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Agency And Constraint: Sterilization And Reproductive Freedom Among Puerto Rican Women In New York City

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ABSTRACT: This research examines the myriad social, historical and personal conditions that have led Puerto Rican women to have one of the highest documented rates of sterilization in New York City. Through the use of the ethnographic method, I examine the interplay between agency and constraints that influence Puerto Rican women's reproductive behavior and shape and limit their fertility options. I also highlight the diversity of their sterilization experiences and reevaluate the appropriateness of the language of choice and resistance in the context of poor women's fertility decisions.

This article focuses on the social, historical and personal conditions that shape, influence and constrain Puerto Rican women's fertility decisions with respect to sterilization.¹ It examines the reasons why Puerto Rican women have one of the highest documented rates of sterilization in the world by concentrating on the interplay between resistance and constraints and by teasing out some of the contradictions in their reproductive decisions about sterilization.² It also highlights the diversity of experiences that sterilized Puerto Rican women
have with *la operación*, the colloquial term used to refer to sterilization among Puerto Rican women.

With the exception of cases of sterilization abuse, this ethnographic study demonstrates that Puerto Rican women make decisions about sterilization that are limited by their sociopolitical conditions. Their reproductive decisions are based on a lack of options circumscribed by a myriad of personal, social and historical forces that operate simultaneously to shape and constrain Puerto Rican women's fertility options. Presenting women as active agents of their reproductive decisions does not suggest that they are exercising free will or that they are not oppressed but that they make decisions within the limits of their constraints. As their oral histories reveal, women do actively seek to transform and improve their lives, and controlling their reproduction is one of the primary means they avail themselves to do so. Yet, as their oral histories also show, the constraints of their lives play an equally significant role in shaping their reproductive decisions and experiences. Consequently, this study takes into account the role that class, race and gender play in determining the range of options that individuals have available and how much control they have over them. While it is undeniable that all women have had their fertility options limited by the types of contraceptives developed and because they have had to bear much of the burden of population control, it is imperative to recognize that poor women are even more constrained.

It is also important to note that while the social and economic forces that limit Puerto Rican women's fertility options are not more or less constraining for them than they are for other lower-income people, particularly poor women of color, the historical antecedents that have led to the high rate of sterilization among Puerto Rican women are unique. In exploring the reasons for the high rate of sterilization among Puerto Rican women, I reformulate the binary model between submission and agency as well as withstand the temptation to use the term "resistance" in a monolithic way in the context of this study. I
found that there are "elements of resistance" in their attempts to forge out a social space for themselves on a personal level. Some women use sterilization as an "element of resistance" against the constraints of patriarchy/female subordination which subjects them to double standards and make them primarily responsible for their fertility, child rearing and domestic work. Other personal difficulties related to female subordination such as abusive relationships that involved substance abuse also play an important role in some women's decisions to become sterilized. However, these "elements of resistance" do not make their decisions an entirely defiant and conscious acts of resistance nor a complete break with the social conditions that have perpetuated high rates of sterilization.

In contrast to most of the studies on Puerto Rican women's reproductive experiences, I diverge from an exclusively cultural perspective that focuses on the women themselves as the principal unit of analysis and consider women within the wider structural and historical contexts that gave rise to and continues to perpetuate the high rate of sterilization. This aspect of Puerto Rican women's reproductive experience is as much a political as a cultural phenomenon, and ultimately speaks to wider issues of reproductive control and women doing the best that they can with their lives within the parameters of their socio-political oppression.3

Migration and Sterilization: Two Sides of the Population Coin

In order to understand the reasons why Puerto Rican women in Puerto Rico as well as in the United States have such a high rate of sterilization, it is essential to examine the sociopolitical and ideological framework in which sterilization developed in the Island. Puerto Rico became a colony of the United States in 1898. As early as 1901 government officials attributed Puerto Rico's poverty and underdevelopment to an "overpopulation problem." Though the "problem of overpopulation" in Puerto
Rico was more the result of U.S. capitalist, policy and legislative interests than of uncontrollable growth in population, an ideology of population was developed and implemented as a rationale for encouraging the migration of Puerto Ricans along with the sterilization of over one-third of all Puerto Rican women (Bonilla and Campos 1983).4 As a result of this ideology, migration was used as a temporary escape valve to the "overpopulation problem," while they experimented with more lasting and efficacious solutions, such as sterilization and diverse methods of fertility control.5

In New York City, sterilization became available for "birth control" purposes in the decade of the sixties. Puerto Rican women migrating to New York City in the fifties were already familiar with la operación because of its extensive use in Puerto Rico. By the decade of the seventies sterilization abuse in New York City had become a pervasive theme among, though not exclusively, poor women of color (CARASA 1979; Helen Rodriguez 1978; Carlos Velez 1978; Angela Davis 1981). Sterilization abuse takes place when an individual submits to a tubal ligation or vasectomy without their knowledge and/or consent or because they are blatantly pressured to accept sterilization. In the seventies, many judicial cases were documented of poor women who had been threatened to have their welfare rights taken away if they did not accept sterilization, not given consent forms at all, or provided with consent forms to sign while they were in labor (Rodriguez 1978). In this study, I found a few cases of women who were interned in a hospital for a different kind of surgery and were sterilized without their knowledge or consent, and many cases of women who were sterilized but were not aware of the permanent nature of a tubal ligation. In 1975, after a long and harrowing struggle undertaken by women's groups, health and community activists, sterilization guidelines were implemented in New York City to protect women and men against sterilization abuse.6

One of the questions my work raises is how do we then talk about agency and/or freedom of reproductive choice among
Puerto Rican women in the context of the historical legacy of coercion and sterilization abuse? Although sterilization abuse is an important part of Puerto Rican women's experiences, on the island as well as in the U.S., it is important to keep in mind that not all Puerto Rican women who have undergone the operation perceive themselves as having been coerced. Therefore, in examining Puerto Rican women's reproductive decisions, I take into account the diversity of their reproductive circumstances by considering the variation of their experiences which range from sterilization abuse to those women who suggest that they have voluntarily made the decision to be sterilized. Rather than pose these experiences in opposition to each other, I contend that all decisions are socially constrained and mediated when individuals confront them as active social agents.

The Setting and Methodology

The high rate of sterilization among Puerto Rican women on the island has been reproduced in the U.S., where Puerto Ricans in New York City have one of the highest documented rates of sterilization. In the context of New York City as a changing metropolis, in one of the inner city's oldest and poorest neighborhoods, I set out in 1981 to learn more about the individual and social conditions that shape on a daily basis the reproductive decisions of Puerto Rican women with respect to sterilization on a daily basis. The neighborhood where these women live is located between Williamsburg and Bushwick in Brooklyn, New York. This is one of Brooklyn's oldest garment districts. It is also the home of one of the largest Puerto Rican communities in New York City. Of the households with one or more Puerto Rican women over age twenty, 47 percent included one or more sterilized women. Ninety-three percent of the sterilized women were born in the island, but they were sterilized between the ages of seventeen and twenty-one, after they
migrated to New York.

The ethnographic method used to collect the data for this study are participant observation, oral histories, and an in-depth survey of a selected sample of Puerto Rican women. Intensive interviews were conducted with 128 Puerto Rican women, 85 of whom were sterilized. After spending two months in the field doing participant observation, I developed an extensive questionnaire which contained open-ended and closed questions. This questionnaire was administered by three women from the neighborhood and myself. After completing the survey, I continued doing participant observation and collecting oral histories from a select number of women who represented different situations that led women to either accept or opt for sterilization. I collected oral histories from seven families which consisted of a total of twenty mothers, daughters and grandmothers. This intergenerational perspective is important because it enables me to compare the perceptions and experiences of women from different generations within the same families. Through the collection of oral histories, I explored the different ways that Puerto Rican women use sterilization, the constraints that they face in making reproductive decisions, and how they resist these constraints and many use sterilization to help them solve the immediate problem of unwanted pregnancies.

Revisiting the Ideology of Choice

The ideology of choice is paramount in a discussion of sterilization among Puerto Rican women. At the heart of this research lies the question of what constitutes a “choice” and what the concept of “voluntary” means in the context of the lives of Puerto Rican women. The “ideology of choice” is based on the assumption that people have options, that we live in a “free” society and have infinite alternatives from which to choose. As individual agents, we are purportedly capable of
making decisions through envisioning appropriate goals, in order to increase our options. Implicitly, the higher the social and class status the greater the options. Striving toward the middle or upper class is, in part, a striving toward a "freedom" of expanded choice, which is part of the reward of upward mobility. By focusing on individual choice, we overlook that choices are primed by larger institutional structures and ideological messages.

The discrepancy and contradictions between agency and constraints led me to reconceptualize the ideology of choice in order to develop and refine a new language that enables us to think in a more dialectical way about Puerto Rican women's fertility behavior. In this formulation of individual choice, a distinction needs to be made between a decision that is based on a lack of alternatives versus one that is based on reproductive freedom. A decision is said to be more voluntary when it is based on a greater space of viable alternatives and the conditions that make this possible. Moreover, it is not simply a matter of the alternatives women have available to them but also the perceptions or knowledge women have about the various alternatives that are available to them. For example, a large number of women in this study did not know about the diaphragm.

Even though today's contraceptive technology is limited for all women, the options presented to these women were constrained by their lack of knowledge about the different forms of birth control technology as a result of limited resources and staff in the clinics/hospitals available to them. Therefore, reproductive freedom not only requires the ability to choose from a series of safe, effective, convenient, and affordable methods of birth control developed for men and women, but also a context of equitable social, political and economic conditions that allows women to decide whether or not to have children, how many and when (Colon et al 1992; Hartman 1987; Petchesky 1984). Consequently, I have deliberately avoided framing the fertility decisions of Puerto Rican
women within a paradigm of choice because it obfuscates the reality of their fertility histories and experiences as colonial/neo-colonial women.

Birth Control Versus Population Control

Although sterilization is technically considered birth control, a distinction needs to be made between sterilization and birth control on an analytical level as a result of the way it is used and its consequences for women's lives. For my purposes, birth control is defined as the ability to space children while sterilization entirely eliminates the management of birth control. In fact it renders the need to control fertility irrelevant. In most cases, sterilization marks the end of a woman's ability to reproduce. It is a method of population control which I have termed "fertility control" rather than "conception control." The important distinction is between population control as a state imposition and birth control as a personal right. It is not between sterilization and other forms of controlling births. Population control may be achieved through other methods: Norplant and abortion, for example, are presently considered. Population control is when a population policy imposes the control of fertility, as opposed to the individual right to control their own fertility, and even be sterilized if that is their desire. Fertility control can be defined as a population policy that imposes the curtailment of population growth on women, eliminating the individual's right to control her own fertility.

In addition to the technical differences between sterilization and birth control, sterilization also functions as fertility control when population policy is defined and implemented by health care providers to curtail the rate of population growth among a particular class or ethnic group because they are considered, in eugenic terms, a social burden, and therefore, should not procreate (Hartman 1987). Consequently, the important issue here is not sterilization technology per se, but
the way population policy is defined, translated and implemented.

On the national and international levels, health care policy plays an important role in narrowing women's fertility choices. Whereas federal funding initially covered the cost of abortion, the Hyde Amendment of 1977 changed this policy by denying women on Medicaid funding for abortions except in restricted cases or special circumstances. The refusal of the state to provide public funds for abortion services except in narrowly defined therapeutic cases, while making sterilization readily available suggests a definite predilection for sterilization over temporary methods of birth control and abortion (CARASA 1979). This reflects the goals of the director of USAID who stated in 1987 that by 1995 he wanted to sterilize one quarter of the world's female population (Hartman 1987).

I depart from a political economic analysis of sterilization as population control in order to consider the diversity of women's experiences and the different levels of resistance they engage in. I seek to establish a much needed new paradigm of reproductive choice that explores, interrogates and expands on what consent, choice, and coercion really mean within the context of these women's lives. In doing this I hope to broaden the concept of what constitutes coercive sterilization -- by showing the variety of factors that lead women to sterilization, including the active participation of women in sterilization and the elements of resistance they engage in. It is then possible to distinguish between birth control and population control.9

Diversity of Experiences

In addition to becoming sterilized for a series of reasons, Puerto Rican women experience sterilization in a host of different ways. For example, while sterilization may give a woman a great deal of freedom, it may be oppressive to another. Moreover, at one point, a woman may perceive ster-
ilization as independence, yet at a different point in her life she may perceive it as oppressive. For example, a woman who is glad she is sterilized may regret it later if her child dies or if she remarry and is not able to have any more children. Sometimes resistance and oppression occupy different spaces and other times they occupy the same space because different realities can, and often do, coexist within a particular content. For example, a Puerto Rican woman may decide to get sterilized because she does not want any more children. This is a vital decision for her because it gives her more control over her body, therefore giving it more self-determination over her life. In contrast, the state's motivation for encouraging her sterilization is due to her dependency on welfare where she is considered a burden on the state. By attempting to control her fertility motivated by consideration of economy and politics, the state imposes its double standard of "choice" and "freedom" which is potent oppression. Consequently, women and the state's interests intersect on the level that there is consensus between the woman and the state -- to control her fertility. Sterilization becomes simultaneously oppressive while it offers elements of empowerment, because both the state and women's motivation for wanting to limit their own fertility are at once synchronized as well as diametrically opposed. Therefore, on this level, there is both consensus as well as conflict and oppression (Lopez 1994).

Another way that women experience sterilization differently is based on their life situation. Often, there are conflicting conditions in women's lives where resisting one set of circumstances subjects them to another, potentially oppressive set. Thus, a woman may get sterilized as a way of resisting forced maternity, submitting as well, to a health practitioner's recommendation or state policy on sterilization (Colon et al 1992).

Finally, it is also important to consider that voluntary sterilization must be available as a means of "birth control" for women to exert their reproductive freedom. Some women seek
sterilization because they have achieved their desired family ties and they either decide independently or with their companion/husband that they do not desire, and/or cannot afford to have any more children. Those women tend to use sterilization as fertility control because of their social and historical predisposition towards this technology and due to the lack of viable options. Given a woman's conditions, in some cases, sterilization may be the most reasonable decision they can make. There is also the possibility that even if these women had viable alternatives and their conditions were different, they still might elect sterilization. However, for the majority of women in this study, this is not the case.

Women's Perceptions of Their Bodies and Agency

In unraveling the complicated subject of the interplay between women's resistance, constraints and agency, I begin with an examination of the ways that women exert agency. This is best illustrated through women's perceptions of their bodies and the question of who should control them, as well as through the circumstances that have led some of the women to use sterilization as an element of resistance to patriarchy and female subordination. The elements of resistance occur as each woman's individual struggle to fight sexism, versus breaking with the constraints that have led them to get sterilized.

With the exceptions of those who were openly victims of sterilization abuse, most women in this neighborhood adamantly shared the view that sterilization was their decision because it was their body and they would do with it as they pleased. Consequently, most women did not feel that they had to ask the men in their lives for permission to get sterilized. Concurrent with this attitude, men rarely objected to a woman's decision to become sterilized unless the couple disagreed about the number and gender of the children desired. This was the case because most couples in this study agreed that it was difficult to raise and provide for more than three children.
It is important to remember that the perception that sterilization was their decision and the fact that they felt they had no viable options, appear to them as two separate issues. When I asked the question: “Who influenced your decision to get sterilized?” only one out of 96 women responded that her husband directly influenced her. This does not mean that women do not consult their husbands/companions about their sterilization decision. In most cases they did. What it means is that regardless of the man’s view, most women felt that they had the right to ultimately make the final decision about sterilization, because they were the one’s who were going to have the baby and would be the primary care takers. This data demonstrates the ways that women assert agency and the ways that agency and constraints sometimes intersect. It also illustrates that what may appear at first glance to be an “individual” or “cultural” factor may actually be socially or economically intermeshed. In addition to attitudes about who should control their bodies and their perceptions that they have been sterilized “voluntarily,” population policy, class and poverty play a critical role in limiting the fertility options of Puerto Rican women.

Socio-Economic Considerations

While most lower-income women experience difficult socioeconomic situations, households headed by female single parents fare even worse. Sixty-six percent of the women in this study are heads of households. Almost all of the women in this study stated that they had been married at least once, though 53.1 percent said that they were separated, divorced, or widowed. Almost three-quarters (70%) received either supplementary or full assistance from Aid to Dependent Children. The mean annual income in 1981 was $7000 or less. This income supports a mean of 3.4 children and two adults. With this money, women support themselves and their children, buy
food and clothing, and also pay the rent.10

The employed Puerto Rican women in this neighborhood are low-wage workers with little job stability, generally working in tedious jobs and often under difficult conditions. Eighty percent of the women in this study claimed that their economic circumstances directly or indirectly strongly influenced their decisions to become sterilized. Forty-four percent felt that if their economic conditions had been better, they would not have undergone surgery. As one woman stated:

If I had the necessary money to raise more children, I would not have been sterilized. When you can’t afford it, you just can’t afford it. Girl, I wish that I could have lived in a house where each of them had their own room, nice clothing, enough food, and everything else that they needed. But what’s the sense of having a whole bunch of kids if when dinner time rolls around all you can serve them is soup made of milk or cod fish because there is nothing else. Or when you are going to take them out, one wears a new pair of shoes while the other one has to wear hand-me-downs because you could only afford one pair of shoes. That’s depressing. If I had another child, we would not have been able to survive.

Although their socio-economic position permeates every aspect of these women’s lives, many of them did not reduce their reasons for becoming sterilized to strictly economic considerations because this was not how most of them expressed their views about sterilization and their lives. Instead they talked about the burglaries, the lack of hot water in the winter, and the dilapidated environment in which they live. Additionally, mothers are constantly worried about the adverse effect that the environment might have on their children. Their neighborhood are poor with high rates of visible crime and substance abuse. Often women claimed that they were sterilized because they could not tolerate having children in such an adverse environment and/or because they simply could not handle more children than they already had under the condi-
tions in which they lived. However, rarely did anyone say that they were sterilized because their annual income was only $7000. They mostly talked indirectly about the conditions that led them to get sterilized.

Lack of Access to Quality Health Care Services

On a local level, a person's resources profoundly affect the type of health care services an individual has access to, as well as their knowledge of their options. On a micro level, the quality of care and information that middle-class women receive in private hospitals broadens their choices by enabling them to make informed decisions within the limits of the contraceptive technology that is available. Conversely, the inadequate quality of care that poor women receive diminishes their ability to make informed reproductive decisions and in this way further restricts their already limited options. For instance, because public hospitals have fewer health providers, facilities, and time to spend with their patients, poor women are not always informed about all of the contraceptives that are available. This is particularly true about the diaphragm.

There is a prevalent belief among health care providers that Puerto Rican women reject the diaphragm because of a cultural aversion to the manual manipulation involved in its use. While this may be true for some Puerto Rican women, there are other equally compelling reasons why a large number of low-income Puerto Rican women do not use the diaphragm. Some of the women in this study did not use the diaphragm because they had never heard of it. This is true primarily because it is not frequently recommended to poor women, since in order to prescribe it the health provider must show the woman how to use it properly. This requires a minimum of ten to fifteen minutes of the health provider's individual time, as well as a private space. Time and space are premium commodities in municipal hospitals. Moreover, if the health providers believe
that the diaphragm is a culturally unacceptable method of birth control for the poor, chances are that they are not going to recommend it. Finally, there is also the attitude among health care providers that it is better to recommend mechanical and surgical forms of fertility control to the poor because they do not have sufficient initiative or responsibility for controlling their fertility.

Problems with Birth Control

The quality of health care services a woman has access to significantly influences her knowledge of contraceptives and attitudes about them. The lack of safe and effective temporary methods of birth control prompted many women in this sample to get sterilized. Although 76 percent of the women used temporary methods of birth control before getting sterilized, they expressed dissatisfaction with the contraceptives available, especially the pill and the IUD. As one woman stated:

The pill made me swell up. After three years, I had an IUD inserted. It made me bleed a lot so I had it removed. I was sterilized at the age of twenty-five because I couldn't use the pill or the IUD. I tried using Norforms and the withdrawal method before I was sterilized but neither method worked very well.

Thus, because women are cognizant of the constraints that their economic resources, domestic responsibilities, and problems with contraceptives place on their fertility options, many of them feel that sterilization is the only feasible "choice." In addition to the combination of social and historical factors previously mentioned that limit and constrain Puerto Rican women's fertility decisions such as socioeconomic considerations, these women's fear to allow their children to play outdoors because of the high rate of crime in their neighborhood, their lack of access to quality health care services, and many of
the domestic difficulties that stem from poverty, personal and familial issues also influence their fertility decisions.

Women Marry Young and are Primarily Responsible for Their Fertility and Child Rearing

The tendency to either marry or have their children while they are still relatively young precipitates their decision to get sterilized at a younger age: 66 percent of these women were sterilized between the age of twenty-five and twenty-nine as compared to Euro-American and Afro-American women at the age groups of thirty to thirty four (New York City Health and Hospital Corporation 1982). Moreover, most of the women in this study married and had their children before the age of twenty-five.

Therefore, by their mid-twenties, they had already achieved their desired family size but still had approximately twenty years of fecundity left. Since the most effective method available to curtail fertility is sterilization, their "choice" was to accept it or continue using temporary methods of birth control for the next twenty years.

The average woman in this study had between two and three children, their perception of the ideal family size. More than half (56.7 percent) claimed that they were completely responsible for their fertility and child rearing. While this may appear as an issue of individual choice, it is part and parcel of the construction of the nuclear family in a patriarchal society in which the brunt of the responsibility of child rearing and birth control is relegated to women. This is accomplished by providing birth control mainly to women and few if any contraceptives for men.
Women’s Religious Views and Familiarity With La Operación

Although Puerto Rico is a Catholic country, Catholicism does not appear to have a direct effect on most women’s decisions to be sterilized. Eighty seven percent of the women in this sample were raised as Catholics. Of these women only 32 percent felt that sterilization goes against their religious beliefs. In contrast, however, women’s familiarity with la operación has had a profound affect on predisposing them towards sterilization.

The prolonged use of tubal ligation has transformed it into part of the cultural repertoire for a large segment of the Puerto Rican population. Women’s perceptions about la operación are also strongly influenced by the large number of females within their own families who have been sterilized. The effect that almost six decades of exposure to this operation has had on predisposing Puerto Rican women to sterilization cannot be underestimated.

To acknowledge that sterilization has a cultural dimension to it does not, however, make the decision to become sterilized one based on free will since free will does not exist in a vacuum. Nor does such a decision suggests that it originates from women’s “folk” culture, as some scholars have implied through the language that they have used to describe this phenomenon (Presser 1973).11

Although the cultural beliefs of Puerto Rican women play an important role in their fertility decisions, particularly because of their misinformation about this procedure, this approach, like the culture of poverty thesis, blames the individual (Lewis 1976). For Puerto Rican women sterilization became part of their cultural repertoire because of the political, social and economic conditions that favored it, creating the conditions for their predisposition towards sterilization through the use of population control policies and initiatives.
Misinformation and Regret

Puerto Rican women have a very high rate of misinformation about the permanency of sterilization. Eighty-two percent of the women in this study make a distinction between the "tying" and the "cutting" of the fallopian tubes, a differentiation that does not exist. In one woman's words:

I feel that if a woman is not sure if she wants anymore kids, then she should have her tubes tied. If a woman has decided she absolutely does not want to have more children, then she should have her tubes "cut."

The importance of the high rate of misinformation about sterilization is that it is one of the main factors that maintains and perpetuates the high rate of sterilization.

The simplistic language used to discuss sterilization in hospitals such as "band-aid sterilization" and the "bikini cut" is another factor that contributes to Puerto Rican women's confusion about the permanency of this operation. This issue is complicated because in some cases, women have these beliefs and do not communicate them to health providers. In other cases, health providers do not tell women about the permanent nature of la operación, or they talk to them in a language that deemphasizes the permanency of this surgery thus making the situation worse. This leads to a high rate of regret among the women in this study.\(^{12}\)

Of the 96 sterilized women, a third (33%) regretted that they were sterilized. Twenty percent do not regret their decision. The others (46%) fall somewhere in the middle. That is, they did not regret their decision but they were not happy with it either, although they felt they made the best decision they could under their given conditions. Women tend to regret their decisions because they remarry and would like to have a child with their new spouse, their socioeconomic situation improves, or because one of their children died.
Conclusion

In order to accentuate the interplay between elements of resistance and constraints/oppression, this study has highlighted the complex, contradictory and multidimensional nature of Puerto Rican women’s experiences with sterilization. The issue of sterilization among Puerto Rican women is a complicated one indeed. On the one hand, with the exception of victims of sterilization abuse, the majority of Puerto Rican women suggest that they made a decision between getting sterilized or continuing to have children under adverse conditions. Because of the limited nature of this “choice,” however, many women feel they had no other viable alternative but to opt for, or to accept sterilization.

In the conceptualization of my work, I have deliberately rejected the language of choice. Such language invokes ideas of free will based on individual freedom, part of the liberal ideology of choice which promotes a binary framework of choice/no choice, voluntary/non-voluntary decision-making, and obscures the interplay between social constraints and human activity. Moreover, all human decisions are socially mediated but some people have more social space to make decisions than others.

In attempting to exercise control over their lives, Puerto Rican women may use sterilization as an element of resistance to forge some social space for themselves by refusing to have more children than they desire, and/or by attempting to exert some control over their socioeconomic situation, female subordination, and/or problematic relationships. This forces us to reevaluate the culture of poverty thesis of Puerto Rican complacency, passivity and lack of planning.

At the same time, it is necessary to frame their reproductive decisions within the context of the constraints that they face. Despite women’s desire to plan their lives, in addition to having children there are other forces operating simultaneously to shape, frame and limit their fertility choices. Puerto Rican
women's "individual choice" has been substantively circumscribed by the United States'/Puerto Rican colonial population policy as well as by women's poverty, race and gender oppression. The problem with sterilization is, of course, not the technology itself but the way it has been used to solve Puerto Rico's economic problem of underdevelopment and poverty by sterilizing Puerto Rican women. Then, moreover, given the social and economic constraints discussed, sterilization appears to them as the only viable alternative.

After four decades of residence in the United States, Puerto Rican women are still living in poverty, and they are still faced with the same dilemma of how to control their fertility. Although there are certainly more contraceptives today than there were in the past, after using and experiencing health problems with the pill and IUD, a large number of Puerto Rican women turn to sterilization, a method of fertility control they have now been practicing for approximately six decades. Aside from their predisposition to la operación, sterilization is also frequently recommended to them in municipal hospitals. Although public attention in New York City is not directed at an overpopulation problem, as it is in Puerto Rico, the "welfare problem," is an item of considerable debate since it is the poor who are considered to have too many children.

In addition to the historical antecedents, there are a host of individual and societal forces that maintain, condition and perpetuate the fertility decisions of Puerto Rican women in New York City. Women's familiarity with la operación, combined with the high rate of misinformation among Puerto Rican women about sterilization procedures, poverty, and lack of access to quality health care, further circumscribes women's fertility decisions by limiting their knowledge about their options. Moreover, the lack of access to safe, effective, convenient, and affordable birth control, in conjunction with the goals of sterilization policy to control the rate of population growth among the poor, play an equally important role in constraining women's reproductive options.
By not offering women alternatives such as quality health care services, safe and effective temporary methods of birth control for both men and women, abortion services, quality and affordable day care centers, and opportunities for a better standard of living, (Hartman 1987) women's fertility options have been effectively narrowed at times making sterilization the only viable alternative. Until Puerto Rican women achieve a more equitable status in society and are able to improve their socioeconomic situation, they will continue to have one of the highest documented rates of sterilization in the world. Reproductive freedom means having all the alternatives and the conditions in order to decide whether or not to have children. As long as women continue to have children under these inequitable conditions we cannot talk about reproductive freedom.

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NOTES

1 Sterilization consists of cutting and suturing the fallopian tubes in the female to permanently block the flow of the sperm to the egg cell and to prevent the egg cell from entering the uterus. In its broadest meaning, sterilization includes hysterectomies and vasectomies. The latter is the method used to sterilize men. Female sterilization is also referred to as tubal ligation.

2 In 1982, a study by a Puerto Rican demographer, Vasquez-Calzada, showed that 39 percent of Puerto Rico’s female population between the ages of fifteen and forty-five were surgically sterilized (Vasquez-Calzada 1982). A similar situation can be found for Puerto Rican women and other minorities in the United States. In New York City, where this research took place, Latinas have a rate of sterilization seven times greater than that of Euro-American women and almost twice that of Afro-American women (New York City 1982). Although information
is scarce for most cities, my study of Puerto Rican women in one neighborhood in New York found that 47 percent of the households of one or more Puerto Rican women over age twenty were surgically sterilized. Moreover, another study reveals that in Hartford, Connecticut, 51 percent of Puerto Rican females of reproductive age were sterilized (Gangalez et al. 1982).

3 Contending views of Puerto Rican women's reproductive decisions are paradoxical because they have been posed in binary terms. Puerto Rican women are either presented as victims of population policy (Mass 196) or free agents making voluntary decisions about their reproductive lives (Stycos, Hill and Back 1959; Presser 1973). There are numerous problems with this logic. The argument that the high rate of sterilization is based on reproductive freedom glosses over the importance of power dynamics in relation to Puerto Rican women as colonial and neo-colonial subjects of population programs in Puerto Rico. In contrast, the view that state initiated Puerto Rican women are victims of sterilization abuse makes them appear passive and does not take into account the range of their diversity or the complexity of their experiences.

4 After World War II, Puerto Rico became a model for the strategy of development known as Operation Bootstrap and a testing laboratory for the pill, IUD, EMKO contraceptive cream and the development of sterilization technology. By 1937 sterilization was implemented in Puerto Rico as a method of "birth control." The legislation grew out of the Eugenics Movement that developed in the United States to sterilize people considered socially or intellectually inferior. Finally, it is also important to keep in mind that for 31 years in Puerto Rico sterilization was systematically available while temporary methods of birth control were only haphazardly available. For a complete history of Puerto Rico's birth control movement see Ramirez de Arellano and Scheipp's (1983) work.

5 Interestingly, sterilization was never official government policy in Puerto Rico (Presser 1973, Henderson 1976, Ramirez de Arellano 1990). It took place unofficially and became a common practice condoned by the Puerto Rican government and many of its health officials, frequently filling the gap for the systematic lack of temporary methods of birth control. Although many birth control clinics opened and closed throughout Puerto Rico's history, it was not until 1968 that federally funded contraceptives were made available throughout the island. It is within this context of a policy prompting population control, particularly for poor women, that decisions regarding sterilization must be analyzed.

6 This legislation mandated that a thirty day period of time be observed between the time an individual signs a consent form to the day she is operated on. It also stipulated that women under the age of twenty-one
could not be sterilized with federal funds, and that a consent form must be provided in a person's native language, and administered in written and oral form.

Although this research originally took place in 1981, in 1993 I collected more oral histories from some of these women in order to update my ethnographic material.

An article on the conceptualization and methods used to collect the data for this research is forthcoming in an anthology on Puerto Rican women entitled "Negotiating Two Worlds: The Experiences of Puerto Rican Anthropologist in Brooklyn, New York," U.S. Puerto Rican Women: Creative Resistance, 1994, editors, Doris Correa Capello and Caridad Souza, Third Woman Press, California [forthcoming].

Time and space do not allow me to elaborate further on the distinction between sterilization and population control and on the different levels that the women in this study resist. This will be the focus of my upcoming book on this topic.

In 1981, more than three-quarters of the women in this study were not working outside the home, although 12.5 percent were actively looking for jobs. Of the women who have spouses, 31.3 percent had husbands who were employed and 15.6 percent had husbands who were not working at the time this study took place.

The language that Presser used to describe this phenomenon is problematic. In reference to sterilization she states: "Its widespread practice represents a 'grass roots' response among Puerto Rican women who sought an effective means of limiting their family size" (Presser 1973:1). The difficulty is not with the acknowledgment that there is a cultural dimension to sterilization but that she disassociates culture from the social, political and historical context.

Although minority and poor women are likely to be misinformed about the permanent nature of sterilization, a study found that, regardless of ethnic group or class, most women are likely to be misinformed (Carlson and Vickers 1982).

REFERENCES CITED


New York City Health and Hospital Corporation (1982). Sterilizations Reported in New York City, Unpublished data, Department of Biostatistics.


Chapel Hill: University of North Carolina Press.