

Advocating for Policy Guaranteeing the Right to Receive Sterilization

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Abstract

The purpose of this essay is to present the need for policy guaranteeing the right for physically and psychologically eligible United States patients to receive a sterilization procedure as a form of contraception regardless of one's number of children or the lack thereof. As such, this essay is structured as an advocacy paper that will utilize medical ethical guidelines as well as the principles of social justice in order to present the guidelines under which an effective policy can be constructed. Since, like other reproductive rights issues, sterilization is a medical, social, and political issue, sources of information drawn upon include compilations of statistics on sterilization, current medical guidelines and perspectives, as well as popular opinion and reproductive justice thinkpieces. The principal findings in developing the guidelines for this advocated policy are the need for a minimum age limit for sterilization; neutral presterilization counseling and questioning to determine patient fitness, ability to give informed, enthusiastic consent, and chance of regret; the ability for policy to be applicable to patients of all genders and assigned sexes at birth; the development of policy based on modern research; and applicability to and moral neutrality towards a wide variety of parenthood structures and sexual lifestyles. Bodily autonomy and reproductive rights have been crucial battlegrounds in not only politics but also public health policymaking and outreach programs, and codifying sterilization as a right can improve prospective patients' access to bodily autonomy-affirming procedures and reduce unwanted outcomes such as undesired pregnancy.

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Preface

I would like to thank my advisors Dr. Wesley Rohrer, Dr. Frayda Cohen, and Dr. Cindy Bryce for their unique perspectives and feedback in the development of this essay.

I would also like to acknowledge the countless members of the childless-by-choice community for their tireless support of enthusiastic, voluntary sterilization as a reproductive right, and for initially piquing my interest in the subject of permanent contraception.

Finally, I would like to thank my friends, partner, and family for their support and guidance, particularly in regards to editing and revising this paper.

1.0 Introduction

Freedom of reproductive choice is essential for a society that desires to be advanced in the spheres of public healthcare, women's rights, and personal liberties. One way that someone may choose to apply their reproductive freedom of choice is through pursuing sterilization as a form of contraception when they have completed their desired childbearing (or lack thereof). Unlike other reproductive rights issues involving deeply personal choices, such as receiving abortion or choosing to have sexual intercourse with a consenting adult of a certain gender, the issue of sterilization has received comparatively little attention in public policy making and advocacy efforts. Sterilization is tied not only to improving individuals' abilities to make the reproductive choices that are right for their lifestyle and the future they envision, but also in reducing undesired health outcomes such as unwanted pregnancy.

This essay is an advocacy for policy codifying the right for adults, who are capable of giving consent to a permanent procedure of this nature, to receive sterilization as a form of permanent contraception. In the sections that follow, the author will detail the benefits and risks of sterilization, the cultural factors impacting one's decision whether or not to receive it, and any current legal or cultural obstacles impacting access to sterilization as permanent contraception. First, a *literature review* will reference relevant statistics about the people who receive sterilization as well as the consequences, positive or negative, that may come about as a result of the procedure, as well as sociological insight about why one may choose sterilization, including a brief history of the laws and cultural attitudes regarding sterilization. Next, the *expected outcomes*, *methodology*, and *findings* sections will outline steps for developing a well-informed policy advocating for the right to sterilization of medically and psychologically fit, enthusiastically consenting adults that

draws upon the relevant medical and sociological literature. The *analysis* and *discussion* sections will discuss in more detail the complex factors implicated in contraception decisions, including but not limited to sterilization, with an emphasis on social justice and fair treatment to diverse patient groups. The *recommendations* section will detail the conditions that must be present for sterilization policy to be implemented fairly to all patients and with the lowest risk of adverse effects, medical and psychological. Finally, a *public health justification* section will connect the topics of this paper to the field of public health and detail why this is an issue of immediate relevance that could benefit from collaboration between both the patient-facing and policy-making sides of medicine.

1.1 Technical Terms Used

BARRIER CONTRACEPTION: Contraception designed to prevent pregnancy by creating a physical barrier blocking sperm from reaching an egg. These may be assisted by or require the additional use of spermicides (chemicals designed to kill or immobilize sperm) for maximum pregnancy prevention potential. Includes condoms, diaphragms, cervical caps, and contraceptive sponges. These typically are usable for either only one act of intercourse or a brief time period during which intercourse may occur.

FERTILITY: The potential to contribute a sizable quantity of sperm capable of fertilizing an egg or to produce eggs capable of being fertilized and implanted in the uterus. *Infertility* is the state of prolonged difficulty conceiving a viable pregnancy despite foregoing contraception and engaging in regular sexual intercourse during expected ovulation times. *Sterility* is the complete inability to conceive a viable pregnancy.

FERTILITY AWARENESS METHODS: A variety of systems to track menstrual and ovulatory patterns to determine one's most fertile days. One popular method of fertility awareness/ovulation tracking is examining one's cervical mucus texture, as this changes throughout the ovulatory cycle (Planned Parenthood, 2023). Another method is lactational amenorrhea, the pausing of menstruation and ovulation during an exclusive breastfeeding relationship with one's child (Planned Parenthood, 2023). Can be used either as a method of trying to conceive a pregnancy, by having sexual intercourse on fertile days, or as a method of contraception, by avoiding sexual intercourse on fertile days.

LONG-ACTING REVERSIBLE CONTRACEPTION (LARC): Contraception that, when administered, is designed to prevent pregnancy for multiple years and result in the swift return of fertility upon removal. Includes the intrauterine device (IUD) and contraceptive implant.

NULLIPAROUS: Someone who has never given birth to a live-at-birth child.

PAROUS: Someone who has given birth to one or more live-at-birth children.

POSTPARTUM STERILIZATION: Sterilization performed shortly after childbirth. May involve laparoscopic surgery or open abdominal surgery accompanying a cesarean section (Csection).

SHORT-ACTING REVERSIBLE CONTRACEPTION (SARC): Contraception that, when administered, is designed to prevent pregnancy for a short time (typically less than a month per dose) and result in the swift return of fertility upon being discontinued. Includes the oral contraceptive pill, the vaginal ring, the contraceptive patch, and the contraceptive shot.

STERILIZATION (or permanent contraception): Any procedure taken to permanently prevent the conception of a viable pregnancy in one's own body or the body of a sexual partner. May include hysterectomy, tubal ligation, bilateral salpingectomy, vasectomy, etc.

VOLUNTARY CHILDLISSNESS: Choosing to completely forego biological parenthood and often adoptive or foster parenthood as well. Voluntary childless people may use reversible or permanent contraception to prevent conception. Also known by other terms including being “childless by choice” and “childfree.”

In addition to these listed terms, the author believes it is important to note that while several different sterilization procedures for both sexes are listed, these procedures may not always be indicated for all sterilization-seeking patients and may even be actively contraindicated. In particular, hysterectomy is a more radical procedure than both tubal ligation and bilateral salpingectomy and is not typically indicated as a contraceptive procedure alone. When the ovaries and Fallopian tubes are also removed along with the uterus, this effectively induces menopause even in non-menopausal-aged women, and as such is avoided unless medically indicated. However, some sterilization seekers may also present with conditions that may indicate hysterectomy, such as uterine fibroids, endometriosis, and chronic pelvic pain (Mayo Clinic, 2023).

While sterilization procedures will often be discussed as a group, it is important to note that no two procedures are exactly interchangeable in terms of medical or interpersonal consequences. Particularly, since two people are required to conceive a pregnancy, one can either rely on their own sterilization, which a person can know with certainty they have actually received, or their sexual partner(s)' sterilization, which is not outwardly visible and requires profound trust that their partner(s) has actually received the procedure in question. As such, relying on partner(s)' sterilization may not be advisable for people with sexual partners with whom they may not be familiar.

2.0 Literature Review

In this section, the author will discuss the relevant medical and sociological literature regarding sterilization, including the statistics about who seeks and receives sterilization, its rates of complications and regrets, as well as prevailing social and political attitudes about sterilization. Since sterilization is both a medical and social issue, it is important to draw upon not only peer-reviewed studies and comprehensive analyses of sterilization in order to gather hard data about the statistics of sterilization but also popular opinion pieces that gauge the feelings of a more lay audience.

Sterilization is a commonly sought form of permanent contraception pursued by both men and women, who may choose sterilization procedures at many different ages during their fertile years. Among women of childbearing age, 27% use their own sterilization as contraception, and 9.2% use the sterilization of their partner, making a total of 36% of fertile women seeking out contraception using this method (Bartz & Greenberg, 2008). Compare this to 30% for the next most common form of contraception - the oral contraceptive pill (Bartz & Greenberg, 2008). Sterilization is sought out by both childless people and parents. Approximately half of all female sterilizations are performed very shortly postpartum, and half do not immediately follow a birth (Bartz & Greenberg, 2008). Vasectomies are less common than female sterilizations with 500,000 and 700,000 procedures respectively, performed annually (Bartz & Greenberg, 2008).

2.1 Factors Influencing the Decision to Receive Sterilization

Sterilization is desired due to its permanence and high effectiveness rate. The 10-year pregnancy rate among women who received tubal ligation was 1.85% (95% CI, 1.51%-2.18%). Among women relying on a partner's vasectomy to prevent pregnancy, the 5-year pregnancy rate was 1.13% (95% CI, 0.23%-2.03%) (Bartz & Greenberg, 2008). In addition to the contraceptive effect, sterilization is associated with health benefits, such as lower rates of ovarian cancer and pelvic inflammatory disease (Bartz & Greenberg, 2008). Sterilization is also very safe, with a death rate of 1-2 deaths per 100,000 female sterilization procedures (Bartz & Greenberg, 2008). Compare this with the higher maternal mortality rate of 17.4 deaths per 100,000 live births (National Center for Health Statistics, 2022). Vasectomy also has a very low rate of fatal complications. According to statistics measured up to 1990, only 2 deaths have been reported that are attributable to vasectomy (Serious complications, 1990).

2.2 Cultural & Sociological Perspectives on Fertility, Parenthood, & Contraception

In addition to the security of permanently preventing unwanted pregnancies and some other reproductive health benefits, sterilization is associated with no change or positive change in libido and sexual satisfaction, at least among women receiving a sterilization procedure. This relates to the sociological implication of increased access to this reproductive right. Sterilization, like other reproductive health issues such as nonpermanent contraception, abortion, and assistive reproductive technology, is as much a medical issue as it is a social one. Modern feminist practice focuses heavily on sexual and reproductive rights as a means to advance gender equality - most

prominently focused on are abortion and sexual consent, but sterilization is also an issue of increasing relevance. According to one feminist perspective, “elective sterilization enables women to permanently control their ability to be sexually active without the risk of pregnancy, a powerful assertion of autonomy that destabilizes patriarchal expectations for women to accommodate men’s sexual pleasure, be monogamous, and maintain feminine ‘purity’” (Davis & Dubisar, 2019).

The key tenet of feminist practice is the choice to be able to live one’s life as desired, free from being forced into a preordained gender role. Since gender discrimination is a very effective tool to keep people within the bounds of gender roles, advancing the social status of all genders so that gender-based discrimination, including lack of access to healthcare, is no longer significant is an important step in accomplishing this freedom. Enthusiastic consent should be able to be given and revoked completely at will by the individual, regardless of their gender, and others should respect this consent or lack thereof.

The current state of United States policy in which sterilization is not a codified right allows too much room for gender discrimination, as in doctors unfairly denying too many women sterilization seekers, and the non-medically-indicated denial of one’s enthusiastic consent. The primary people whose consent is most directly relevant are persons who seek sterilization, any of their current or future sexual partners who are possibly capable of impregnating them or being impregnated by them, and healthcare providers such as gynecological and urological surgeons who are trained and licensed to perform sterilization. To properly apply feminist thought to sterilization would be to consider the consent of all these groups, how they interrelate, and how matters of sterilization can be discussed and planned to improve the quality of life of those involved. Under such a policy, a sterilization seeker should not have to fear their procedure being rejected for non-medically-indicated reasons such as the doctor’s personal philosophy, but a doctor would also have

the ability to override the enthusiastic consent of a sterilization seeker who faces undesirably high risks of complications from a procedure.

Both modern and classic feminist literature focus heavily on the freedom to choose one's romantic, sexual, or parenting lifestyle. Particularly, freedom to make the parenting choice is prominently discussed in Betty Friedan's 1963 book *The Feminine Mystique*, which notes the dissatisfaction many contemporary American women were feeling regarding their lives as housewives or mothers. Friedan summarizes this by saying, "we can no longer ignore that voice within women that says: 'I want something more than my husband and my children and my home'" (Friedan, 2010). Parenthood, while nonetheless a desired life choice for many people, is undergoing a change from being the expected norm to a voluntary choice that can be opted out of, whether by abortion terminating an existing pregnancy, adoption relinquishing parental rights to an existing child or fetus that the pregnant person is planning to carry to live delivery, or sterilization preventing conception in the first place. While *The Feminine Mystique's* perspective is more focused on women having a husband and children as well as more than just that, it and other contemporary second-wave feminist perspectives focused heavily on women's desire to choose between domesticity and career, housekeeping and the life outside the home, and the well-being of a woman's husband and children and the pleasure of the woman herself.

The second wave's focus on women's autonomy and agency built the groundwork for modern third-wave feminism, with its broader focus on sexuality as a whole, not solely the sexual lifestyles of cisgender women who have or desire a husband and children. While the second wave's strive for women to have romantic and/or sexual agency were monumental in advancing the social value of a woman's enthusiastic consent, the third wave asks the radical question of why such an issue should fall solely on the shoulders of women in the first place. Contraceptive responsibility

notoriously falls overwhelmingly on the woman, despite the significant side effects many forms of contraception may pose for her (MSI Reproductive Choices, 2022).

As such, a well-informed, feminist sterilization policy should emphasize the agency of all genders when making contraceptive decisions. Women should be uplifted in their ability to make informed romantic, sexual, or parenting decisions, but not in a manner that unfairly places the burden of parenthood or contraception on them rather than their partner(s). While initially considering this paper, the author considered focusing on solely female sterilization, but upon reflection such a focus would not accurately convey the importance of both the masculine and feminine in impacting contraceptive decisions.

There is a need for nuance in constructing good policy here, since while easier access to enthusiastic consensual sterilization sounds like the most reasonable idea on paper, there are certain groups of people who may not look so fondly upon sterilization and contraception. A true feminist policy would engage deeply with intersectionality, noting not only the sex and genderbased biases at play in sterilization decisions, but also one's other identity categories, their relations to one's gender roles, and their relations to one another. Sterilization in the United States has a long, complex history of being used to perpetrate eugenicist ideas by preventing those deemed as inferior from reproducing - particularly people of color and members of the disabled community. Policies were developed not only allowing but actively encouraging the forced sterilization of those deemed inferior (Davis, 1982). The 19th century saw forced sterilizations and reproductive experiments performed on enslaved Black women, and the 20th century saw continued abuse of what many policies deemed "the feeble-minded," which often included Black people, welfare recipients, and the developmentally disabled. While the influence of these eugenicist opinions and practices has dulled over time, this historical precedent still casts a

looming shadow on present and future sterilization policy that must be cautiously avoided and rejected.

One crucial failure of the second wave's drive for abortion rights was not giving voices of color the opportunity to be heard. Contrasting with the more hopeful picture painted by white abortion activists, abortion for women of color was not so much an enthusiastic decision to terminate their own pregnancies, but rather to avoid subjecting their fetus to a birth into a world rife with discrimination and racism (Davis, 1982). Another factor breaking apart the supposed enthusiasm that white activists claimed should be a crucial part of every decision to receive an abortion was the passage of the Hyde Amendment, which withdrew federal funding for abortion, and thus the Medicaid coverage that was and still is used more by women of color than by white women. Impoverished women, then, may not have the economic ability to make the enthusiastic decision to terminate their pregnancies. Notably, following the Hyde Amendment, sterilization procedures would remain free of charge to Medicaid recipients. As such, in order to avoid the consequences of having an undesired pregnancy they could not terminate, many Medicaid recipients need to turn instead to sterilization as a permanent pregnancy prevention, even though they may not ultimately desire such (Davis, 1982).

In a vacuum, a policy ensuring one's right to a voluntary contraceptive procedure is entirely noble. However, in practice, it is crucial to research, draft, and revise policy in order to avoid repeating the mistakes of the past. Ideally, everyone should have complete autonomy over their reproductive choices, but the present culture and socioeconomic factors in the United States does not allow everyone that opportunity. Any drafted policy must not deprive nor excessively grant the privilege of receiving sterilization, lest eugenicist ideas be allowed to once again flourish as a result.

The attitudes influencing a person's decision to forgo having children entirely, or to permanently remove one's ability to conceive additional children, are incredibly diverse. It is important for potential sterilization providers to have some knowledge of the attitudes influencing family planning decisions, as this empowers both providers and their patients to make more responsible decisions about their reproductive health and reduce possibilities of regret.

- Antinatalism/environmentalism/"sparing children from the future": Antinatalism is a philosophy that advocates against having children. The reasons for adopting this philosophy are incredibly diverse, but one of the most common reasons is a reaction to human-induced environmental damage (Schumer, 2022). Some believe that it would be cruel to subject a child, who had no decision in their own birth, to an uncertain future that may see severe environmental damage, human rights offenses, and the risk of war.
- Generational/familial trauma: Adult children of abusive parents are more likely to abuse their own children than individuals who did not experience familial abuse (Greene et. al, 2020). As a result, some survivors of abuse choose not to have children in order to prevent perpetuating cycles of abuse.
- Tokophobia, reproductive/sexual trauma, and gender dysphoria: Tokophobia is a pathological fear of pregnancy and/or childbirth. Some people elect not to experience pregnancies of their own due to this fear. As well, reproductive and sexual trauma, such as child loss, rape, or genital mutilation, as well as gender dysphoria in transmasculine individuals, may influence people to not undergo pregnancy.
- Bodily autonomy: Sterilization can accomplish one's contraceptive goals without the risk of side effects posed by nonpermanent contraception.

- Preference for other types of interaction with children than parenting: It is a common misconception that the voluntarily childless necessarily dislike children. They may still desire positive interactions with children in non-parenting contexts such as teaching, providing social work or pediatric care, or having meaningful relationships with the children of family members.

2.3 Challenges to Receiving Sterilization as a Permanent Method of Contraception

2.3.1 Objections from Society

The societal expectation for couples, and especially heterosexual cisgender couples, to produce children is deeply ingrained in several cultures, which can be thought of as an “assumption of fertility” (Hadley, 2018). Childlessness is rarely viewed as a voluntary, enthusiastic decision. “It is assumed that if individuals do not have children, it is because they are infertile, they are too selfish, or they have just not yet gotten around to it. In any case, they owe their interlocutor an explanation” (Overall, 2012).

2.3.2 Objections from Medical Professionals

Upon seeking sterilization consultation from a medical professional, people (and especially women) are often told to wait until they are older and/or after having one or more children - the line “you’ll change your mind” is common among doctors refusing the procedure, especially when sought out by childless individuals (Bahadur, 2018). Many doctors believe that childless by choice

people will later decide they truly want biological children, and thus may regret sterilization, or even seek out reversal procedures or *in vitro* fertilization. This is contrary to medical evidence - a study from 1999 determined that rates of regret for sterilization procedures among women who were sterilized before age 30 were lowest for women who had never given birth - 20.3% of all women (including both nulliparous and parous women) sterilized under age 30 studied regretted the procedure, compared to only 6.3% of nulliparous women sterilized under age 30 (Hillis et. al, 1999). There is also an assumption on the part of doctors that people request sterilization on a whim, but members of the American Urological Association found that many men who requested vasectomy “[gave] the procedure serious thought for months or years” (Oster, 2016).

2.4 Political Battlegrounds & the Changing Reproductive Rights Climate

The issue of difficult and unequal access to sterilization services is an urgent one given the political climate of reproductive rights policy in the United States. The precedents set by landmark reproductive rights cases such as *Roe v. Wade* (1973) and *Griswold v. Connecticut* (1965) have been in a precarious position in more recent years. *Planned Parenthood v. Casey* (1992) partially overturned *Roe* (1973), and *Dobbs v. Jackson Women’s Health Organization* (2022) overturned the *Roe* (1973) decision in full. Associate Justice Clarence Thomas even hinted that the future of cases such as *Griswold* (1965) and *Obergefell v. Hodges* (2015) may have their precedent overturned as well. As of the time of writing, no major political or judicial opinion has been put forth that may threaten the legality of sterilization. Regardless, it is important to recall that reproductive rights issues exist in a complicated social climate as well as a legal one. In the wake of *Dobbs* (2022), the legal groundwork for reversing or significantly upsetting major sexual and

reproductive rights has been laid, and an abundance of caution is crucial to protect rights so fundamental as the right to control what happens within one's own body. Codifying sterilization as a legal right would have tremendous effects in advancing its status as a legally mandated right, and hope for it to be widely socially accepted.

The fact that the right to abortion has just had its precedent massively shaken, and that similar reproductive, sexual, and marriage rights may also be in danger, presents a clear indication of the urgency of codifying the right to receive sterilization as a form of permanent contraception. *Dobbs* (2022) created a massive impetus for personal contraceptive planning, in some cases including sterilization. People who were not already seeking sterilization began considering receiving a procedure, and people already seeking out sterilization felt a new sense of urgency to get their desired procedure done as quickly as possible. On June 24th, 2022, the day the *Dobbs* (2022) decision was announced, “online traffic to Planned Parenthood Federation of America’s web page on how to get a [female] sterilization procedure increased by 2,205%,” and interest remained increased by “more than 300% through July 21 [2022]” (Waltz, 2022). Interest in vasectomy saw a similar increase in interest of more than 1,500% on the date of the *Dobbs* (2022) decision and remained with at least a 200% increase in interest through July 21st, 2022 (Waltz, 2022).

Still, it is important to recognize the ethical challenges presented by this increased interest in sterilization following such a major reproductive-rights upset. Pittsburgh residents interested in sterilization who were interviewed by the local alt-weekly *Pittsburgh City Paper* overwhelmingly noted the current political climate following the *Dobbs* (2022) decision as a major impetus to seek out sterilization. One local woman noted that “the *Dobbs v. Jackson Women’s Health Organization*

ruling that overturned Roe v. Wade sealed a choice [to receive sterilization] she was already mulling over” (Waltz, 2022).

While most of the people interviewed by the *Pittsburgh City Paper* expressed a bold certainty about their decision to forego having more or any children, their enthusiasm for undergoing a sterilization procedure seemed to be, in some cases, paradoxically coerced. Rather than being a decision coerced by one’s partner or family, the current political climate surrounding reproductive rights has led many to believe that their reproductive rights rest in the hands of a select few political and judicial elite, whose decisions may be more influenced by partisan politics than public health good. The author has come up with their own term to define this phenomenon of engaging in an otherwise enthusiastic choice that still feels uncomfortable due to not being entirely in the hands of the person making the choice - “coerced enthusiasm.” As one man interviewed by *Pittsburgh City Paper* echoed,

“Although it was easy, although it was inexpensive for me, although it was a decision I was comfortable making, it is a drastic decision...Because of the state of politics, I ended up making that decision. And I would have preferred if it was not because of politics. I would have preferred if it was strictly a conversation that was had in my own home with my family. But it wasn’t.”

This idea of “coerced enthusiasm” brings with it a complication of patient priorities that will have to be considered in developing ethical sterilization policy. Outward coercion, whether directly by an individual or indirectly through cultural norms, is a crucial factor providers must consider when evaluating whether or not a patient is at high risk of regret for a sterilization

procedure. Providers must be able to reliably determine whether patients are unenthusiastic about sterilization but fearful of potential consequences of unwanted pregnancy - for whom a LARC method may be a better recommendation - or are deeply passionate about their sterilization decision and only further incentivized by the *Dobbs* (2022) decision to undergo sterilization as soon as possible. Presterilization counseling would be a powerful means to determine patient competency and regret risk. Due to the complex medical and social factors at play in influencing family planning decisions, these presterilization counseling questions should reflect not only patient medical history, including chance of high-risk pregnancy and birth, but also patient beliefs, including but not limited to beliefs that involve religion, politics, sexual lifestyle, and major life plans such as one's career and relationship plans.

2.5 Proposed Guidelines for Developing Ethical Sterilization Pathways

Enthusiastic choice is crucial in informing the decision to receive (on the part of patients) or perform (on the part of physicians) a sterilization procedure. Sterilization shares a number of similarities with abortion in this regard, and as such, legal, medical, and ethical precedent regarding abortion are a helpful starting point for evaluating sterilization policy. Abortion, like sterilization, is associated with a low overall rate of regret, with estimates of positive or neutral feelings including relief and describing the procedure as “the right decision” ranging from 84% to 99% (Kurtzman, 2020). It is clear that a person who elects to receive an abortion or sterilization procedure under duress from another person such as a partner or parent, or solely due to extenuating factors such as money or living situation, would be more likely to regret receiving

these procedures than someone who has thoroughly evaluated the pros and cons of parenthood versus the lack thereof and made a carefully thought-out, deeply personal decision.

Regardless of the overall low rate of regret, the possibility of regret is still non-negligible and must be factored into any policy decisions. Again, sterilization can be compared with abortion in this regard. Thirty-three states require mandatory pre-abortion counseling before the procedure is performed (Guttmacher Institute 2023). The notion of requiring counseling before this irreversible procedure is noble in theory and can be read as designed to prevent regret of a truly unwanted procedure, but in practice it is often politicized. Some states require providers of this counseling to provide specific information about risks of abortion that have been shown to be unproven, exaggerated, or falsified, which may unfairly frighten previously-willing abortion patients into not terminating their pregnancy (Guttmacher Institute 2023).

Those who draft pre-sterilization counseling should, then, be cautious to avoid the pitfalls of politicizing medical counseling and potentially presenting biased or inaccurate information, and should draw influence more from the positive elements mandated by some states' abortion counseling policies. For example, some states' pre-abortion counseling guidelines must include information informing patients about their choice in the matter and that abortion is not a matter of coercion (Guttmacher Institute 2023). These pieces of information are designed neither to dissuade nor encourage a patient but provide them with the unbiased, factual information needed to make an informed decision. Applying these ideas to sterilization, one might design presterilization counseling to include accurate, unbiased information about risks and benefits, such as chance of regret given a person's age and parity status, risks of undergoing surgery, and other health changes including risk of severe bleeding or scarring events and changes in cancer risk, both positive and negative, following sterilization.

3.0 Expected Outcomes

In forming the background for the policy suggestion, the author will be considering these questions:

- *What is the evidence supporting and opposing the right to voluntary, enthusiastic permanent sterilization?*
- *What elements of medical and/or sociological opinion should inform this policy?*
- *How can this policy be constructed to right the present inequalities involved in permanent sterilization?*

Existing policies to draw upon when forming this policy include topics such as abortion, personal medical freedom, gender equality, malpractice, the right to privacy, and fertility and family planning. Due to the lack of presently existing legal precedent regarding voluntary sterilization as a form of permanent contraception, there will be a need to extrapolate based on related case law, particularly that which results to abortion and nonpermanent contraception.

A well-constructed policy will achieve the goals of:

- Codifying the right to receive sterilization, pending presterilization counseling
- Outlining the guidelines for presterilization counseling that takes into account one's medical and psychological history and personal lifestyle preferences
- Not showing preference to any group of people, including but not limited to parents, men, white people, the able-bodied, or other groups who have historically had their reproductive choices validated more so than their counterparts

The risks posed by a poorly-developed policy may include unexpected rates of:

- Patient regret

- Approving too many or too few candidates for sterilization
- Approving medically and/or psychologically unfit candidates for sterilization and thus increasing preventable post-operative complications

4.0 Methodology

Here, a few guidelines will be provided to be drawn upon in implementing policy suggestions. These guidelines are informed by relevant medical and sociological literature and are designed to increase access to sterilization for indicated patients but also effectively reduce the risk of adverse effects, including poststerilization regret. A well-informed policy for guaranteeing the right to enthusiastic, voluntary sterilization should follow the following guidelines:

1. **Evidence-based.** Follows scientific evidence of benefit to the patient being cared for, rather than physicians' individual, subjective personal beliefs about gender, parenthood, and life planning
2. **Safe.** Emphasizing safety and minimizing regret while still providing care that emphasizes the patient's bodily autonomy and empowers their reproductive/sexual lifestyle
3. **Equal.** Provides equitable care to patients of all gender identities, races, parenthood structures (including voluntary childlessness), etc.
4. **Accessible.** Does not create an undue burden to receiving voluntary sterilization
5. **Multi-faceted.** Combines the desires of sterilization-seeking patients and the capabilities and expertise of sterilization providers and reproductive rights experts

In order to establish a basis for how these guidelines will be enforced in the final policy proposal, evidence will be drawn mostly from formal medical surveys regarding sterilization and expert opinion on the subject both from a medical and sociological perspective. Popular opinion from patients who have considered, are planning to receive, or have received sterilization is also an important resource to consider even though it is less formal.

5.0 Findings

These findings will draw upon the points addressed in the *Methodology* section to provide an outline for guidelines that are necessary to implement an effective, equitable sterilization policy. Below is a list of considerations to be included in the final policy, including the guidelines that the considerations draw upon. This matrix was completed based on the author’s review of the literature regarding relevant topics such as medical ethics, reproductive healthcare and justice, and feminist justice.

Table 1

	Evidence-based	Safe	Equal	Accessible	Multi-faceted
Setting a minimum age limit for sterilization		✓			
Requiring presterilization counseling	✓	✓		✓	✓
Includes male and female sterilization procedures, and also does not exclude intersex or transgender candidates			✓		

Reflects modern research into sterilization	✓		✓		✓
Can be applied to a wide variety of parenthood structures including voluntary childlessness		✓	✓	✓	
Does not make value judgments about sexual lifestyle, such as number or gender(s) of sexual partners, or parenthood structures	✓	✓	✓	✓	

6.0 Analysis

This section will summarize the benefits and risks of sterilization as are relevant in informing sterilization policy. While this section does not include every pro and con of receiving a sterilization procedure, these particular points have been selected because they have been evaluated to have particular gravity when informing one's own medical decisions or evaluating one's patient's medical decisions.

Voluntary sterilization can have many benefits to those who wish to receive it, including but not limited to:

- Increased control over one's own body and fertility improving confidence in one's reproductive and sexual lifestyle
- Decreased risk of certain cancers, including reduced risk of ovarian cancer after tubal ligation or hysterectomy (Green et. al, 1997)
- Preventing life-threatening pregnancy and/or birth in those who may have conditions exacerbated by these phenomena
- Preventing passing down severe and/or fatal genetic illness to a potential fetus, if applicable
- Providing contraception without the negative side effects and discomforts that may be present when using hormonal, nonhormonal, and barrier methods of (nonpermanent) contraception
- Permanently preventing conception of any children in the voluntarily childless, or conception of additional undesired children in people who have completed their desired childbearing
- Being more effective and more long-acting than the next-best option of LARC

- Being, at the time of writing, the only existing contraceptive method usable by men, with the exception of the external condom and the withdrawal or “pull-out” method (which are far less reliable than sterilization and only effective for one act of intercourse)

However, it is also important to note the disadvantages of sterilization as opposed to using nonpermanent contraception or forgoing contraception entirely.

- Increased risk of developing breast cancer post-menopause among nulliparas and people who experienced their first live delivery after age 25 compared to people who experienced first live delivery before age 25 (Schonfeld et. al, 2011)
- Difficulty of conceiving a pregnancy and/or reversing sterilization procedures for both men and women, sometimes requiring *in vitro* fertilization or sperm donation to facilitate a pregnancy post-sterilization
- Increased relative risk of ectopic pregnancy among women who have received tubal ligation as opposed to non-sterilized women (Shah et. al, 1991). Ectopic pregnancy has also been reported to occur following bilateral salpingectomy (Al-Sunaidi & Sylvestre, 2007)
- Risks of undergoing surgical procedures, including the chance of negative reactions to anesthesia, hemorrhage, nerve damage, and excessive scarring

7.0 Discussion

This section will touch upon some important points that are historically and/or culturally significant to informing sterilization policy. As sterilization is a social issue as well as a medical one, it is impossible to form an informed opinion on what constitutes the most equitable sterilization policy without some understanding of the sociological history of sterilization and other reproductive rights and bodily autonomy issues.

Any policy relating to reproductive rights must also take into account a broad variety of opinions influenced by socioeconomic factors including race, gender identity, and marriage/longterm partnership status. For example, during the early-to-mid 20th century when most of the forced sterilizations in the United States were performed, Black women were disproportionately sterilized compared to members of other racial identities. For example, between 1930 and 1970, 65% of the forced sterilizations in North Carolina were performed on Black women (Lennard, 2020). For a myriad of reasons including not only forced sterilizations but also experimentation on enslaved people and unethical studies including the Tuskegee syphilis study, 55% of Black Americans report a distrust of the healthcare system at large (Fletcher, 2020).

As such, voluntary sterilization policy must be monitored closely to ensure it is not disproportionately applied to certain groups of people. Such a failure might manifest as, but is not limited to, high rates of regret among voluntarily-sterilized people of color due to doctors downplaying expressions of hesitancy during initial consultation or presterilization counseling compared with white patients. As long as there is confidence that sterilization policy can be applied fairly and with the proper accountability, there is a need for policy guaranteeing the right to receive

sterilization if it is desired by a consenting adult. Poorly-implemented policy may as well be as inappropriate, if not moreso, as upholding the current status quo.

A properly-implemented, high-accountability policy would fall in line with the legal precedent set by other reproductive rights issues as well as prevailing medical opinion on the benefits and risk of sterilization. Codifying sterilization as a legal right would be an important step in bringing together scientific opinion and sociological opinion regarding these procedures. Patient self-advocacy and the right to determine one's own desired treatment path are crucial in enhancing patient trust in the medical system at large, increasing patient satisfaction, and improving patient confidence in themselves and their doctors.

As defined briefly in the *Technical Terms Used* section, there are several available methods of both permanent and nonpermanent contraception. The following chart will provide more context about these procedures, why they may be chosen, and how they may align with the goals of an ethical sterilization policy. Methods usable by men will be italicized. Please note that while postpartum sterilization procedures are simply conventional female sterilization methods performed on a postpartum patient, the context under which these procedures may be pursued presents unique benefits and risks.

Table 2

Contraception Method	Benefits	Risks & Contraindications
NONPERMANENT		
Barrier Methods (ex. <i>condoms</i> , diaphragms, cervical caps, sponges)	<ul style="list-style-type: none"> -Inexpensive -Condoms and sponges are available over-the-counter -Usable for one act of intercourse or a short time period (less than a day), allowing freedom to choose times of fertility vs. contraception without having to discontinue a hormonal contraceptive or have an implantable contraceptive removed -Condoms are the only contraceptive method that can prevent spreading or contracting STDs 	<ul style="list-style-type: none"> -Relatively high failure rate compared to other contraceptive methods listed -User discomfort, such as from latex allergy, condoms not properly fitting the penis, or spermicide-induced itching/discomfort
Fertility Awareness Methods (ex. ovulation tracking, lactational amenorrhea)	<ul style="list-style-type: none"> -Free -Requires no prescription or over-the-counter medications 	<ul style="list-style-type: none"> -Requires daily planning, diligence, and tracking -Lactational amenorrhea is usable only by mothers participating in exclusive breastfeeding
Long-Acting Reversible Contraception (ex. implants, intrauterine devices)	<ul style="list-style-type: none"> -Very low failure rate -Effective for 3-12 years, depending on brand -The copper IUD can be used as emergency contraception -The copper IUD is nonhormonal and may be indicated for patients with history of negative experiences with hormonal contraception -Sometimes associated with desirable off-label effects, 	<ul style="list-style-type: none"> -Can be extremely painful to insert and remove, especially for IUDs -Must be inserted by a specially-trained healthcare provider, and thus may not be accessible to all prospective users -May have unpleasant side effects such as depression

	such as reduction in acne or menstrual cramping	
Short-Acting Reversible Contraception (ex. the pill, the ring, the patch, the shot)	<ul style="list-style-type: none"> -Requires a prescription, but may be inexpensive or free on many insurance plans -Sometimes associated with desirable off-label effects, such as reduction in acne or menstrual cramping 	<ul style="list-style-type: none"> -Requires regular maintenance (taking a pill, receiving a shot, etc.) to maintain effectiveness -Contraindicated in patients with a history of blood clots -May have unpleasant side effects such as depression
PERMANENT		
Bilateral Salpingectomy	<ul style="list-style-type: none"> -Maintains the presence of other reproductive functions, such as normal ovarian hormone production and menstruation -Can be performed laparoscopically 	<ul style="list-style-type: none"> -Cannot be reversed. Any desired pregnancies following bilateral salpingectomy must utilize surrogacy or assisted reproductive technology -Requires general anesthesia and carries risks of surgery, such as bleeding and infection
Hysterectomy	<ul style="list-style-type: none"> -May improve quality of life for sterilization seekers who also have gynecological disorders (such as uterine fibroids or endometriosis) 	<ul style="list-style-type: none"> -Generally not indicated solely as contraception -Cannot be reversed. Any desired pregnancies following hysterectomy must utilize surrogacy -Creates a shortened vagina that may cause pain during sex -If ovaries are also removed, results in induced menopause -Requires general anesthesia and carries risks of surgery, such as bleeding and infection

<p>Postpartum Sterilization</p>	<ul style="list-style-type: none"> -Patients delivering via cesarean section will only require one abdominal surgical opening to accomplish both delivery and sterilization -Combining a sterilization procedure with a delivery reduces overall healing time compared to sterilization and delivery occurring totally separately 	<ul style="list-style-type: none"> -May not be readily available when desired, such as due to shortage of qualified surgeons or operating rooms at time of delivery -Requires general anesthesia and carries risks of surgery, such as bleeding and infection
<p>Tubal Ligation</p>	<ul style="list-style-type: none"> -Maintains the presence of other reproductive functions, such as normal ovarian hormone production and menstruation -In some cases, can be reversed -Can be performed laparoscopically 	<ul style="list-style-type: none"> -Requires general anesthesia and carries risks of surgery, such as bleeding and infection
<p><i>Vasectomy</i></p>	<ul style="list-style-type: none"> -The only sterilization option available to men -In some cases, can be reversed -Shortest recovery time and simplest procedure of all sterilization methods -Can be performed without utilizing general anesthesia 	<ul style="list-style-type: none"> -May reverse itself over time through regrowth of the vas deferens -However, surgical reversibility may also decrease over time, as pregnancy rates are higher in patients who received reversals sooner

Note. Data in table sourced from National Health Service (2023), Planned Parenthood (2023), Mills et. Al (2020),

ACOG Committee (2021), and Penn Medicine (2020).

8.0 Limitations

In this section, the author will address some of the difficulties faced in producing this policy advocacy and introduce ideas for future research to better develop this advocacy.

First, the author found a relative lack of relevant literature directly addressing motives of certain specific demographic groups to seek sterilization. Some literature reported higher rates of sterilization among certain minority groups compared to their majority or plurality counterparts (Li et. al, 2018) (Shreffler et. al, 2015) and some posited theories as to why these increased relative sterilization rates may occur, but there was a notable lack of directly surveying patients of certain socioeconomic groups about their motivations to receive sterilization or having this data evaluated to reflect different diverse groups' motivations rather than simply sterilization seekers as a single group.

One important limitation of developing this sterilization policy is the United States culture in which it is enveloped. United States culture is a tense battleground between sexual conservatism, which values monogamy and traditional heterosexual family structures with multiple biological children, and sexual liberalism, which values personal sexual choice which may or may not include multiple lifetime sexual partners or nonmonogamous lifestyles, or foregoing having children. Regardless, it is still a culture with a relatively high emphasis on personal choice. In cultures where reproductive rights are less advanced, there is far more of a trend towards a sexual conservatism that encourages having as many children as possible with only one's spouse as the only desirable choice for all genders. In such cultures, a policy advocating the right to sterilization would be far less effective at improving reproductive choice unless it was accompanied by a substantial cultural shift to emphasize personal sexual and reproductive freedom. As such, the policy being proposed

here could, in its current form, only be extrapolated to international cultures with levels of sexual freedom similar to that of the United States.

As well, since contraception, sexual lifestyle, and the parenting choice are deeply personal decisions that may necessitate compromise between sexual partners, there is a level of human error, so to speak, when considering the ramifications of sterilization decisions. Even if one were to develop policy or public health programs advocating for more balanced administration of each sex's available sterilization procedures, so the burden would hopefully be somewhat lifted from women, these decisions involve intensely personal, intimate lifestyle choices, and not to mention body parts to which many people may feel deeply sensitive towards and attached to when considering having medical procedures performed on them. As such, it cannot always be guaranteed that an individual and their sexual partner will make the sterilization choice that is statistically most likely to result in the fewest complications and shortest recovery time.

9.0 Conclusions

In summation, an effective sterilization policy must be sound within not only the field of medical ethics but also the broader area of social justice. Like other reproductive rights issues, the medical evaluation of a decision must be considered alongside the interpersonal evaluation and the broader social evaluation, such as how a sterilization may impact one's relationship with their sexual partner(s) or their community. As such, policy must reflect these intersecting issues as to focus on only one of them would be to see an incomplete picture of a prospective sterilization patients' motivations and values, and could lead to a patient or their doctor making an incorrect, irreversible decision. One who develops a policy advocating for the right to receive sterilization should be informed about the historical context of sterilization, including inequities in who had access to it or who even had the ability to consent to the procedure or lack thereof at all, as well as modern reproductive justice practice that emphasizes informed consent that should not be unfairly burdening one particular group of people, such as women. Since research into sterilization among other reproductive rights is a constantly changing issue that responds to changing cultural climates, such a policy needs reevaluation periodically over time to ensure that it meets the needs of the modern citizen.

10.0 Recommendations

All of the factors listed in the “Analysis” section are important to consider when developing sterilization policy, including presterilization counseling. The information must be presented objectively and without, intentionally or not, pushing a potential sterilization candidate into making an unwanted decision. This is especially important when presenting sterilization information to candidates with preexisting health conditions and family predisposition, especially in regards to cancer. For example, the decreased risk of ovarian cancer and the increased risk of breast cancer that may present with sterilization are statistically significant enough that the author believes they should be presented to patients in the spirit of full disclosure, but not so significant that they should be emphasized as a primary factor in influencing one’s sterilization decision. Indeed, the perceived improvement in life quality due to permanent contraception may, for some patients, outweigh the negative outcome of a somewhat increased rate of breast cancer.

Presterilization counseling as mandated by the proposed policy must be blunt and must accurately convey the gravity of potential consequences of one’s sterilization decision, but mustn’t be fear-mongering. In order to help ensure sterilization candidates fully understand the information they are presented with, it would be very beneficial to also create guidelines to accompany the presterilization counseling guidelines outlining strategies for communicating information to audiences with wide varieties of health literacy.

In order to ensure that sterilization policy including presterilization counseling is implemented in a way that is safe, ethical, and equitable, it will be necessary to conduct epidemiological research in the future following the implementation of such a policy. This epidemiological research should evaluate the rate of positive health outcomes including overall

life satisfaction as well as negative health outcomes including poststerilization regret or failure of the procedure to prevent conception. Basic demographic data will also need to be collected to ensure that sterilization is not being recommended to certain groups over others, such as an unexpectedly high ratio of disabled persons or racial minorities being recommended for sterilization over able-bodied persons or white people. If there is an imbalance of negative health outcomes versus positive health outcomes, or unequal consideration for sterilization depending on one's class membership, the sterilization policy as proposed and implemented will need to be reconsidered to right the wrongs that present themselves.

10.1 Future Work

As mentioned in the prior section, it is highly recommended that additional research be pursued to more effectively understand sterilization motivations as they differ by socioeconomic group as well as sterilization motivations and access for male sterilization seekers. Even broadly among patients as a whole, not stratified by socioeconomic group, there was a relative lack of relevant literature that was either specific to United States patients, as this policy advocacy would be applicable to, or conducted within the past 30 years. Due to the rapidly changing climate and fierce political battleground of reproductive rights that has been seen in the years just prior to this paper's publication, it would be highly recommended for more research to be done specifically addressing modern-day United States patients' reasons for seeking sterilization, with special attention paid to differences among socioeconomic groups. As well, in the pursuit of reducing the burden on women to be the primary providers of contraception in their sexual relationship(s), additional research into not only novel male contraceptive techniques but also the motivations for,

barriers to, and consequences of male sterilization should be pursued to develop further policy or public health programs.

11.0 Public Health Justification

Reproductive rights are a major topic of importance in public health policymaking. These issues are very heavily politicized and moralized, with the conservative side tending to argue against abortion and encourage childbearing, sometimes including opposition to any contraception, and the progressive side tending to argue in favor of keeping things like abortion, contraception, and sterilization legal and able to be accessed by consenting adults. However, while there are many policies and court cases addressing reproductive rights issues such as abortion and contraception, none exist to guarantee the right to receive sterilization (there are, however, laws prohibiting involuntary sterilization of nonconsenting individuals).

The ruling in favor of the right to use nonpermanent contraception signified a huge leap forward in not only reproductive healthcare but also the sociological issues that are directly affected by quality reproductive healthcare. Easy access to contraception is a safe and effective way to reduce negative consequences that may be associated with unwanted pregnancies, such as decreased life satisfaction, abortions, child relinquishments, or even neonaticides. Nonpermanent contraception is an invaluable tool for those whom it fits into their life plan - those who want children someday, but not now; or who are not sure about whether they want to have any additional children or any children at all. However, the side effects of nonpermanent contraception can range from uncomfortable to debilitating, and some may not be able to use it at all, including those with a history of blood clots or gynecological cancer. As such, permanent contraception may be the sole desirable option of contraception-seeking patients.

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