regard sterilization as liberating, especially because procedures have become less invasive and more affordable. Data on sterilization rates are on the traditional tubal ligation, or “having one’s tubes tied,” which is a surgical procedure to cut or block the fallopian tubes. There is, however, a newer, outpatient sterilization technique, called Essure, which has been gaining popularity in the United States since its 2002 approval by the Food and Drug Administration. In fact, as Essure rates have increased, rates of other female sterilization procedures have decreased (Shavell, Abdallah, Shade, Diamond, & Berman, 2009). According to the company website, half a million women have gotten the Essure since 2002 (Essure, 2012). The procedure is too new, however, to have any documented, large data collection on actual usage rates.

The Essure procedure entails placement of nickel covered steel coils into the fallopian tubes through a hysteroscope passed through the cervix. Once in place, the device is designed to elicit tissue growth that scars shut over the coils, preventing sperm from reaching the egg. Procedure success rates range between 81–99% (Leyser-Whalen, Rouhani, Rahman, & Berenson, 2012). One advantage of this technique are that it can be performed as a short, outpatient procedure requiring only local anesthesia with a same day recovery period (Connor, 2009). Furthermore, compared to tubal ligation, Essure is more cost effective (Levie & Chudnoff, 2005) and has fewer potential complications (Lessard & Hopkins, 2011). Essure is covered by most private insurers as well as Medicaid (Essure, 2012), government funded insurance for people unable to afford some, or all, of their health expenses.

Given that women of color and lower SES receive tubal ligations at higher rates (Bass & Warehime, 2009), researchers have questioned whether White women of higher SES have more contraceptive options. Further, little is known about Hispanic contraceptive decision making. With Essure currently on the market, we wonder if this new technique changes how women, specifically Hispanic women, view their contraceptive options, including sterilization. In this article we present data from interviews with a mostly Hispanic sample of 44 women who received the Essure at a public, family planning clinic in southeast Texas. We first present our background and theoretical frameworks, then outline three main factors given by respondents on why they chose sterilization. We then present their reasons as to why Essure specifically was chosen. We conclude with discussion on how medical practices related to sterilization have improved over the years, and why more contraceptive choices are still needed.

Background Literature

Contraception and Race/Ethnicity

In general populations, several personal factors predict contraceptive use, such as parity, marital status, ideas of motherhood, sexuality, and relationships. Moreover, women with less education use long-lasting contraceptive methods in higher proportions than women with more education. It is unknown whether medical practitioners suggest long-lasting methods more often to women with less education, or if highly educated women do more research or ask more challenging questions regarding negative effects. Some also speculate that disadvantaged women might choose long-lasting methods because they have more to lose if they became pregnant (Metoyer, 2009).

Although one must be sensitive in research to political issues that stigmatize and place surveillance on Hispanic reproduction, not enough is known about the effects of acculturation, external attitudes, and factors influencing contraceptive use by Hispanic women, especially those who are Spanish speaking, unacculturated, or of low SES. Several studies examined correlates of low contraceptive usage rates among Hispanic women. These

include: lack of access to or information about contraception, and values related to male dominated Hispanic culture, family and motherhood (Chavez, 2004; Unger & Molina, 2000).

Moreover, very little is known about the effects of interpersonal relationships on Latinas/Latinos contraceptive decisions (Harvey, Henderson, & Casillas, 2006). Kavanaugh, Lindberg, and Frost (2012) found that non-U.S. born Hispanic women were almost four times as likely as White women to report partner involvement with contraceptive services. However, this might have been because of needing their partner's help in navigating the health care system. Another study showed that about half (48%) of the Hispanic women sampled believed that birth control was the woman's responsibility, and almost half (42%) reported that their partner did not want to use birth control (Unger & Molina, 1998).

Studies on Hispanics and sterilization include Velez-I's (1980) writing on nonconsensual sterilization of Mexican women in Los Angeles during the early 1970s, when they, or their husbands, were pressured by medical staff to sign papers during childbirth labor. Studies from the early 1980s on Puerto Rican women in New York showed high rates of sterilization because of familiarity with tubal ligation because of its extensive use in Puerto Rico, or women's lack of knowledge of the permanent nature of tubal ligation, partially because of a lack of Spanish consent forms and medical encounters. Many women were also not given adequate time for reflection between signing the consent form and the procedure itself. In some cases, women were sterilized without their knowledge or consent. Additionally, because there was a lack of resources in public hospitals, these women were not always informed about all available contraceptive options (Lopez, 1993; Schensul, Borrero, Barrera, Backstrand, & Guarnaccia, 1982).

As seen in current trends in the United States, female sterilization continues to be more common among women of color, with lower levels of education and income, and public or no insurance. Furthermore, Hispanic women were more likely to receive counseling about tubal sterilization than White and Black women (Borrero, Schwarz, Creinin, & Ibrahim, 2009). Women gave several reasons for choosing sterilization, such as problematic reproductive histories with other forms of contraception, pregnancy, or delivery. Many were also young and wanted to achieve accomplishments in their lives aside from motherhood. Last, women also gave gender related reasons, such as not wanting to be primary care givers in economically trying conditions, or that their spouses refused vasectomy (Bass & Warehime, 2009; Borrero et al., 2011; Chan & Westhoff, 2010; Chandra, 1998; Hunter, Linn, & Stein, 1983–84; Lopez, 1993, 1998; Metoyer, 2009; Miller, Shain, & Pasta, 1985–86; Schensul et al., 1982).

Theory: Gender, Structure, and Agency

We derived our theoretical model from work that examined how gendered behaviors were influenced by, and in turn influenced, larger structures in people's lives. Gender is socially constructed and reenacted in our daily activities, including health practices (Schofield, Connell, Walker, Wood, & Butland, 2000). This relationship is mediated by micro-, meso-, and macro-level social processes in individuals' lives. The interplay of these relationships is dynamic, complex, multilayered, and can even contain contradictory ideas (Gallagher, 2007). The incongruous and changing nature of these social dynamics allows space for individuals to exercise an amount of agency. This agency can maintain the status quo, attempt to modify parts without threatening the whole (e.g., question certain gender roles), or challenge the whole structure (e.g., question the underlying ideas of gender dichotomization).

As a result of uneven positions of power and gender stereotyping, women are faced with negotiating their statuses within multiple settings, such as family, work, and health care. For example, Sen (1990) noted that members in a household were simultaneously faced with the work of cooperation and conflict, or what Connidis and McMullin (2002), called “ambivalence,” which affected family members to different degrees, depending on the amount of power they brought to the relationship. When women had less household power, they felt greater ambivalence.

Essentially, women strategize within a set of concrete constraints, or what Kandiyoti (1988) called the “patriarchal bargain” (p. 275). She found that often, rather than engaging in large scale collective action, women used coping strategies, active, or passive resistance, either separately or in combination. The chosen strategies were dependent on changing social circumstances and other opportunities or constraints connected to social statuses such as race, class, and sexual orientation. Subsequent studies on patriarchal bargaining focused mainly on women in orthodox, religious settings or societies with more restrictive women’s rights. For example, Gerami and Lehnerer (2001) identified four strategies that women utilized to negotiate Islamic fundamentalism: collaboration (enforcing), acquiescence (submitting), co-optation (manipulating), and subversion (undermining).

One goal of the authors of this body of work was to move past victimization narratives and gain a greater sense of the complexity of both domination and resistance. They also show that even if few gender schemas get redefined, subtle shifts in the whole gender structure might be occurring. Structures shape people’s practices and people’s practices simultaneously (re)produce structures, which not only includes maintaining the status quo, but changing it as well (Abu-Lughod, 1990; Avishai, 2008; Gallagher, 2007; Gerami & Lehnerer, 2001; MacLeod, 1992; Mahmood, 2001).

Data and Methods

We conducted 44 interviews with women who utilized a public, family planning clinic in southeast Texas for an Essure procedure between May-September, 2011. Forty two women were attempting Essure for the first time and two were returning after having had a recent, failed Essure attempt. Interviews were digitally recorded, lasted about 30 minutes and were conducted in English or Spanish with the patients in private rooms. Informed consent was obtained from all respondents. This study was approved by the University of Texas Medical Branch Human Subjects Review Board and the authors have no conflicts of interest to report in association with the Essure product.

Surveys were administered after the interviews, but survey data are not presented in this article, except for the following demographics: the majority of women were in their mid-30s with three children. Of the 28 Hispanic women, 25 were born in Mexico, and 15 interviews were conducted in Spanish. Twelve women self-reported as non-Hispanic White and four as non-Hispanic Black. Slightly more than a third (34.1%) did not finish high school and an equal number (34.1%) finished high school or received a GED. The remaining third either had some college or received a college degree. Approximately one-third (29.5%) of the sample reported an annual income of less than \$15,000. Another third (34.1%) fell in the \$15,000–29,999 range, with eight (18.2%) in the \$30,000–49,999 range, and five (11.4%) in the \$50,000 or above range.

We used grounded theory (Charmaz, 1990) to analyze our data. We coded line by line to identify recurring concepts. Respondent accounts guided both the theoretical framework and the conceptual themes. This allowed us to create categories of types of attitudes and motivations as well as find associations between attitudes and behaviors, and between

circumstances and motivations, both between and within cases. This process is made transparent in the manuscript where we display respondent quotes for illustrative purposes.

Analysis was dynamic and open to change throughout the analytic process. Because all questions on the interview schedule were answered by all respondents, there was some amount of systematic and comprehensive coding based on the a priori issues identified in the original research aims of wanting to ascertain why these women wanted to get sterilized in general, and why they chose the Essure specifically. Yet given the variation in answers, in addition to supplementary answers and probes, coding also took on a fluid aspect where different respondent answers, even to the same questions, belonged in different categories.

The first author familiarized herself with the data through conducting the interviews. Interviews were digitally recorded and transcribed the same day. The first author read through the transcripts several times to identify a thematic framework, which in this case became gendered agency within larger structures. The issues that emerged were identified and categorized into analytical themes of: relationships, betterment of self and children, and reproductive history. There were always multiple reasons given for wanting to get sterilized. None of these reasons seemed “grouped” in that if one certain reason was given, it was unlikely that another certain reason would also be stated. A common thread throughout all interviews, however, was that these women felt like they were taking control of their lives.

Results

Relationship Factors

Many women discussed sterilization as a means to take control over their personal relationships. Relationship factors included: unstable relationships, men’s lack of initiative resulting from ideas that contraception belongs in a woman’s domain, or men’s refusal to get a vasectomy. Women who were in, or had a history of, unstable relationships, also discussed having the sole decision making power over family planning. They wanted to ensure that they could avoid pregnancy either with current, or potential future, partners. For a couple of women, race played a factor in the relationship instability; their problems were exacerbated by having husbands living in Mexico (one woman’s husband had been deported). One of the women explained:

... he’s one of those guys ... “macho.” But I think that if I don’t do it, next year he’ll come here and I’ll be pregnant again and we’ll have problems. I don’t want to go through that again, where he comes and leaves me with more children to take care of.

It is possible that men also made contraceptive decisions based on relationship instability, yet this was difficult to ascertain given that men were not interviewed and our respondents were often unsure what their male partners thought based on poor relationship communication. Yet, one woman speculated that the uncertainty of her previous marriage might have been a reason as to why her husband refused a vasectomy at the time: “He just doesn’t want to get cut. I think it was more him wanting me to do it in case we did get divorced. I don’t know what the deal was with that.”

There also seemed to be communication and trust issues in another woman’s relationship. She did not have confidence that her husband would get a vasectomy because of his ambiguous statements and her gendered ideas of “how men are:”

He said he was willing, but I don’t believe it. He jokes a lot and then he always says, “If we broke up, I can’t get another girl pregnant.” I don’t know if he’ll do it ... I’d rather be safe, you never know with him. Men change their minds a lot.

Thus, it seems that the level of communication between partners might influence contraceptive use, as has also been suggested in another study (Forste & Morgan, 1998).

There were, however, many cases where women more thoroughly discussed sterilization with their partners. Yet despite having open communication, the sterilization decision was ultimately the woman's. As one woman said: "He took it well. I told him, 'If you don't agree, it's not my problem. It's my business and I'm going to do it anyway.'" This might also be related to race in that both U.S. and non-U.S. born Hispanic women believe that contraception is a woman's responsibility (Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006).

More negotiation was required when spouses disagreed on how many children each desired. Several women did not want more children, as opposed to their partners, at different points in their lives. Some women appeased their partners and had more children, yet were beyond that stage when presenting for sterilization. The question then became, what made this the "right" time to get sterilized? One woman said that having four children, believing she was getting older, and being in an unstable marriage prompted her to get sterilized. She took contraceptive initiative because she said that her husband was young and might want more kids in the future if he had a new partner.

This woman was no stranger to unstable relationships or thinking about the continuation of childbearing in other relationships. She had one previous marriage and two of her four kids were from her current husband. Additionally, her current husband had left her in the past: "He says he won't do it again, but who knows about men? I don't want to be stuck with more kids. And it's my body." Similarly, another woman had five children, three from her current partner of 6 years. She was getting the Essure, but said that her partner was also going to get sterilized because of an uncertain future.

Some women did not have personal histories of unstable relationships, but instead had friends or family serve as examples. Even though one respondent was seemingly in a stable marriage, she first discussed that life in general is uncertain and circumstances are fluid:

In the future ... if something happens and I'm not going to be with him anymore, I'm going to have a lot of kids, and what's going to be their future? I'm not going to be able to work, not even two jobs, and buy shoes, clothes, or whatever they want. When they are ready for university, they are expensive. I have four and it's really expensive. So I'm like, "that's it." It's not because of him, I'm doing it for myself. Nothing guarantees that he is going to be with me forever, but my kids are. I have to think of them.

The woman later talked about a hypothetical future, other man, plus discussed her sister's past unstable relationships:

My sister said, "What if you get with another guy and he wants his own child?" I said ... "too bad for him." I can't have no more. If I meet someone, "if you're looking for babies, go somewhere else. You can love mine." My sister, with seven kids, are from three different dads. That's not for me. I told my husband, "I picked you to have kids with" and that's it.

Also seen in these statements was decision making based on what this woman felt was best for her and her family, irrespective of what a current or even hypothetical, future partner might want.

Better Life for Self and Children

Although wanting to ensure a better future for children was mentioned in the above thread in reference to unstable relationships, this idea was also an overarching theme that deserved its own discussion. In this analysis, a continuum of change emerged, based on the amount of change that women wanted in their lifestyles. This change was also related to societal and personal notions of gender and culture, which also encompassed the idea of caring for children.

On the end of the continuum with the least amount of change, were women who did not want to drastically change life circumstances, but rather wanted to return to past lifestyles, which mostly surrounded the enjoyment of leisure activities. One woman had two kids in school and two little ones at home:

It's hard. They want to go swimming, I can't go swimming ... if I take the baby, I have to get dressed really fast because one of them will cry. You can't do nothing. You can't even go out. With a lot of kids, to go to a restaurant, they'll be crying and people will be looking at you like, "Woah." We just have to wait 'til they grow up and learn their manners and learn how to eat at a restaurant. Just go to McDonald's, they have playgrounds, that's it.

A few other women discussed longer lifestyle goals where they focused on a time when the children will no longer be living at home. One woman's dream included: "... a Harley to go riding and we have a camper, so we want to go traveling."

Other women used terminology that maintained existing gender norms and practices. For example, women used maternal language in stating that their primary goal for not desiring more children was to be able to adequately care for, and give enough attention to, their existing children. As one woman said, "when the oldest one is playing football, when I had to go with the babies, it's hard to keep them still, we cannot watch the games because they are little." Moreover, the women in this study were coming to a publically funded clinic, so it was not surprising that several women mentioned monetary issues, regardless of the number of children they had. Having more children, of course, can create more economic strain. One woman had four kids and did not want any more: "It costs a lot to give them everything they need."

Women in the middle of the continuum stated that ending childbearing would help them attain personal goals of working outside the home. These aspirations, however, did not necessarily reflect nonmainstream views of gender. For example, several women wanted to go into cosmetology, which is a gendered occupation. One of these women discussed the importance of being at home for her children. She said she would pursue her goals only after all the kids are in school: "Cosmetology school is nine to twelve. School for the kids is eight to three, so I have time for everything."

Yet, probing women more about their decisions also revealed their awareness of breaking with certain gendered and racial ethnic traditions. For example, one Hispanic woman was studying for a cosmetology certificate, which again, is a highly gendered profession. Yet, when we asked her why she broke from tradition and only had two children (she had seven siblings and a husband with nine siblings), she answered: "Times are different from twenty years ago. Before, the mother didn't work and stayed home. Today both work." Whereas she might have needed to work out of economic necessity, she also acknowledged changing gender dynamics.

Although these women seemingly reinforced gendered ideas of child care and work, they were simultaneously constrained by larger, gendered structures, such as dependency on a

man's salary. These women had what Finch (1989) called "legitimate excuses," such as men's paid employment, for maintaining gendered caregiving. This was also confirmed in the other direction; having an adequate support system made it possible for one woman to work outside the home full-time with three kids. She said her working outside the home was not a factor for getting sterilized: "My mom retired and takes care of the kids."

On the end of the continuum with the greatest amount of change were women who spoke as more powerful agents. For example, one woman wanted to be a massage therapist and a role model for her daughter. She gave an empowered statement, one that ended with a gender identifier that might have been redefining what it meant to be a "woman:" "I want to grow as a person and work, I want to do something. I have dreams, I have a life to live. I want to be a woman."

Another woman also discussed wanting to be a positive role model for her entire family. She was 24 years old with five kids:

I want to get my GED [General Educational Development] and I want to go to college and be a culinary chef. I have things I want to do with my life. Not saying I don't love my kids, but they are standing in my way to getting to my goals and being somebody. I'm twenty four, I have nothing to accomplish but kids. I want to show something for myself to my parents. Only one of four of us have graduated, she went and got her GED. I'm the oldest of four, I should have been setting the example.

In addition, a few women broke away from some glorified, societal maternal myths by discussing the realities of the difficulties of motherhood. One woman did all the childcare for her three children: "The baby is cute now, but he'll turn terrible when he turns two. My four year old is a terror ... I would shoot myself if I had any more babies." Another young Hispanic woman who was not very traditional and had just separated from her husband, had kids aged 14 years, 7 years, and 4 months. She was "thinking about going to school and doing a part time job. If I stay in the house, I'm gonna go crazy."

Reproductive History

Similar to other research findings on contraception (Guendelman, Denny, Mauldon, & Chetkovich, 2000) and sterilization more specifically (Lopez, 1993), past reproductive histories were a component in our respondents' decision making. Women gave reasons for not wanting more children as a result of older maternal age or specific health issues they had that could complicate pregnancy and birth. They also spoke of health problems they had experienced as a result of pregnancy or childbirth. These included a history of caesarean sections and wanting to avoid future surgeries, depression, seizures, blood pressure issues, premature babies and miscarriage.

In all cases, women chose sterilization over other contraceptive options. Twenty seven women discussed having one or more side effects with past forms of hormonal birth control, which included irregular bleeding, headaches, weight gain, lowered libido, and mood swings. With specific reference to the birth control pill, many mentioned that they would forget to take it daily at the same time, which led some to get pregnant. Others worried about the threat of getting pregnant, which two women specifically mentioned being related to decreased sexual enjoyment or frequency. Three other women did not want to take the pill as a result of a family or personal history of cancer.

Some respondent reports of contraceptive difficulties were attributable to outside constraints. Several women had trouble with continually returning to the clinic for contraception or a prescription. The clinic was funded by state monies and served a

population of women who could not afford to go to other clinics, which meant many were traveling up to a few hours, one way. Additionally, not having personal transportation meant that many women had to find friends or family who were available to give them rides. One woman said she was inconsistent with her contraception because she could not get transportation to the clinic and ultimately had her third baby, who was unplanned.

Other women stated that they were on and off of health insurance, which created timing issues for obtaining contraception. The transportation and health insurance issues might have been particularly salient for the women in our sample because data show that low income and Hispanic women experience significantly higher rates of contraceptive failure (Kost, Singh, Vaughn, Trussell, & Bankole, 2008). As a result of multiple difficulties, these women wanted to get permanent contraception when the opportunity arose.

Most women discussed contraception with their family and friends, which also influenced their decisions. Twelve women would not try nonhormonal methods because they had heard stories about severe side effects or “accidents.” Almost all these conversations revolved around the intrauterine device (IUD). Guendelman et al. (2000) found that social networks were strong influences on women’s views of contraceptive methods. This appeared to be the case with many of the women in this study because they had been repeatedly counseled on contraception by health care practitioners, yet still had aversions to certain types of contraception.

Social networks also provided narratives of women who had undergone tubal ligations. This is not surprising because sterilization is common in Latin America (da Costa Leite, Gupta, & do Nascimento, 2004). This knowledge simultaneously served as a positive influence in decisions and exposed some bad experiences. These accounts helped women think about sterilization as an option in general (see section below for contrast between the tubal ligation and Essure), and hoped to avoid the potential negative side effects. For example, one woman’s children were teenagers and she had been thinking of sterilization for 10 years:

Two relatives of mine had their tubes tied. One gained excessive weight and couldn’t lose it. Both of them got real nervous and depressed, I don’t know if it came from having their tubes tied. So I was always thinking I don’t want to do that to my body, but I was taking the Depo [shot] and that’s doing something else to your body too.

Other women disassociated themselves from the bad experiences, citing how their cases were different from the others. One woman said that her age influenced her certainty about sterilization, in contrast to both her mother getting a tubal ligation years ago and a friend who got a tubal ligation 2 months previous: “My mom afterwards, she regretted it, because she was young. I had another friend who regretted it. She thinks she’s ready now. But she had her kids young and she got it early.”

Again, these women were active agents in decisions on a birth control method that would suit both their lifestyles and their bodies. They were, however, constrained by larger economic systems as well as the health field that focuses more heavily on women’s bodies for sites of reproductive technologies. Thus, women are subject to a greater reliance on the health care system that increases their costs, consumes more time, and demands greater surveillance into their personal lifestyles when clinic visits ask about sexual behaviors and take their weight.

Another prominent trend in the data was many women’s personal histories with sterilization. These women complained of the difficulty in getting to the point of the actual sterilization procedure, either at the time of the interview, or in the past. First, they encountered a waiting

list of several months for Essure at our clinic. In addition, there was a 30 day legal waiting period between signing the consent form and getting the actual procedure, which several women found problematic. For example, one woman signed her paperwork for her postpartum tubal ligation 30 days before her due date, yet ended up not obtaining the surgery because her baby was born four days early.

A quarter of the women in the study were unable to get postpartum tubal ligations as a result of pregnancy complications that prohibited surgery. Moreover, two women reluctantly declined their postpartum tubal ligations when they were informed that an operating room was not available because of caesarean sections. They were unwilling to prolong the period of fasting after already having not eaten during two days of labor. A quarter of the women also encountered bureaucratic problems. Several women signed sterilization paperwork for our hospital, yet had to unexpectedly switch hospitals for their births. Others had experienced miscommunication about paperwork or had not been continuously enrolled in a health insurance plan.

Many women were also denied sterilizations in the past because of Medicaid requirements regarding the woman's age or parity. Currently, the Texas Medicaid age requirement is 21 years old. There is no minimum on the number of children a woman has, although there had been one in the past. Why this minimum was mentioned recently by our respondents could be a result of patient misinterpretation, especially for Spanish speakers if the medical visit was conducted in English. Whereas the physicians are strictly trained in our clinics, the possibility also exists that other practitioners were not current on requirement standards. Medical sociology literature shows that physicians can also be influenced by personal views (Mitchell & Georges, 1998); thus we cannot rule out this possibility. One respondent said that she had split from her husband and her physician in another clinic would not sterilize her because she was not in a monogamous relationship.

Physicians could also be influenced by a professional culture that has cautioned them about patient regret (Curtis, Mohllajee, & Peterson, 2006). One woman was 24 years old with five kids, but had been thinking of sterilization for quite some time. She said that her husband and doctor had dissuaded her in the past: "He always talked me out of it. Him and the doctor. 'Oh, you're too young, you should wait, you should be for sure.' Guess what? I'm not too young anymore and I'm for sure!"

Another woman had a 13 year old child from her first marriage and an unplanned pregnancy with her second husband. She emphasized that her physician was a woman yet still advised against her wishes for sterilization:

My female doctor ... told me that I could take the pill and wait a little while, because this baby was from my 2nd husband and she said, "Maybe you might decide that you want another child." So now we're divorced and I'm forty one years old. My daughter is about to be seven. I have no desire to have any more kids. I don't want to see myself being sixty years old and having an eighteen year old child.

Why Essure?

In the previous sections of this manuscript we outlined reasons respondents gave for choosing sterilization. Another question still remains: why the Essure procedure? The vast majority of women contrasted this procedure with tubal ligations; the new sterilization procedure was viewed as a separate, contraceptive option. Only two women stated that they would have preferred tubal ligation, but their insurance only covered Essure. This might

have been a misunderstanding because insurance plans should have covered tubal ligations, but our facility only offered Essure.

Sixteen women cited apprehension of surgery and full anesthesia required for tubal ligation for their preference for Essure. For example, one woman had her second, and last, child 13 years ago, but was scared of surgery. She told herself that she would wait until “something comes out that is just ‘in-and-out’ and no pain or minimal.” Eleven women also cited the short recovery time of the Essure procedure that allowed them to get back to working outside the home or domestic duties.

Other contrasts between the Essure and tubal sterilization came from many women who had been frightened by negative tubal ligation stories (as also mentioned above) such as early menopause, other physical side effects, and unexpected pregnancy. Furthermore, many women thought that the Essure procedure seemed more effective than tubal sterilization: “it’s actually gonna be blocked, it can’t grow back together.” Data show that non-U.S. born Hispanic women have more concerns about the efficacy of sterilization (Sangi-Haghpeykar et al., 2006), but the women in our sample were rigorously counseled, which might have increased their confidence in Essure.

Furthermore, tubal ligations have been performed for many years, thus the potential to hear of negative experiences is much greater. One woman was aware of this when she stated that she thought the Essure was more effective than the tubal ligation, but still had confidence in the newer procedure: “I’ve never heard anyone bad mouth it. I know it’s new, but it seems safer.” In addition, a quarter of the women in this study knew others who had gotten the Essure and had not heard any negative stories from them, which also points to the influence that friends and family can have on women’s reproductive choices.

Discussion

We found some similarities and some major differences in our data compared with other sterilization reports. Similarities included rare objections to sterilization by partners unless the couple disagreed about the number and gender of children desired. We also found that women opted for sterilization because of dissatisfaction with other forms of birth control, familiarity with sterilization, and their cognizance of structural constraints such as economic conditions and domestic responsibilities (also see Lopez, 1993; 1998).

Large differences between our data and those presented in other studies include a paucity of patient complaints about the medical establishment seen in other studies from a few decades ago (Lopez, 1993; Schensul et al., 1982; Velez-I, 1980). The women in our study did not feel rushed in their decisions because current law requires a 30 day waiting period, which was rigidly adhered to in our clinics. Other positive indications of informed consent were that only women obtaining the sterilization procedure could sign the consent form (as opposed to husbands in past studies). Also in contrast to past studies, our patients were counseled in English or Spanish, informed of all birth control alternatives, and asked many times to reiterate what procedure they opted for, what it was, and if they still desired it. We assume that these differences were attributable to an improvement in sterilization policies and health care delivery overall over the past few decades, and possibly the level of professionalism at our clinics.

Women were not pleased, however, with the Texas Medicaid minimum age requirement of 21 years. This might be problematic because in Texas in 2009, 55% of the Medicaid population was female and 77% was under age 21 (Texas Health and Human Services Commission, 2011). As seen in this study, many women with children wanted to get sterilized earlier but had to wait, and as a result, had difficulty with side effects, accessing,

or consistently using other birth control methods. One option might be to give women greater contraceptive autonomy wherein they need not rely on frequent clinic visits. For example, an injectable contraceptive is now available in a form that allows women to self-administer the injection, although it is more expensive. In addition, our clinics administered an initial supply of 3 months of oral contraceptives. Clinics might want to administer a 12 month initial supply as a standard.

Previous studies have shown that the younger women were at the time of sterilization, the more likely they were to report regretting that decision (Curtis et al., 2006). Given this, we suggest rigorous counseling on long-acting contraceptive methods be given to young women under the age of 21 who request sterilization. Hispanic women rely heavily on information from social networks (Yee & Simon, 2010), and the women in our sample had heard negative stories about the IUD, which swayed their opinions. More accurate knowledge about long-acting, and less invasive, contraception could increase their options.

Additionally, multiple women on Medicaid unsuccessfully attempted to get sterilized in our small study. This is in direct contrast to the assumption of potential discrimination based on large scale sterilization rates and public insurance status (see Bass & Warehime, 2009), without access to proximal data on recipient intentions. The researchers might assume that sterilization was not wanted, or coerced, when in fact there were other structural factors that disadvantaged low income women and limited their contraceptive options. For example, the women in our study opted for sterilization because they were unable to afford more children or had problems obtaining timely birth control. Furthermore, a number of these women's husbands refused vasectomies, which is consistent with data on educated, White, middle class men having the highest vasectomy rates (Barone, Johnson, Luick, Teutonico, & Magnani, 2004).

Returning to the larger, theoretical framework of women's agency, we confirm Lopez's (1993) conclusion of a false dichotomy of choice/ no choice for sterilization recipients. Although the women in Lopez's (1993) study had received tubal ligations, they mirrored the women in our study in that their reproductive freedom existed within a larger system of constraints. Many women in our study did not desire tubal ligations yet were ready for permanent birth control and saw Essure as a viable contraceptive choice. Despite the added option of Essure, we also conclude that more safe, effective, convenient, and affordable methods of birth control for women are still needed. Moreover, compared to men, more reproductive interventions are aimed at women and tend to be more invasive (Ratcliff, 2002:195), thus the need still exists for more male contraception.

We also concur with Lopez (1993) that more equitable social, political and economic conditions that affect family planning decisions are needed. We posit that the decision to get sterilized and breaking from, or adhering to, gendered and cultural norms is not a dichotomy, but rather exists on a continuum, similar to studies on women in restrictive religious societies (Abu-Lughod, 1990; Avishai, 2008; Gallagher, 2007; Gerami & Lehnerer, 2001; MacLeod, 1992; Mahmood, 2001). Some women in our study desired little change and others felt comfortable having personal goals if they fit within a maternal caregiving framework. These women were not confronting large gendered norms, but were breaking from the idea of the homemaker as a sole role for women. On the other hand, there were other women who explicitly discussed self-fulfillment, not wanting to do full-time care work, and their dislike of being homemakers.

With regard to the literature on contraceptive use among Hispanic women, this study begins to fill some gaps concerning the association between interpersonal relationship factors and contraception. Women, including Hispanics, in our study placed primacy on their roles as

mothers. They decided on sterilization and took initiative to end childbearing, especially if their partners refused vasectomy. In addition, a current or past history of relationship instability was a large component of their decision making. More information is still needed on couple level dynamics, and how each individual influences joint sterilization decisions.

Additionally, an assessment of the level of provider influence in the consultation and initial decision making processes would be helpful, because almost all the women in our study learned about Essure for the first time in the clinic at an annual exam, family planning visit, or postpartum check up. Studies have reported that much of women's health knowledge comes from strong recommendations from medical staff (Ratcliff, 2002; Taylor, 2004), and differ by clinic setting (Rapp, 1999). Last, the Hispanic women in our study were Mexican or Mexican-American, and we do not assume homogeneity among cultures and subcultures in Central and Latin America. More research with a closer cultural analysis of levels of acculturation, language, and subcultures is still needed.

Acknowledgments

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and or publication of this article: Dr. Berenson, under a mid-career investigator award in patient-oriented research (K24HD043659). Dr. Leyser-Whalen, as an NRSA postdoctoral fellow under an institutional training grant (T32HD055163; Berenson, PI). The content is solely the responsibility of the authors and does not necessarily represent the official views of the NICHD or the National Institutes of Health.

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