Women's Decision-Making for Postpartum Sterilization: Does the Medicaid Waiting Period Add Value?

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TITLE: Women's decision-making for postpartum sterilization: Does the Medicaid waiting period add value?

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Purpose: Currently, patients with federally-funded insurance are required to sign a sterilization consent form (SCF) at least 30 days prior to sterilization, while privately insured patients are not. This policy creates a disparity in access to an effective birth control method. Our qualitative study aims to clarify the decision-making process surrounding postpartum sterilization to better understand if the SCF adds value to this process.

Methods: We enrolled 25 women who underwent desired postpartum sterilization procedures, ten with private insurance and fifteen with Medicaid. We interviewed them using a semi-structured guide that explored topics such as reproductive history, reason for choosing sterilization, and decision-making timeline. We transcribed and coded the interviews and identified themes.

Results: Emergent themes were comparable between patients with private insurance and those with Medicaid. For most women, the decision to undergo sterilization took place over the course of their reproductive lives. Participants expressed that non-biased provider counseling, autonomy, and information from other women were helpful to their decision-making. Most subjects felt that the SCF might benefit other women, but did not/would not affect their own decision-making.

Conclusions: We found no evidence that decision-making processes differ between women with Medicaid and those with private insurance, suggesting that these groups should not be subjected to disparate restrictions on sterilization. The timeline surrounding this decision appears to be much longer term than the mandated 30-day waiting period. Characteristics of the decision-making process that women personally value, which in this population did not include the SCF, should be prioritized.

Student Contribution

Dr. Dutton, Dr. Janiak, and I each contributed to the conception and design of this project. I performed a literature search for prior studies looking at sterilization decision-making. The three of us met regularly in the fall of 2014/spring of 2015 to develop a targeted research question and to prepare a study methodology to best answer that question. Dr. Dutton and Dr. Janiak had past experience with qualitative investigations and guided me through the creation of a methodology for this project. I submitted the project to the Partners IRB for approval and later submitted amendments to the IRB as the need arose. I applied for and was awarded a Trainee Grant from the Society of Family Planning to fund this investigation.

I conducted the participant interviews involved in this study, collected information about the participants from the medical record, and transcribed the interview recordings verbatim. I used the funding from SFP to purchase gift cards to thank participants for their time and mailed them to the women we interviewed. I also responded to any calls/emails from participants with questions about their involvement in this study.

Dr. Dutton, Dr. Janiak, and I independently coded the first four interview transcripts, and the three of us met to resolve any discrepancies in the way we were identifying important comments/themes. I then created a final codebook with each code carefully described in order to ensure consistency in the way we were utilizing these markers. Dr. Janiak and I used this codebook to independently code the remaining 21 transcripts. We then met to resolve any differences. With regards to analysis, I initially looked through the data and compiled important themes that appeared. I shared my impressions with Dr. Dutton and Dr. Janiak, both of whom built upon the ideas that I had developed and contributed additional findings that they had taken from the raw data. We met on multiple occasions to discuss the most important themes within our data and how to best present them.

Next I wrote up a first draft of a manuscript describing our study and its findings. Dr. Dutton and Dr. Janiak provided multiple rounds of feedback for the manuscript, and I incorporated their suggestions. In early January 2018, I submitted our manuscript to Contraception for publication. We are currently awaiting a decision from this journal.

Appendix 1: Manuscript

1. Introduction

Female sterilization is the most prevalent contraceptive method among married women and the second most common method for women of reproductive age in the United States [1]. Women with government-sponsored health insurance or who are uninsured rely on sterilization more frequently compared to women with private insurance [2]. Currently, anyone with federally-funded insurance must sign a separate sterilization consent form (SCF) to verify receipt of counseling and then wait at least 30 days after signing the SCF before undergoing sterilization. Patients seeking sterilization who have private insurance coverage have no mandated waiting period [3,4].

In 1979, the US government established consent regulations for patients with government-sponsored insurance in response to historical occurrences of coercive or involuntary sterilizations [3]. The SCF and waiting period requirement are intended to protect the reproductive rights of vulnerable populations by guaranteeing sufficient time for informed decision-making prior to undergoing a permanent sterilization procedure. The consequences of this waiting period can include unfulfilled sterilization requests because the SCF was not signed, signed in the wrong time frame, or unavailable at the time of request [5]. SCF barriers are estimated to be the direct cause of 24-44% of unfulfilled requests [5,6,7,8], and in postpartum women, an unfulfilled sterilization request has been associated with increased risk of unintended pregnancy within the subsequent year. For this reason, and because women with private insurance are not required to sign the SCF or wait 30 days before undergoing sterilization, the American College of Obstetrics and Gynecologists (ACOG) has argued that this law creates a "two-tiered system of access" and has called for re-evaluation of the policy [4].

Prior studies investigating the impact of the SCF have evaluated the readability of the form, reasons for unfulfilled sterilization requests among individuals with Medicaid coverage, and women's feelings and attitudes around a declined request [5,8,9,10]. No prior studies have addressed the perceived value of a 30-day waiting period. This study clarifies the role of a waiting period in women's decision-making regarding postpartum sterilization through a qualitative exploration of the time frame in which women make this decision, patient perception surrounding the waiting period, and other factors that add value to the decision-making process.

2. Materials and Methods

2.1 Eligibility Criteria

We recruited English-speaking women ages 18-50 who underwent postpartum tubal sterilization immediately after childbirth, either during cesarean delivery or as a separate procedure following vaginal delivery, at an academic medical center between July 2015 and January 2016.

2.2 Data Collection

We identified eligible women using the electronic medical record. A member of the postpartum care team approached each patient to assess interest in participation. A research coordinator then met with interested patients to obtain written consent and conduct interviews, with 74% of subjects approached agreeing to participate. We planned for a convenience sample of 25 total participants to reflect a variety of experiences and opinions. In order to compare themes in responses between Medicaid-insured and privately-insured patients, we aimed to enroll at least 10 women from each group. We ultimately interviewed 15 Medicaid-insured and 10 privately-insured patients.

A designated research team member (OF) conducted roughly 20-minute interviews with each participant. We utilized a semi-structured interview guide that covered topics including reproductive history, contraceptive methods used in the past, factors that influence contraceptive choice, timing of decision-making surrounding postpartum sterilization, reasons for undergoing postpartum sterilization, and patient demographics (Appendix). We provided a paper calendar to improve patient recall regarding timing of events. Every attempt was made to interview the patient alone, but seven women preferred to be interviewed with a partner or relative present. We provided each woman with a $50 Visa gift card to thank her for participating. The Partners Human Research Committee approved this study.

2.3 Analysis

We recorded, transcribed, and analyzed all interviews in ATLAS.ti 7.0® using content analysis strategies. Initially, three investigators (CD, OF, EJ) independently coded four interviews. We reconciled coding schema, resolved discrepancies via discussion and consensus, and created a final codebook. Two investigators (EJ, OF) used this codebook to independently code the remaining interviews. We identified patterns and themes in participants' responses from transcript codes.

3. Results

3.1 Participant characteristics

More privately-insured patients were married when compared with Medicaid-insured patients (Table 1). Sixty percent of patients with private insurance obtained sterilization after C-section, while seventy-three percent of Medicaid-insured patients underwent sterilization after vaginal delivery. More women in our study with Medicaid insurance had five or more pregnancies prior to sterilization.

3.2 Contraceptive history and pregnancy intention

Most subjects reported using multiple contraceptive methods in the past. Many participants discussed reasons they prefer sterilization over the oral contraceptive pill (OCPs). Eight women reported past unintended pregnancies while using OCPs, and five explained that they prefer a method that does not involve a daily medication. Women also frequently reported undesirable side effects from various hormonal birth control methods (n=17). Nineteen of the twenty-five participants reported having at least one unintended (mis-timed or unplanned) pregnancy in her lifetime. Most women confirmed that the pregnancy resulting in their recent delivery occurred when they were not trying to or expecting to become pregnant (n=15).

3.3 Reasons for choosing sterilization

Our subjects described a diverse set of reasons for choosing to undergo sterilization. These reasons were similar regardless of insurance type. Many women reported that their families were complete (n=24), stated they were the right age for sterilization (n=12), and cited effectiveness of the procedure (n=10). Comments regarding method efficacy were often made in the context of discussion surrounding recent unintended pregnancy. Participants also commonly reported that the convenience of obtaining a sterilization procedure at the time of delivery was important in their decision-making (n=6). One 35-year-old mother of three commented, “And I knew that if I didn’t do it now, because my life is so busy or whatever…I wouldn’t just come to the hospital just to have my tubes tied.”

3.4 Timeline of decision-making

The timeline of sterilization decision-making was similar among women with private insurance and those with Medicaid. Women reported thinking about sterilization as an option over the course of their reproductive lives (Figure 1). For many, this decision-making process began at a young age when they heard about family/friends undergoing sterilization and continued throughout multiple pregnancies into their most recent pregnancy. Only one participant, who was privately insured, first began considering sterilization in the last trimester of her current pregnancy. She reported that she initially didn't know that she could have a tubal sterilization after a vaginal delivery. The majority of patient decision-making experiences began either prior to the most recent pregnancy – in some cases, many years before becoming pregnant - or shortly after finding out they were pregnant (n=20). Despite the fact that many women considered tubal sterilization earlier, most participants reported being 100% certain of a decision for sterilization in their second or third trimester (n=20).

3.5 Provider role and patient autonomy in decision-making

Almost all participants reported receiving valuable information about sterilization from their healthcare providers. Subjects discussed this option with their providers 3-5 times throughout their recent pregnancy. Women particularly appreciated when their providers highlighted the permanence of the method, gave them non-biased counseling, and tried to get to know them and their families personally. One 30-year-old mother of four commented on the impact her provider had on her decision-making process: "Um, you know the doctors kind of…She wasn't pushing me either way. It was more her just giving me information not making an opinion on what I wanted to do. And it kind of just made me feel very at ease with the decision I was making."

Participants in both the private insurance and Medicaid insurance groups also consistently reported appreciating the fact that they could change their minds throughout the decision-making process. In particular, women who signed the SCF 30 days in advance felt reassured by its non-binding nature and described that the opportunity to change their decision after signing was specifically discussed by their provider.

3.6 Role of family and friends or other resources in the decision-making process

Women often discussed sterilization with family and friends. When asked what resources she found important, one subject reported, "People's personal experience. Like I said, I've seen it for

myself, the scar is nothing, it's nothing. And the people are healthy." Women rarely identified the Internet or other written resources as their primary sources of information, instead valuing in-person information. For example, one woman stated, "I was talking with some friend, and they say, the best one I think it's [sterilization]. And I start to look for some information, on the Internet or online, and after that I talked to the…my provider. And she talk a little bit about it, and I say definitely I want that one."

3.7 Perceived benefits and drawbacks of SCF and mandated waiting period

One of the fifteen Medicaid-insured women named the mandate to wait at least 30 days as helpful to her decision-making process. She explained, "I did think about it some more, even though I knew I wanted it and knew I had to. But, I still like, you know, I did still think about it, even the day before... Is this what I really want? You know and it gives you time to go back and let them know if you really want it or not." Only one Medicaid-insured subject was unaware of the required sterilization consent form and waiting period.

When asked about the potential benefits of a waiting period, many patients in both the privately insured and Medicaid insured groups could not identify any utility of the policy. Several others identified hypothetical upsides; they most commonly cited increased time for decision-making. One Medicaid-insured subject commented, "I just…the only benefit is like, they have time to like, really read on it, do their research, and make a decision whether they want to really get it done or not."

However, in both populations, patients regularly reported that while the waiting period could theoretically be useful for other women, it did not/would not affect their own personal decision. The words of one subject insured by Medicaid reflects this discrepancy between self and others: "I mean, I think for people that are not a hundred percent sure like I was, it is a benefit because it gives you time to really think about, you know, what you're doing…But in my case, I already knew a hundred percent, you know."

Several participants recognized that the waiting period could be burdensome for women. One patient with a sister who had been denied sterilization because she missed the deadline for signing the SCF was particularly concerned. Another participant, who was insured by Medicaid, noted that she had to ask several times during prenatal visits before she was allowed to review and sign the consent. "[My baby was delivered at] 36 weeks and five days. So, I mean, I would have never made

that 30 day cut off if I wouldn't have been pressuring my…I mean I had to tell them like…I've been telling them since March. And they were like, oh OK, we'll get you the consent form. And every time I'd go in I'd go, you know, I really want to get this tubal ligation done…Oh, we'll get it for you next time…if it didn't happen the way that I made sure it happened, then I probably would have missed the cutoff."

4. Discussion

To our knowledge, this study constitutes the first investigation to specifically investigate patients' perceptions of the SCF mandated waiting period and its potential value in decision-making surrounding postpartum sterilization. We identified no major differences in emergent themes between women with Medicaid, who must sign the SCF 30 days before their procedure, and women with private insurance, who are not required to do so. Although the groups were disparate demographically, the comments surrounding decision timing and priorities were comparable. We found no evidence supporting the discrepant requirements for obtaining a sterilization procedure between these two groups of women, since there are few true differences between the populations' decision-making.

Most participants described an iterative decision-making process that took place over the course of their reproductive lives. Although participants rarely made an absolute decision to undergo sterilization prior to their recent pregnancy, most women had heard about and considered it, and thus begun the decision-making process, earlier in life. This timeline matches the most commonly cited reasons for choosing sterilization, patient age and completion of childbearing. These are longer-term life circumstances that supersede the patient's experience with her most recent pregnancy. Given that many women began thinking about sterilization well before the final month of pregnancy, the waiting period as a mechanism for increasing time for decision-making seems arbitrary for the women in our study who successfully obtained sterilization after delivery.

Many women reported that the ability to change their minds about the decision to undergo sterilization up until the time of the procedure was important to their decision-making processes. Neither privately insured nor Medicaid-insured patients in our study expressed feeling pressured into sterilization, and they valued their continued autonomy over this decision. The importance of autonomy also manifested itself in participants' responses regarding the value of the mandated waiting period. Some participants hypothesized reasons for why it might be of benefit to other

women, including increased time for decision-making and the attendant ability to change one's mind. However, participants repeatedly commented that the waiting period did not or would not benefit their own personal decision-making, and a few women expressed concern that the SCF could be a barrier to a desired sterilization procedure.

Comprehensive, non-judgmental counseling from a provider appears to be important to women making a decision for sterilization. Input from other women, such as family or friends, who previously underwent sterilization also seems to add value to decision-making. This finding suggests that there may be a role for connecting women considering sterilization with patients who have gone through the procedure.

This study has several limitations. We did not include women affected by medical or logistical barriers to fulfillment of a sterilization request; thus, our results may only be generalized to women who received a desired sterilization. In addition, patient populations particularly vulnerable to forced sterilization are not well represented at our institution. Finally, our study methodology entails a risk of social desirability reporting bias in the context of in-person interviews.

The ethics surrounding the SCF present real concerns [3]. Given the serious negative consequences of the waiting period, and the differential burden that it places on women of lower socio-economic status, the lack of value in the decision-making process identified in this study further suggests that the policy requires re-evaluation. However, ACOG accurately points out that promoting true reproductive justice requires striking a difficult balance between protection for the most vulnerable women and open access to contraceptive methods [11]. Further investigation into the consent process surrounding sterilization for these vulnerable women is needed. Meanwhile, the characteristics of the decision-making process that appear to add value for patients, such as non-biased counseling, input from women who have undergone sterilization, and patient sense of autonomy should be prioritized.

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Table 1. Participant demographic characteristics.

Characteristic	Number of Privately-Insured Participants (%)	Number of Medicaid-Insured Participants (%)*
Age		
21-25	0 (0)	2 (13)
26-30	1 (10)	2 (13)
31-35	2 (20)	5 (33)
36-40	6 (60)	6 (40)
>40	1 (10)	0 (0)
Marital Status		
Married	8 (80)	5 (33)
Single	2 (20)	6 (40)
Divorced		2 (13)
Separated		2 (13)
Mode of Delivery		
C-section	6 (60)	4 (27)
Vaginal	4 (40)	11 (73)
Number of Pregnancies		
1-2	0 (0)	1 (7)
3-4	8 (80)	6 (40)
≥5	2 (20)	8 (53)
Living Children		
2	2 (20)	2 (13)
3	4 (40)	5 (33)
4	4 (40)	6 (40)
5	0 (0)	2 (13)
Total	10	15

*Percentages rounded to whole number.

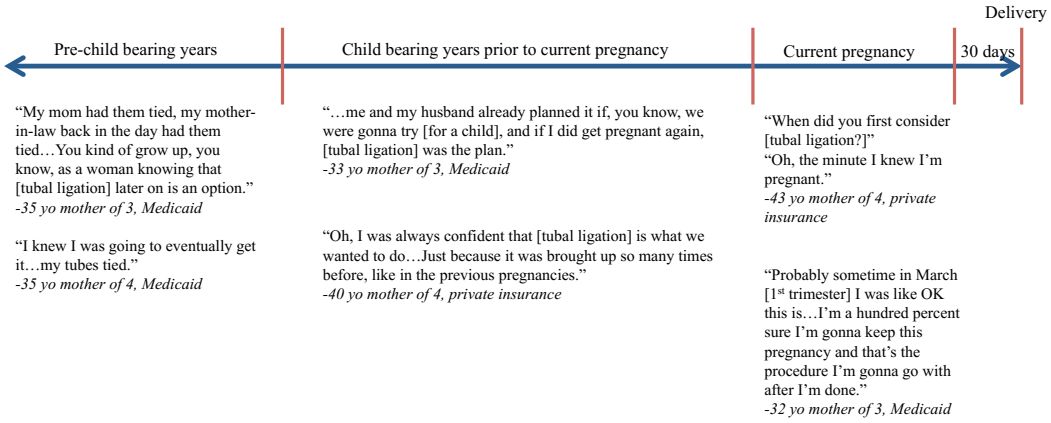

Figure 1. Participant thought processes surrounding sterilization on a timeline of reproductive life, with illustrative quotations.