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Empowered Minds and Sterilized Bodies: The Decisions and Lived Experiences of Surgically Sterilized Women in Santo Antonio de Jesus

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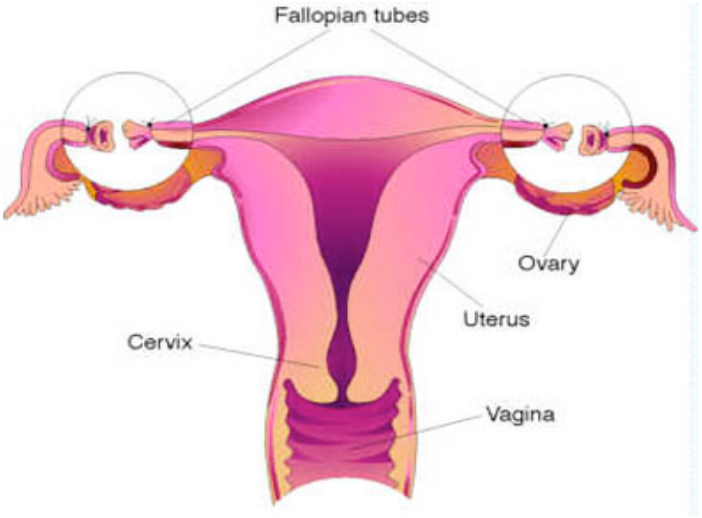

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SIT Salvador Spring 2012
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Abstract
During the last several decades, Brazil has experienced a rapid fertility decline from 6 births per woman in 1965 to 1.8 births per woman in 2006. Though Brazil lacks a significant and organized family planning program, this fertility decline has been caused in large part by an extremely high rate of female sterilization. Of the 81 percent of women living in union who use birth control, 29 percent are surgically sterilized, placing Brazil at the third highest rate of female sterilization in the world. This research analyzes the sterilization narratives of 10 women from the city of Santo Antonio de Jesus in the northeastern state of Bahia in order to understand their motivations for becoming sterilized and to place their choices in the context of economic class and social relations. In addition, two doctors and one nurse were interviewed in order to understand the influence of medicalization on the choices and experiences of the women. The research found that there is a distinction between the choice that women make to become sterilized and the lived experience of the sterilization procedure. The choice that women make to become sterilized is an empowered and determined decision to create a better life in the face of precarious economic conditions. However, when women enter the medical sphere to realize the surgical procedure, the knowledge asymmetry between doctor and patient leave women alienated from their bodies, especially as they continue to live in fear of becoming pregnant again. The research concludes that the disparity between the choice to become sterilized and the experience of sterilization leave women in a conflicted position in which they have taken control of their lives at the cost of losing control of their bodies.

Resumo
Durante as últimas décadas, o Brasil tem experimentado um rápido declínio na fertilidade, passando de seis partos para cada mulher em 1965, para 1,8 partos em 2006. Apesar da falta de um programa significativo e organizado de planejamento familiar no Brasil, este declínio na fertilidade tem sido causado em grande parte por uma taxa extremamente alta de esterilização feminina. Dos 81 por cento das mulheres quem vivem em união e usam controle de natalidade, 29 por cento delas são esterilizadas cirurgicamente, colocando o Brasil com a terceira maior taxa de esterilização feminina no mundo. Esta pesquisa analisa as narrativas de esterilização de dez mulheres da cidade de Santo Antonio de Jesus, no estado nordestino da Bahia, para compreender suas motivações pela esterilização, e para colocar suas escolhas no contexto de classe econômica e relações socias. Além disso, dois médicos e uma enfermeira foram entrevistados para compreender a influência de medicalização nas escolhas e as experiências das mulheres. A pesquisa descobriu que há uma distinção entre a escolha que as mulheres fazem para serem esterilizadas e a experiência resultante do procedimento da esterilização. A escolha que as mulheres fazem pela esterilização é fortalecida e determinada para criar uma vida melhor em face de condições econômicas precárias. Entretanto, quando as mulheres entram na esfera médica para realizar o procedimento cirúgico, a assimetria do conhecimento entre o médico e a paciente deixa-as alienadas de seus corpos, especialmente porque elas continuam a viver com medo de engravidar novamente. A pesquisa conclui que a disparidade entre a escolha de ser esterilizada e a experiência da esterilização coloca as mulheres numa posição conflituosa, em que elas assumem controle de suas vidas, mas com o preço de perder o controle sobre seus corpos.

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Acknowledgements

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A huge thank you to the doctor and nurse at the Family Health Post, for clearing time in your busy schedules to indulge my curiosity about the politics of sterilization, and all the technical details of the procedure. You both gave me the same attention you would have given a patient and for that I am immensely grateful.

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A Note on Translations

All of the interviews for this project, as well as much of the literature reviewed were originally in Portuguese. Except where indicated, I have done all the translations from Portuguese into English myself. In several cases however, I felt that the original Portuguese better captured the essence of what was being said and thus in addition to the English translation, I have provided the original Portuguese text as well. In addition, some of the translations will appear quite awkwardly because the two languages simply do not flow in the same way. That said I have done my best to accurately present what was largely a project in Portuguese for an English-speaking audience. Thus, I only ask that you bear with me.

Introduction

Over the last several decades, Brazil has been experiencing a rapid decline in fertility. Though in 1965, the fertility rate registered extremely high at six births per woman, that rate fell to 2.5 births per woman by 1996 (O'Doughtery 2008:415). In the past ten years the fertility rate in Brazil has continued to fall, as in 2006 the fertility rate registered at 1.8 births per woman (BEMFAM/DHS 2006). Today, the fertility rate continues to remain below two births per woman and as such, the population is barely reproducing itself (Potter, et al. 2010:284).

Family Planning and Birth Control in Brazil

What is especially striking about this rapid fertility decline is that it is occurring in a country that has not and still does not have a significant and large-scale public family planning program (Dalsgaard 2004:27). In 1983, Brazil implemented the *Programa de Assistência Integral à Saúde da Mulher* (PAISM), or the Program for Integrated Women's Health, and since the program launched, the government of Brazil has been dealing with questions of family planning and providing contraception to the public. PAISM sparked these questions because it was the first public health program in Brazil to have provisions for providing contraception in public health services and for training medical professionals to provide quality family planning care. However, PAISM as a whole is not a family planning program. Rather, some family planning provisions were included in an attempt to increase the overall health of women, and thus the efforts to provide these services were extremely slow and largely ineffective (Osis, et al., 2006:2481).

Today, PAISM is still the only public program in Brazil that touches on questions related to family planning, yet even after 29 years, family planning is not the main focus of the program, and the family planning services that the program does provide are of very low quality. In addition, the program also operates within Brazil's public health system, *A Sistema Única de Saúde* (SUS), or the Unified Health System. This system is working to provide health services to all 190 million citizens of

Brazil, in a country with extremely diverse needs. Thus, the distribution of services and providing education through PAISM is often encumbered by the bureaucracy of SUS (Osis, et al., 2006:2485).

In a 2006 study of the family planning services available at Family Health Posts (PSF), Osis, et al. found that distributing contraceptives was particularly complicated because the Post managers often did not know who, and at what level of government, was responsible for supplying the contraceptives to the posts. Furthermore, they did not know who to contact when no shipments were received, or when the amount received was insufficient to meet the demand (2006:2485-6).

Osis' study also found that family planning services were lacking in large part because of the attitudes of the medical professionals who are meant to be providing it. Not only did the health professionals not consider themselves able to provide family planning services, but they also did not view family planning as part of their job description. Health professionals who work at PSFs are part of SUS's system of basic, preventative care. Thus, their jobs require them to identify and correct potential health problems before they start. However, the health professionals interviewed did not view family planning as part of preventative care for women and children and usually they only discussed it with their patients in the context of pre-natal care (2006:2484).

Yet despite the poor family planning services and lack of an efficient and large-scale family planning program, there has been an extremely high demand for and increased usage of contraceptives since the 1970s. In 2006, it was found that 81 percent of women living in some kind of union use contraceptives. Of those 81 percent who use contraceptives, female sterilization is the most common form used at 29 percent, and oral contraceptives or “the pill” is the second most commonly used form at 25 percent (BEMFAM/DHS 2006). These numbers indicate that even in the absence of a large-scale family planning program, there is a desire amongst Brazilian women to limit the number of children that they have, and they are actively seeking out and using methods that enable to them to do so. The statistics on birth control use, paired with a fertility rate below population reproduction suggests that

even without quality education on and access to contraception, many women are still finding a way to access fertility control, and many of them have in fact been successful in their quest to limit and control the number of children that they have.

Sterilization as Birth Control

When I began reading about female sterilization in Brazil for this project well over a year ago, I saw the statistic that 29 percent of women living in union are sterilized, and I was jarred by it. Brazil has the third highest rate of female sterilization in the world, with one quarter of women becoming sterilized by the age of 30 (O'Doughtery 2006:415). My immediate assumption was that this extremely high rate of sterilization had to be an indication of some kind of rights violation. To me, these statistics were jarring because I could not imagine the use of sterilization as birth control. I saw sterilization only as a way to end birthing ability, not as a potential option to control it.

However, the more I read on the subject, the less clearly defined sterilization became. The third highest rate of sterilization in the world occurs in a context where women who wish to control their reproductive ability have a difficult choice in front of them.

As I discussed earlier, family planning in Brazil is lacking. Thus, although hormonal contraception—including oral and injected forms—is easily available, the choice to use it often means doing so without the knowledge of proper usage that a public family planning program would provide. In addition, by law, hormonal contraception, and especially oral contraception (the pill) must be available to all without a prescription. This means that women can always access the pill and that they do not have to go through their doctors in order to determine the appropriate brand and dosage for their particular case. Thus, without medical oversight, many women choose brands and dosages that cause side-effects and other health problems, or they use the pill incorrectly, which reduces its effectiveness (de Bessa 2006:437). Thus, as a result of poor family planning and medical oversight, the pill has come to represent an unsatisfactory and ineffective option for birth control.

For many women, negotiating condom use can also be extremely difficult. The difficulty of this negotiation is reflected in the fact that only 12 percent of the 81 percent of women in union who use some form of birth control use condoms (BEMFAM/DHS 2006). In many cases, the decision to use a condom is out of the woman's hands, and resistance to their use is high among men, many of whom describe condom use as being like “eating candy with the wrapper on.” Furthermore, condoms are much more frequently associated with prevention of sexually transmitted infection and especially HIV than they are with the prevention of pregnancy (de Bessa 2006:437). With the association of condoms being on sexually transmitted infection, their use may not be the obvious choice for women who wish to control their fertility.

The context of the third highest rate of sterilization in the world is even further complicated by the fact that abortion is illegal in Brazil. Though abortions cannot be obtained legally in a safe and medically monitored environment, research from 1990 and 2000 shows that 13.7 percent of pregnancies in Brazil are still terminated by induced, clandestine abortion (Ali and Cleland 2005:1180). Yet, despite such high rates of usage, these clandestine abortions are extremely dangerous and according to SUS, abortion is the third largest cause of maternal mortality in Brazil, with incidences of death around 12.5 percent (Domingos and Merighi 2010:178).

Despite the fact that the other choices available for birth control represent very poor options, the high rates of sterilization in Brazil are intriguing when one considers its legal status. Prior to 1997, female sterilization was not legal in Brazil (O'Doughtery 2008:418). However, if a woman had the means to pay, most doctors would be willing to perform one at the same time as a Cesarean birth. For women who did not have the means to pay, it was often possible to secure payment from a politician in exchange for votes from the woman, her friends and family (Caetano and Potter 2004:83). Even though sterilization was not legal before 1997, there were still many options available for obtaining one, and it represented a better choice than the other options that were available.

In 1997, the government passed family planning legislation Federal Act 9,263, which requires that all modern forms of contraception be made safely and legally available for all. This legislation included sterilization however, it also put certain requirements in place that a woman must meet in order to obtain one. These requirements include that the woman must be 25 years of age, have at least two children and obtain a signature confirming the consent of her husband (Vieira and Ford 2004:1202-3). Although there are certain limitations on its use, sterilization today is legal and safely available for free in all public hospitals. Therefore, for many women it often represents the best option available for fertility control.

As a result of extremely poor family planning, options for fertility control in Brazil often leave women at a "dangerous crossroads" at which they must choose between unreliable or ineffective contraception, a clandestine abortion, unwanted pregnancy or sterilization (O'Doughtery 2008:417). In this context then, with limited options for fertility control, sterilization is more than just a means to end fertility—it is indeed a method of fertility control.

Sterilization: An Empowered Choice or a Decision of Necessity?

While it became clear to me that sterilization is a viable choice for fertility control in Brazil, I was still left with the question of whether or not women who choose sterilization are empowered in their decision. It was clear to me that women were finding a way to control their fertility in a context where the odds of doing so successfully and safely were stacked against them. However, perhaps the unavailability of other methods of fertility control meant that women weren't exactly choosing sterilization so much as being forced into it.

In the literature on sterilization, the question of disempowerment in the decision is usually presented in terms of medicalization. In the case of reproduction and fertility control, medicalization is defined as the process by which reproduction and birth have come under the "clinical gaze," and are increasingly seen as "problems" that are best "solved by physicians through medical practice and

management" (de Bessa 2006:222). One of the strongest critics of the medicalization present in sterilization is Suzanne Serruya, who in her book *Mulheres Esterilizadas: Submisão e Desejo* (*Sterilized Women: Submission and Desire*), argues that sterilization represents a "submission" and "alienation" of the body by allowing medical authority to take control of reproductive ability (1996:114, translation of Maureen O'Doughtery). When women become sterilized, they abandon control over their bodies and their fertility and "annihilate the possibility of new decisions" (1996:138).

On the other hand, those who believe sterilization is an empowered decision tend to view the choice within the context of the life conditions of those who choose it. In her book *Matters of Life and Longing*, Anne Line Daalsgard presents women who choose sterilization as "agents in their own lives." The women with whom she worked "did not see themselves as dominated or alienated...[they] knew what they wanted; they just did not have the wherewithal to reach it. Sterilisation [sic] was an attempt to create such conditions in their lives" (2004:31). Daalsgard concludes that even if sterilization resulted from "a situation with contradictory concerns and demands," the choice was still "empowering for the individual woman" (2004:175). In a similar vein, Gina de Bessa argues that "the meaning of sterilization extends beyond fertility control and represents women's attempt to gain a measure of control and construct a better life" (2006:226).

Most of the literature on female sterilization in Brazil seems to fall into this dichotomy of thought on whether or not women who choose to become sterilized are empowered in their choice. The "empowerment" camp argues that women are making an active decision that helps them to improve their lives and the lives of their children (Daalsgard 2004; de Bessa 2006; O'Doughtery 2008), while the "disempowered" camp argues that women are submitting their bodies to medical authority and thus are being alienated from their reproductive abilities (Serruya 1996). Throughout my research, I have seen elements of truth in the arguments of both camps, yet I do not feel that either side accurately captures the full scale of the reality that women face when they choose to become sterilized.

In order to begin to understand the reality of sterilization in Brazil, one must make a fundamental distinction between the choice to become sterilized and the experience of the sterilization. The choice to become sterilized is an empowered and active decision and represents a means to a better life for the woman and her children in light of poor social and economic conditions. However, the lived experience of sterilization places women in a position of submission to medical authority in which their urgent need not to have more children must take precedence over the possession of knowledge of their bodies. Thus, in the process of taking control of their lives at large, women lose a measure of control within their own bodies.

The Fieldwork

The research for this project was carried out over a period of three weeks in the city of Santo Antonio de Jesus, a small city in the interior of the Brazilian state of Bahia with a population of approximately 100,000 inhabitants. While the city is still very small, it is becoming an important center of commercial activities and thus it is growing rapidly.

The women I worked with were all patients of a particular PSF that was strategically located on a street that separated a lower class community (*bairro popular*) from a middle class community. I am purposefully omitting the name of the PSF in order to protect the privacy of all of my subjects. The majority of the inhabitants in Santo Antonio are familiar with the names of the PSFs in the city, the areas that they cover, and in many cases the names and identities of the people who work at them. For the sake of ease, I will refer to my work site simply as "The PSF." In addition, I use Pseudonyms to refer to all my informants, including the medical professionals with whom I spoke, and to further protect their identities, any particular identifying details about their lives have been altered.

I was granted permission to access The PSF by my local adviser Tatiane Couto, who in addition to being a nurse also works at the Secretary of Health in Santo Antonio as the coordinator of all the PSFs in the city. She brought me to the Post and introduced me to the A*gentes Comunitários de Saúde,*

or community health agents (ACS) who were responsible for the area.

I worked primarily with three ACSs, each of whom was responsible for a different micro-area within the region that The PSF covered. Each one would take me on domestic visits with her, at which point the ACS would inquire as to the sterilization status of the women in the home. If we encountered a woman who had been sterilized, the ACS would introduce me and my project and ask the woman if she would agree to a short interview. In this manner, I conducted nine interviews, all of which took place in the women's own homes, usually with their children or partners within earshot. I conducted three more interviews in The PSF itself, two of which were with women who had come in for routine check-ups and one of which was with another ACS who had been sterilized herself. Of the twelve interviews I conducted, I have only drawn data from ten. The other two were too difficult to understand and also presented information that I later found to be untrue.

In addition to interviews with women who had been sterilized, I also conducted interviews with the nurse and the doctor at The PSF and with an obstetrician who has actually performed the procedure at a specialized secondary care clinic. I also had a number of informal conversations with the ACSs walking to and from domestic visits, and much of the information I gleaned about people's attitudes towards sterilization came from these conversations.

The women with whom I worked were an even mix of those who lived in the *bairro popular* and those who lived in the middle class neighborhood. In talking to women from different socio-economic statuses, I had hoped to gain an understanding of a wider range of sterilization experiences. What I found however, was that all the women in the middle class neighborhood, with the exception of one, had been in much more precarious economic situations when they chose to become sterilized, or had grown up in extremely poor homes, and thus their stories were very similar to those of the women in the *bairro popular*. Even the woman who gave no indication of serious economic difficulty at the time of her sterilization echoed motives that were similar to the rest of the women with whom I spoke.

The women were all between 27 and 52 years old and had between two and four children. Most of the women had been sterilized in their early to mid-twenties and the oldest age at sterilization that I encountered was 38. Several of the women from the *bairro popular* were illiterate, which presented several problems when it came to obtaining their informed consent. Fortunately, the ACSs were all willing to read the consent forms to the women, especially when they women had difficulty understanding my accent.

Limitations to the Research

During the course of my fieldwork, there were two main limitations to my research that I believe had some impact on the depth and quality of my findings.

The first limitation, which was also the most difficult to overcome, was my own ability with the Portuguese language. While I speak relatively well and have a fairly good grasp of vocabulary and grammar, I learned all of the Portuguese I know when I arrived in Brazil three months prior to the start of this project. Furthermore, I learned to speak in the city of Salvador, which has a very different accent than that of the interior. My difficulty in understanding the accent was particularly pronounced in working with the women in the *bairro popular*. In addition to having a thick, rural, interior accent, most of the women were also uneducated and thus spoke with erroneous grammar that also made comprehension difficult. The women themselves also had limited exposure to foreign accents and they had a great deal of difficulty understanding me as well. In many cases, the ACSs were able to interpret for the women and me, but there were just as many cases where the slang of the interior was simply lost on me. I also recorded many of the interviews so as to listen to them again later, dictionary in hand. This helped to increase my comprehension, but again there were just as many things that were lost to me. Furthermore, many of the women, especially in the *bairro popular* were uncomfortable with the idea of being recorded, and so I had to do the best I could taking notes during the interview. Thus, while I did gather a great deal of rich and significant data, there was a certain level of depth that I was

unable to obtain as a result of the language barrier.

The second limitation was the time constraint. I had only three weeks to collect and analyze the data for this project. This short time did not allow for me to do follow-up interviews and this also prevented me from reaching some of the depth that I would have liked. Many times I would be listening to an interview recording and realize that I had several follow-up questions I wanted to ask, but not enough time to return to the same woman to ask them. Therefore, I still many questions that were left unanswered. The time constraint also meant that I was unable to immerse myself in the lives and community of these women as much as I would have liked. Three weeks was just enough time for me to establish myself as the "American Researcher," but not enough time to develop significant rapport with the women. Thus, I know there was a great deal of knowledge that I was excluded from simply because of my status as an outsider.

Despite these limitations however, I did find answers to many of my burning questions, and I do feel that the range of information I collected is quite rich, and accurately represents many aspects of these women's lives. Sterilization is a complicated subject, and I do not claim to understand it in its entirety. I am however, able to present a significant analysis of the conditions women in Brazil face when they make the decision to end their reproductive ability.

Choosing to be Sterile: A Determined Decision

As I have already mentioned, when I first began researching for this project, I could not come to terms with the fact that women were voluntarily choosing to permanently end their reproductive ability. Though the literature I read painted a much more complex picture of what the decision to become sterilized actually means for many Brazilian women, I still struggled with the idea of voluntary sterilization, and especially with those who argued that in making the decision women were achieving agency in their lives. It was not until I actually started interviewing women for myself that I began to understand how making the choice to become sterilized represents agency and empowerment in lives

that are otherwise marginalized and disenfranchised. Before I begin my analysis of the empowered decision however, it is crucial to the understanding of sterilization to present these narratives in the context of motherhood.

The Meaning of Motherhood

Except in extreme cases of medical necessity, none of which I encountered or even heard about during my time in the field, sterilization is always a choice that is made by women who are already mothers. Of course, this is in part because the family planning legislation Federal Act 9,263 of 1997 requires that a woman must have at least two children in order for her to become sterilized legally (Vieira and Ford 2004:1202-3). However, the requirement of being a mother in order to become sterilized is a trivial consideration when compared with the high value that is placed on motherhood by society at large and by individual women themselves.

That motherhood is a necessity for women is largely a taken-for-granted fact of life in Brazil. Within the social realm, having a child and entering the role of motherhood is the marker of a solid union between a woman and her partner. Without children, the union does not fulfill its traditional role of procreation and may be seen by society as illegitimate, while the woman may have trouble holding onto the man for whom she does not provide children (de Bessa 2006:436). Furthermore, in a society where the socially ideal place of a woman is in the home, "motherhood is central to the identities of ... women," (de Bessa 2006:242) and women who have not yet achieved motherhood are sometimes seen as not yet having achieved full womanhood (Dalsgaard 2004:179). Thus, for women who want to achieve and keep stable unions as well as be accepted by their society as full women, "having no children [is] out of the question" (Dalsgaard 2004:16).

Yet, motherhood is not a necessity only because of prescribed social roles and values. Individual woman also view motherhood as an ideal and a goal they hope to achieve for themselves. In her fieldwork in Recife, Anne Dalsgaard found that "for the women, living was synonymous with

having children," and that "becoming a mother was often referred to as a 'dream' and a 'happiness' as it promised the fulfillment of one's life in the venerated role of the loving, dedicated mother" (2004:180).

Thus, motherhood represents a role with incredible social value and a dream in life that very few women are willing to sacrifice. Indeed, in talking about their motivations for becoming sterilized, none of the women with whom I spoke expressed a desire to end their motherhood. Rather, they cited providing a better life for the children they did have as a primary reason for choosing sterilization. Instead of seeing sterilization as an end to potential future motherhood, they saw it as a means to take responsibility and enhance the motherhood they already had.

Responsible Motherhood in the Context of Poverty

While motherhood has an extremely high value attached to it and is a necessity in many ways, simply having children is not enough to fulfill the role of motherhood. Fulfilling the role of motherhood also means being a "good" mother, and in order to be considered a "good" mother, women must provide a decent life for their children. This decent life includes good education, good food, good health and sufficient love and attention. Providing all these things however, costs money and can be particularly difficult for women in poverty. Thus, as Dalsgaard found in her fieldwork, the predominant attitude about responsible motherhood is that people should "only have as many children as they could afford to bring up." Those who have more children than they can afford are looked down upon and generally ridiculed by society as having "children just to let them suffer" (2004:16).

These attitudes, while not necessarily expressed directly, were nevertheless pervasive in the narratives of the women I spoke with about sterilization and motherhood. The women's most frequently cited reason for choosing sterilization was that they did not have "the conditions to have more children" (*não tenho as condições para criar mais filhos*). When I asked them to explain to me what those "conditions" included, most of the women were resistant to delving into the details of their difficult conditions, even when it was apparent from their homes that they lived in poverty. However, they

would usually tell me that with too many children, they would not be able to provide sufficient food, good education or good health.

One woman, Marcelle, looked at me as though I was crazy when I asked her to tell me about the life conditions that made her want to become sterilized. During our interview, she was rolling bits of gunpowder into colored paper to make noise-makers, which are popular in Brazil for festivities and especially when a favored soccer team wins. The ACS I was with for the day explained to me that Marcelle sold the noise-makers and that the profits from their sale and from a tiny grocery store that she ran out of the front of her house were her only sources of income. At my insistence that she explain her difficult conditions in more detail, she sighed, gave me a sad smile and gestured around her run down house and the half-finished pile of noise-makers in her lap. “When you have too many children you can't give them a good education, good health or a good future,” she told me, but that was all she would say on the subject.

Another woman I spoke with, Dalva, was currently working as an ACS and has managed to scrape together a “decent” middle-class life for herself and her children. However, she grew up in an extremely poor family with “too many” children. Thus, she described her own responsible motherhood in the context of her mother, whom she did not believe had provided a good life for her and her siblings:

> People who have a lot of children can't give them a good life: good education, good health and good nutrition. I learned this from the experience of my mother who had six children. I am the oldest, so when my parents had my siblings, I had to help my parents to take care of [the other children] while they worked. I started working at the age of three to [take care of my siblings]. I don't want this for my children. I have two children, and the first one I am able to put in a private school. I can pay for a health insurance. People with a lot of children, they can't do this. I wanted to give my children a good education and good health. So for me, two children was enough.

While Marcelle and Dalva both spoke only about the “conditions” to have children in terms of providing education, health and food, the subtext of their narratives speaks of a tacitly held belief that

poverty is perpetuated by excessive fertility, and that having an excessive number of children means hindering one's ability to be a good mother and provide for those children. For Marcelle, poverty was a present force in her life and even with only two children, it was clear that she struggled to make ends meet. Thus, by guaranteeing that she could not have any more children, Marcelle felt that she was fulfilling her responsibility to her two living children to make sure that the "conditions" she had were good enough for them to have a good life. For Dalva, poverty was no longer a presence in her life, yet the memory of it reminded her to stay responsible; to only have two children lest she end up like her own mother, unable to provide a decent life for an excessive number of children.

In many ways, motherhood is the axis around which the decision to become sterilized rotates, and the considerations that come with the decision are more often than not related to the state of motherhood and the well-being of the children that already exist. The choice to become sterilized cannot exist independently of the role of motherhood, especially when the woman making the choice is living in poverty and must consider the limited resources she has to care for her living children. Thus, in the context of motherhood and poverty, the choice to become sterilized is a woman's determined decision to fulfill her responsibility to her children when she has limited resources with which to provide them a good life.

Forging a Better Life with their Bodies

When looking at sterilization from within the context of motherhood, it is clear that women are making an empowered decision to control their fertility so they can make a better life for their children. However, when one considers that sterilization is an invasive surgery that involves bodily modification, the empowerment of the decision to become sterilized is less clear. In thinking about Suzanne Serryua's assessment of sterilization as "radical," Maureen O'Doughtery wonders whether perhaps the idea of sterilization is "radical" because of the "bodily cutting" that it entails (2008:420). From my perspective at least, the idea that an invasive surgery that permanently alters the body could be empowering is a

little hard to stomach.

However, the narratives that my informants constructed about their motherhood and the conditions of their lives suggests that it is precisely the bodily modification involved that makes the decision to become sterilized an empowered one. When other routes to constructing a better life fail, women make a decision to improve their lives with the last tool that is available to them and that is wholly in their control: their bodies.

The failure or outright lack of other means to construct a better life is a theme that repeatedly came up in interviews with the women. Other methods of birth control were often what failed, yet the women also saw unstable relationships, unemployment, sickness and various other conditions of poverty as barriers to achieving a better life that were simply outside of their control.

Julianne, a middle-aged woman living in the *bairro popular* behind The PSF told me that at the time of her surgery, she chose to become sterilized because she had neither a steady partner nor a home of her own. She was a live-in domestic worker for a wealthy patron who lived on the "*avenida*" and both her employment status and whether or not she had a place to live depended entirely upon her employer. With four children, no guarantee of long-term employment and thus, no guarantee of a place to live, Julianne decided to become sterilized. For her, the decision was her choice to control the only things in her life that she had the ability to control: her body and her fertility. She could not raise a family alone without a partner and she could not ensure whether or not she would remain employed and with a place to live. However, she could control whether or not she would have more children and thus more mouths to feed. When I asked Julianne why she chose sterilization rather than another form of birth control, she told me that "other methods don't work as well," and that "sterilization is the only thing that is free" (*livre*). With all the other worries in her life, she had neither the time nor the energy to worry about whether or not her chosen method of birth control was actually working.

After hearing the circumstances of Julianne's life that led her to choose sterilization, it is

difficult to argue that her choice was a “radical” one. Rather, by choosing to become sterilized she took control in the only arena that she could and in doing so, she gained a measure of power in her life that she had been denied up until that point. Her body was the only route to a better life that was left to her, so she made an empowered decision and took that route.

The narrative of another woman, Simone, also spoke of sterilization as an empowered decision to take control of her life. What was especially poignant to me in her story was how young she was—she was 31 when I interviewed her, but had become sterilized at 26—yet how sure she was that she did not want more children. Of all the women I spoke to, Simone was perhaps the most adamant in her determination not to have more children. She told me that she had been using a hormonal contraceptive injection for five years before she became sterilized, but that she became pregnant with her third and final child while she was using the injections. That third child, her youngest son was present in the living room while we spoke, and though it was clear that she adored him—she was constantly stroking his head during the interview and described for us with a kind of loving exasperation how he had recently had surgery to remove a bean that he had pushed too far into his ear—she also openly admitted that her final pregnancy was not wanted and that “it is a big headache to have more children” (*muito dor de cabeça para criar mais filhos*). Like Julianne, the father of Simone's children was also out of the picture, and she was left alone with the sole responsibility of caring for them.

Simone's situation is was not quite as precarious as Julianne's. She at least had a home of her own, although she was unemployed. However, sterilization was just as much an empowered decision for Simone to take control of her life as it was for Julianne. Even at such a young age, Simone knew that she could not support children, and especially not alone. She also learned from personal experience that other forms of birth control were not reliable. For her, getting pregnant again was a matter of great severity and something she could absolutely not afford, yet the hormonal injection, which she was assured would be effective, failed her. Thus, she took action on her body to ensure that pregnancy

would not occur again. Like Julianne, Simone took control of the one area of her life that she had the ability to control, and like Julianne, she was able to guarantee herself a route to a better life when other routes—hormonal birth control and her partner—failed her.

These two women's narratives are quite representative of the struggles that women face to gain control of their lives. For them the "normal" support systems of society—money, a stable partner, employment, etc.—do not exist or are not accessible, so they determine to forge their own control in their lives with their bodies, which is the one thing that they have definitive and unquestionable control over. In this context, sterilization is not just an empowered decision because the women are choosing responsible motherhood and to make a better life for their children. Sterilization is also an empowered decision because these women are altering their bodies in a permanent way in order to gain a permanent measure of control, and forge a better life for themselves and their children.

Becoming Sterile: The Lived Experience

While the choice to become sterilized represents an empowered and determined decision to forge a better life, the actual lived experience of the sterilization procedure presents a murkier situation for the women. From the time a woman requests sterilization up until the time she completes her last follow-up exam after the surgery, she must rely on medical professionals to orient her mind and modify her body. While these medical professionals theoretically should understand the women's motivations and have their best interests in mind, both the narratives of the women I spoke with and my interviews with the medical professionals themselves have shown that there is a great disparity between the motivations and knowledge of the women who are becoming sterilized and the understanding and knowledge of the professionals who are doing the sterilizing. Thus, while women enter the clinical setting with empowered intentions, their interactions with medical professionals represents a submission and a surrendering of their bodies to medical authority which they did not intend, but over which they have no control.

Medicalization and the Disparity Between Doctor and Patient

As soon as women enter the clinical setting for the first time to request sterilization, they become subject to medicalization. Gina Hunter de Bessa describes this kind of medicalization as the process by which reproduction has come under the "clinical gaze," and is increasingly seen as a "problem" that is best "solved by physicians through medical practice and management" (2006:222). However, it is not the "clinical gaze" alone that renders women subject to medicalization. It is also that within the clinical realm, medical professionals by necessity occupy a position of authority. Though women enter the clinical setting with the intention of taking control of their lives, sterilization is still a medical procedure which they cannot achieve without submitting themselves to the authority of medical professionals. Furthermore, when they do submit themselves to this authority, they are submitting themselves to medical professionals who have largely divergent views of the women's lives and their motivations for becoming sterilized. Yet, because the medical professionals are in a position of authority, their views and professional opinions take precedence over the women's own views of their lives.

Perhaps one of the most disturbing finds in my fieldwork was the great disparity that existed between the women's explanations for why they wanted to be sterilized and the medical professionals' understandings of the women's motivations. While the women framed their motivations in terms of poverty, motherhood and an attempt to make a better life for themselves and their children, the medical professionals with whom I spoke chocked the choice up to an attempt to escape from responsibility.

Louisa, the nurse at The PSF had a particularly interesting take on the reasons why women in Brazil become sterilized:

> It's like this: Brazil is a country of the third world, with lots of social conflicts and inequality. Because of that, Brazil has a lot of policies of social support, but these policies end up taking people's sense of responsibility for themselves away from them. For example, when there's a woman in our area that needs pre-natal care, but she doesn't come to

> the post, we go to get her and bring her here to do the pre-natal care. So, everyone is a little infantilized in that way because SUS keeps coming and calling and taking their responsibility away. Until we can put that consciousness in every person that they need to take responsibility for themselves and use contraceptives, sterilization will be necessary. Here, we offer condoms, we offer oral contraception, we offer everything, but still we have people with five, six children. They just don't have the consciousness, you know?

In Louisa's view, women who choose sterilization have been infantilized by SUS and the other systems of social support in Brazil to the point that they do not have the ability to take responsibility for themselves and use methods of contraception like the Pill or the condom that require maintenance and effort. Instead, they opt for sterilization because it is the one method of birth control that prevents pregnancy without requiring the woman to take responsibility for its proper use.

Dr. Geraldo, an obstetrician at a specialized secondary care clinic in Santo Antonio who regularly performs the sterilization procedure expressed a similar view to Louisa. During our interview, I told him that all the women I had spoken with had cited not having the conditions to have more children as one of the primary reasons they became sterilized. “I do not think that's a good reason,” he told me. “The municipality of Santo Antonio spends thousands of *Reais* every year on contraceptives and they are all available for free. If a woman does not want more children, she can easily use another method, but I think they choose sterilization because they don't want the responsibility that comes with other methods.” In Dr. Geraldo's view as well, women choose sterilization because it is the one method of birth control that doesn't require them to take responsibility for not getting pregnant; once the procedure is done, there is nothing else they need do in order to prevent pregnancy. In his opinion, it is this escape from responsibility that the women are seeking when they choose sterilization rather than an escape from poverty.

This disparity between the views of women and the views of their medical professionals is particularly problematic because the medical professionals are in positions of authority and the women

must rely on them in order to achieve sterilization. Though the women view themselves as agents in their own lives who are taking responsibility for themselves and their children, they cannot achieve sterilization—the expression of their responsibility—alone. They must submit themselves to the care of medical professionals who view the women's choice condescendingly, as though the women were attempting to escape the responsibilities of "real life."

While Louisa believes that the systems of social support in Brazil infantilize women to the point that they are unable to take responsibility for themselves, perhaps it is really the condescending attitudes of medical professionals that infantilize women. When women must turn to an authority who views them as running away from life's responsibilities, they lose a measure of the control that they entered the clinical setting to gain.

The Lack of Education: Misinformed or Uninformed?

Although the attitudes of the medical professionals I spoke with were undoubtedly condescending towards the women, one could still make the argument that those attitudes have no bearing on women's empowerment as long as the women are secure in their choices. And indeed, I did not find that the women had internalized the medical authority's condescending attitudes. All of the women I spoke with had been through the clinical process, and all of them still spoke about their decision in terms of forging a better life.

I did find however, that the attitudes of the medical professionals seem to have had a significant impact on the way the women were oriented in the process of sterilization and the amount of information they were given. A theme that repeatedly came up in the women's sterilization narratives was the pure lack of information they received either before or after the procedure. A common refrain, and one I heard from almost every woman when I asked her to tell me what kind of information her doctor gave her before the procedure was: "he didn't tell me anything" (*ele não me falou nada*). Raimunda, a middle aged woman who lived in the *bairro popular* behind The PSF also echoed this

refrain when I spoke to her. At that point however, I had already interviewed six women before her who had all given me the same response and I was beginning to get frustrated with the simplicity and lack of detail in their answers. “So,” I asked her, “if the doctor didn't explain anything to you, do you know what he did inside your body during the procedure?” Raimunda stared at me for a moment contemplating before responding, “No. All I know is that I am not getting pregnant anymore.”

This lack of knowledge continued after the procedure as well. Of the ten women I interviewed, four of them did not have a follow-up appointment, citing that either they did not think they needed one because they didn't feel any pain or that their doctors did not tell them they needed one as reasons. The other six women did have follow-up appointments, but they all said that either no further information about the procedure was given, or that the type of information given was related to caring for the incision rather than what was done during the surgery.

I also found that none of the women had been counseled about the other options for contraception that are available to them. While some of the women had used oral or injected contraception before the sterilization, most of them had not used any other form of contraception and none of them were aware of the wide range of options that are available. This lack of information both about the procedure and about the other forms of contraception available is particularly disturbing in light of the fact that this kind of prior counseling is one of the legal requirements for a sterilization procedure. The family planning legislation Federal Act 9,263 of 1997 requires that prior to becoming sterilized, a woman must both be offered all other forms of contraception and she must be counseled about the procedure and its results (Vieira and Ford 2004:1203).

When I asked the medical professionals I spoke with about the blatant lack of information being given to the women about the sterilization procedure, I got some complicated responses. In my interview with the doctor at The PSF, Dr. Francisco, I first told him that none of the women I had spoken with had been properly oriented or counseled by their doctors about what would happen during

the procedure and I then asked him why he thought that was. At the time, I was unaware that it is the responsibility of the professionals at the PSFs to do the majority of the counseling before the procedure, as the Posts are the place that a woman must go in order to get the referral to the doctor who will perform the procedure. Therefore, the fact that none of the women I had spoken to, all of whom were patients at The PSF, had been properly oriented implicated Dr. Francisco and the other professionals at The PSF. Thus, in retrospect it is not surprising that in response to my question, he launched into a long tangent about how sterilization used to always be performed at the same time as Cesarean births.

Realizing that I was not getting a straightforward response, I decided to redirect my question and instead asked the doctor to explain to me the process that women go through when they arrive at The PSF requesting sterilization. This time he answered my question, but continued to stay vague on the details:

> First, we talk with her to see if she has more than two children or is older than 25. We talk with her too to see if this would be the best thing for her, and we talk with her husband to see if he could do a vasectomy. A vasectomy is a simpler, safer procedure that takes less time to heal after. Then we choose a day for her to come back and we send her home to think for three months. So she comes back one more time for us to talk about this. That's what we do.

His response was relatively in line with the requirements of the 1997 family planning legislation (the woman must be at least 25 years old, have two children and there is a mandatory 60 waiting period after the woman has requested the procedure and before it can be performed). However he did not mention whether or not the procedure was properly explained to the woman, or whether or not she was offered any other form of contraception in addition to a vasectomy. Furthermore, his statement that "we talk with her to see if this would be the best thing for her," suggests that the final assessment on whether or not a sterilization is the "best thing" for the woman is made by the medical professionals rather than the woman herself and without giving her any concrete information on how a sterilization is

done and how the procedure will alter her body and her life.

My conversation with the nurse, Louisa, clarified the situation a little more, but still demonstrated that the medical professionals are not fulfilling their legal obligation to fully inform their patients about what a sterilization procedure entails:

> Here in Brazil, a patient of SUS generally passes first through the PSF and then we send them to a referral clinic. But the ones who have the responsibility to do the explaining are the PSF, really. It's us. We have a lot of themes to talk about, prostate cancer, tuberculosis, sexually transmitted diseases, all the themes possible, including tubal ligation. So when we do an activity on a theme, we can't ensure that the entire community comes to hear about these themes. When the woman comes here, she has a consultation with the doctor here and then she should get another lecture at the referral clinic.

From this interview, it became clearer that it is The PSF that is responsible for orienting the women, but because of the amount of educational topics they have to cover, many cases seem to fall through the cracks. At the end of this explanation, Louisa also told me that perhaps all the women I talked to had told me that they had not received any information about their procedures because they were lying. Perhaps they had in fact been properly oriented, but were just telling me that they had not.

This thought sat with me until I went to speak with my adviser, Tatiane. Although she does not do it anymore, Tatiane worked as a nurse in a PSF in Santo Antonio for many years before moving to the municipal Secretary of Health to work as the coordinator of the PSFs. When I spoke to her about the lack of information amongst the women I had spoken to, she did not seem surprised by this information at all. She explained to me that it is a well-known problem in Brazil that lower class women do not receive adequate sex education and as a result they do not have the proper educational base to understand what happens during the sterilization procedure even if it was being explained to them properly. She also said that the doctors are aware of this educational deficit but that many times they felt that attempting to explain the procedure to uneducated women who wouldn't understand anyway was a waste of time, especially when they were overbooked with patients.

Thus, a combination of the doctor's condescending attitudes towards the women and the characteristic over-crowding of SUS health facilities results in a situation where the medical professionals neither have the will nor the time to properly inform the women about the sterilization procedure. Being uninformed about their bodies in this way, the women end up surrendering much of the control that they originally sought to medical authority and as such, they are rendered alienated from their bodies.

Still Living in Fear

Perhaps the biggest manifestation of the women's alienation from their bodies is the fact that the majority of the women I spoke with continue to live in fear of becoming pregnant again, even years after they underwent sterilization. Though some women were more afraid than others, all of them had some level of doubt that the procedure is actually as effective as they had been lead to believe, and all of them believed that becoming pregnant again was still a possibility, even if it was not probable.

Simone, the woman I spoke with who was the most adamant about not having more children was also the one who was most afraid of becoming pregnant again. She told me that she had been sterilized five years before and that for the time being the surgery had been effective, but she felt that she could never be sure whether or not the procedure was actually done correctly. She had heard of other women who had conceived after they were sterilized, and she was desperately afraid that this might happen to her too.

Another woman, Fernanda has been sterilized after three Cesarean births, and she too had doubts about whether or not the procedure was effective. For her, not becoming pregnant again was all the more pressing because a pregnancy after three Cesarean births carries an increased risk of a ruptured uterus and can be life threatening. “I know someone who conceived again after,” she said. “So I have doubts. Until now, I haven't gotten pregnant, but I have a little doubt.” She tried to remain calm as she told me this, but I could see that her hands were clenched in her lap and the look on her face

suggested that she had spent more than a few sleepless nights worrying about the possibility of a new conception.

When I asked the medical professionals with whom I spoke about these fears, I got the same response from all of them: "the method is secure." The tubes are tied and then cut, and while there is a chance of the tubes reconnecting, it is an extremely rare occurrence. Although several of the women claimed they had friends in the *bairro* whom had conceived again after being sterilized, the doctor and the nurse at The PSF both assured me that in all their time working at the Post, they had never seen a case of conception post-tubal ligation. Dr. Geraldo, the obstetrician told me that in his many years working as an obstetrician he had also never seen a case of tubal reconnection, nor heard of one occurring in Santo Antonio.

After talking with the doctors, I felt conflicted about who to believe, since many of the women claimed they knew someone to whom this had happened personally, so I decided to ask the ACSs to help me find a case. They too, were stumped, however. We asked around the neighborhood at several houses, following a few rumors, but in the end we could not find any real cases of women who had conceived again. There were only stories.

This unfounded fear of becoming pregnant again is almost certainly a result of the lack of education and information that the women receive before becoming sterilized. If they were well informed about the way their bodies function, and the way in which the sterilization procedure modifies that function, it might be more difficult for rumors about post-ligation pregnancy to plant doubt in their minds. And while all the women with whom I spoke were satisfied with the sterilization precisely because they had not gotten pregnant again, the fact that they continue living in fear suggests that a large measure of control over their bodies was lost once they underwent the procedure.

Conclusion

The process of doing this research project was both heartening and discouraging. After long and

tiring days of interviews, I would come home to process the day's work and find myself cheering the women in their efforts to make a better life for themselves, while quietly fuming at the systems in place that denied them the information they deserved and which ultimately left them alienated from their bodies.

The sterilization narratives of the women I interviewed clearly show that these women are striving to make a better life for themselves even with the limited resources that they have. Though other means to a better life are either taken away from them or unavailable to begin with, the women are empowered and unafraid to take responsibility for themselves and their children by taking action on their bodies in a permanent way.

In light of their difficult situations, the women are taking the right steps towards control and empowerment in their lives. However, systemic medicalization, a lack of proper education and the attitudes of medical professionals towards their patients are all barriers to achieving that empowerment in full. In order to pave the way for these women to become truly empowered actors in their own lives, the government of Brazil needs to find a way to reach all women, including adolescents and single women, with proper sexual education and a large-scale family planning program. Though medical professionals are authorities by necessity, women do not have "submit" to that authority when they enter the medical sphere to obtain sterilization or any other form of contraception. It is possible to level with that authority, but women need the knowledge of their bodies in order to be able to do so. If women just had access to proper education, they need not be alienated from their bodies by medical authority.

To close my discussion of sterilization and empowerment, I want to stress that I do not critique sterilization as a form of birth control or as the choice of individual women. I believe that the women themselves are better placed than anyone else to determine what it is that they need and what is best to meet their own needs. Though I originally dismissed sterilization as something the women had been

"duped" into rather than a determined choice, I now understand that even without the full range of knowledge, women are well placed to make a decision for themselves about how to improve their lives by controlling their fertility.

On the other hand, I do strongly critique the system that is in place to deny the women the full range of information about contraception and their bodies. The women are well placed to know what they need, but they could be much better placed to make an informed decision if they had access to all the knowledge available. Furthermore, while the medical professionals I spoke with were well aware of the lack of education in Brazil and were quick to critique the government for not providing better education programs, my strongest critique is reserved for those same medical professionals. While they attempt to place responsibility on the government, they deny their own complicity in denying women information and alienating them from their bodies. The women have done their part to take responsibility to improve their lives. Now it is time for the medical professionals who care for them to do the same.

Glossary of Terms

A avenida
The Avenue. A general term that is used by the residents of Santo Antonio to refer to a wealthier area of the city where middle and upper-class families live, and where one can find an array of expensive boutiques and other stores.

Agentes Comunitários de Saúde (ACS):
Community Health Agents. In Brazil's effort to bolster it's preventative health program, the government instated Community Health Agents at every Family Health Post in every municipality. The Job of the ACSs is to monitor the health of the people in their area, make sure people come in for routine check-ups, and to help people get appointments for more specialized care at secondary clinics and hospitals. It is the job of the ACSs to know everyone in their community and be aware of the health status of all community members.

Bairro Popular:
A *bairro popular* is a poor, lower-class neighborhood in Brazil. *Bairros populares* are often referred to as Favelas, but the neighborhood in which I worked in Santo Antonio was not referred to as one. These communities are classified by poor resources, impermanent homes and poor sanitation. The residents are usually the most marginalized residents of the municipality.

Programa de Assistência Integral à Saúde da Mulher (PAISM):
The Program for Integrated Women's Health. This program was implemented in Brazil in 1983 by the Ministry of Health with the objective of reducing morbidity and mortality in women and children. It was also the first public health program in Brazil that included provisions for providing contraception and family planning, although these efforts were largely unsuccessful.

Sistema Única de Saúde (SUS):
The Unified System of Health. SUS is the Public Health system in Brazil, which was created by a provision in the 1988 Constitution. The Constitution states that all Brazilian citizens have the right health and thus to free access to healthcare. SUS is based on the principles of universality and equity which state that all patients have the right to be treated according to their needs. SUS is a decentralized system that is operated by the three levels of government—municipal, state and federal. Treatment in SUS is organized into three levels of care: basic preventative care; secondary care, which includes specialization and the treatment of diseases and their consequences; and tertiary care, which includes the treatment of chronic illness, rehabilitation and emergency care.

Postos de Saúde Familia (PSF):
Family Health Posts. A PSF is part of the primary level of care of SUS. There are PSFs located in each community of a city and are staffed by doctors, nurses and ACSs based on the number of people living in the community. PSFs are responsible for basic and preventative care.

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Appendices

Appendix I – Interview Questions in English

Women who Have been Sterilized:

1. When were you sterilized?
    - How old were you at the time?
    - How many children did you have?
    - What was your marital status?
2. Why did you decide to become sterilized?
3. Did you request a sterilization from your doctor or did he/she recommend one to you?
    - If you requested the sterilization, how did your doctor react? What he/she helpful and compliant or resistant?
    - If you requested the sterilization, where did you get the idea?
    - If your doctor recommended the procedure to you, how did you react? Did you already want one, or was it a new idea to you?
4. What was your impression of the doctor you went to for your sterilization? How did you feel about him/her?
5. What kind of information did your doctor give you before the procedure?
6. How was the experience of the procedure itself?
7. Did you have the procedure individually, or was it performed with another procedure?
8. What kind of follow-up was done with you after the procedure?
9. In retrospect, do you think your doctor accurately represented the procedure to you?
10. Overall are you satisfied with your procedure? Why or why not?
11. Overall, how do you feel about the medical professionals who took care of you before, during and after your sterilization?

Medical Professionals:

1. How did you come to work specifically in reproductive health?
2. Do you see many patients who are seeking birth control and family planning?
3. What is the most commonly requested form of birth control?
4. What form of birth control do you most commonly recommend?
5. When you recommend any form of birth control, do your patients usually follow your recommendation? Why or why not?
6. Have you had many patients that are seeking sterilization?
7. Is it more common for you to recommend a sterilization or for your patients to request one?
8. Under what circumstances do you normally recommend a sterilization?
9. Under what circumstances do you believe a sterilization would not be appropriate?
10. When a patient is going to have a sterilization, what information do you usually give to her before the procedure?
11. How are sterilizations usually performed? Is it an individual procedure or is it performed at the same time as another procedure?
12. What sort of follow up do you do with your patients after the procedure?
13. What is your overall opinion of sterilization as a form of birth control?

Appendix II – Interview Questions in Portuguese

Mulheres Que já Foram Esterilizadas:

1. Quando você foi esterilizada?
    - Quantos anos você tinha quando o procedimento foi atualizado?
    - Quantos filhos você tinha?
    - O que era seu estado civil?
2. Por que você decidiu se tornar esterilizadas?
3. Você solicitou uma esterilização o seu médico recomendou?
4. Qual era sua impressão do médico que você foi para sua esterilização? Como você se sentia sobre ele(a)?
5. O que tipo de informações seu médico te deu antes do procedimento?
6. Como era a experiencia de procedimento?
7. Você tinha o procedimento separado o com um outro procedimento?
8. O que tipo de revisão era feito depois do procedimento?
9. Em retrospecto, você pensa que o seu médico representava exatamente o procedimento e os resultados dele para você?
10. Agora, em geral, você está satisfeito com sua esterilização? Por que o por que não?
11. Agora, em geral, come você se sente sobre os profissionais médicos quem cuidavam de você antes, durante e depois de sua esterilização?

Profissionais Médicos:

1. Como você veio para trabalhar especificamente em saúde reprodutiva?
2. Você ver muitos pacientes quem estão buscando controle de natalidade e planejamento familiar?
3. O que tipo de controle de natalidade é solicitado o mais?
4. O que tipo de controle de natalidade você recomenda o mais?
5. Quando você recomenda um tipo de controle natalidade, suas pacientes geralmente seguem a sua recomendação? Por que o por que não?
6. Você já teve muitos pacientes quem estavam buscando esterilização?
7. É mais comum para você recomendar uma esterilização o para suas pacientes solicitar?
8. Em que circunstâncias você normalmente recomenda uma esterilização?
9. Em que circunstâncias você pensa que uma esterilização não é apropriado?
10. Quando uma paciente vai ter uma esterilização, que tipo de informações você normalmente dá a ela?
11. Como esterilizações são feito normalmente? Elas são feito individuais o com um outro procedimento?
12. O que tipo de revisão você normalmente faz com suas pacientes depois do procedimento?
13. Em geral, o que é sua opinião sobre esterilização como forma de controle de natalidade?

Appendix III – Consent Form in English

Information About the Study

Who is responsible for this study? You are being invited to participate in a research project by Leah Smith, an anthropology student of the exchange program SIT World Learning do Brasil (71-9353-3302, lsmith@brandeis.edu). The Academic Director of this program is Damiana de Miranda (71-9978-8305). The principal investigator of this study is Elizabeth Ferry, an associate professor of anthropology at Brandeis University (781-736-2218, ferry@brandeis.edu).

What is the aim of the study? The aim of this study is to learn about women's motivations for choosing sterilization.

Why was I chosen? You were chosen because you work with women on reproductive issues, you have been sterilized yourself, or are seeking a sterilization.

What will be involved in participating? Leah Smith will interview you at a time and place of your convenience. The interview will probably take about one hour, and if you are comfortable with this, it will be tape-recorded. The interview will be informal, and the questions will largely center on your thoughts and opinions about sterilization, and if you have been sterilized, why you made that decision. Leah Smith will also be spending time with the NGO that serves you, or where you work. She may ask you to participate in some of the activities of the NGO.

What are my rights as a participant? Your participation in this project is entirely voluntary. If at any time you would prefer not to answer an interview question, you wish me to turn off the recording device, you prefer that I not use some portion of material already recorded, or you do not wish me to participate in an NGO activity, I will honor your request. You may ask any question regarding this research, and I will answer it fully.

Who will know what I say? In any presentation or publication of the information I collect in this study, I will protect your confidentiality by changing your name to a pseudonym and altering any markers (such as your profession, your age or elements of your life history) that could be used to identify you. Only the researcher (Leah Smith) will have access to the interview records and tapes.

What are the potential benefits of the study? There are no direct benefits to you of participating in this study. However, you may enjoy discussing your views and experiences with an interested listener. The information that you provide will be used to contribute to understandings of women's choices, the reproductive options available to them and access to family planning resources. If you would like to see the written results of this study, I will be glad to provide them to you once available.

University Review Board. This study has been approved by Brandeis University's Review Board for the Protection of Human Subjects. If you have questions regarding your rights as a participant, or if you have any questions or complaints regarding this research study, you may contact the Brandeis Committee for the Protection of Human Subjects (BCPHS) in the Office of Research Administration at Brandeis University. (MS #116, P.O. Box 549110, Waltham, MA, 02454-9110, USA. Phone: 781-736-8133. Fax: 781-736-2123).

Appendix IV – Consent Form in Portuguese

Informações Sobre o Estudo

Quem é responsável por este estudo? Você está sendo convidado a participar em um projeto de investigação de Leah Smith, uma estudante de antropologia da programa de intercambio SIT World Learning do Brasil (71-9353-3302, lsmith@brandeis.edu). A diretora academêmico desta programa é Damiana de Miranda (71-9978-8305). A investigadora principal deste estudo é Elizabeth Ferry, professora associada de antropologia da Universidade Brandeis (781-736-2218, ferry@brandeis.edu).

Qual é o objetivo deste estudo? O objetivo deste estudo é aprender sobre as motivações das mulheres para escolher a esterilização.

Por que eu fui escolhido(a)? Você foi escolhido(a) porque você trabalha com mulheres sobre questões reprodutivas, você foi esterilizada, ou você está buscando uma esterilzação.

O que envolve sua participação? Leah Smith vai entrevistá-lo(a) em um momento e local de sua conveniência. A entrevista provavelmente vai durar uma hora e se você se sentir confortável com isso, será gravada. A entrevista será informal e as questões serao dos seus pensamentos e sentimentos sobre esterilização e (se aplicável) suas motivações para escolher a esterilização. Leah Smith também irá passar um tempo na ONG onde você trabalha, ou lhe da assistência. A investigadora peça para participar em algumas atividades da ONG.

Quais são meus direitos como um participante? Sua participação neste projeto é totalmente voluntário. Se a qualquer momento você não quiser responder a uma pergunta, você queira que eu desligue o dispositivo de gravação, você não queiraque eu use algum material já gravado, ou você não queira que eu participe de uma atividade de ONG, eu vou honrar o seu pedido. Você pode fazer qualquer pergunta sobre este estudo e vou respondê-la prontamente.

Quem vai ter acesso ao questionário? Em qualquer apresentação ou publicação das informações que eu relaciono neste estudo, eu vou proteger a sua confidencialidade, mudando seu nome para pseudônimo e alterando qualquer marcadores (como a sua profissão, idade, ou elementos de sua história de vida) que poderiam ser usadas para identificar você. Somente a pesquisadora (Leah Smith) terá acesso aos registros e fitas da entrevista.

Quais são os benefícios potenciais deste estudo? Não há benefícios diretos para você por participar deste estudo, mas você pode aproveitar para discutir as suas opiniões e experiências com um ouvinte interessado. As informações que você fornecer serão utilizadas para contribuir para o entendimento das escolhas das mulheres, as opções reprodutivas disponíveis para elas e acesso a recursos de planejamento familiar. Se você gostaria de ver os resultados escritos deste estudo, eu ficarei feliz em fornecê-los a você uma vez disponíveis.

Conselho de Revisão da Universidade. Este estudo foi aprovado pela o Conselho de Revisão para a Proteção dos Seres Humanos da Universidade Brandeis. Se você tem perguntas sobre os seus direitos como um participante ou se você tem quaisquer perguntas ou reclamações sobre este estudo, você pode contactar o Comitê para Protecção dos Seres Humanos de Brandeis (BCPHS) no Escritório de pesquisa em administração da Univsersidade Brandeis. (MS #116, P.O. Box 549110, Waltham, MA,

02454-9110, USA. Telefone: 781-736-8133. Fax: 781-736-2123).

Appendix V – Evaluation Questions

1. Could you have done this project in the USA? What data or sources were unique to the culture in which you did the project?

I do not think it would have been possible to do this project in the US for two main reasons. The first is that female sterilization is an extremely rare occurrence in the US. Women who do choose to become sterilized usually do so out of medical necessity rather than to control their fertility, and furthermore because the cases of sterilization in the US are highly medicalized, it would be difficult because of privacy laws to find and gain access to the women who actually are sterilized.

The second reason is that people in the US are much more closed to talking about the personal details of their lives with people they don't know very well. Brazilians generally tend to be more open and willing to talk about themselves and their lives. I also had the assistance of the ACSs at The PSF whom the women knew and trusted. However, no such system exists in the US so again, gaining access to the women would be extremely difficult.

2. Could you have done any part of it in the USA? Would the results have been different? How?

I do not think any part of this research could have been done in the US. If I was able to carry it out however, the results would be completely different. In the US female sterilization is not usually an option for a woman who does not want to have more children. Thus I imagine that the motivations of American women who had chosen to be sterilized would be completely unrelated to poverty or forging a better life.

3. Did the process of doing the ISP modify your learning style? How was this different from your previous style and approaches to learning?

Doing the ISP was the first time that I have ever had to collect, handle and analyze such a large amount of information. Usually my writing and thinking style is much more free form and my academic work tends to take shape as I am writing and without a lot of prior planning. However, because the ISP included so much data, I had to learn to be more organized and to plan what I was going to argue and how I was going to present my data in advance.

4. How much of the final monograph is primary data? How much is from secondary sources?

The majority of my argument in the final monograph is supported by primary data. There were a few areas of my discussion that were never covered in any of my interviews, thus for those sections I relied on primary data. However, I feel confident in my conclusions because they are supported by experiences, observations and dialogues that I witnessed and participated in myself, rather than by data that was collected by others.

5. What criteria did you use to evaluate your data for inclusion in the final monograph? Or how did you decide to exclude certain data?

As I discussed in my introduction, I only excluded two interviews from the final monograph. One

interview was excluded because it was nearly impossible to understand the accent of the woman and at the end of the interview she told me that she had lied about some of the details of her narrative. The other interview was excluded because the woman was not very forthcoming, did not give me any information I could work with and because her story did not follow the theme of the others, thus there was very little I could do with the information she gave me.

6. How did the “drop-offs” or field exercises contribute to the process and completion of the ISP?

I think that the field exercises helped me to be more aware and take note of everything around me. I was really surprised by how every detail of what I was experiencing, from facial expressions to the way people's homes were arranged had some bearing on the way that I received and interpreted my data. The field exercises really trained me to take note of all these details.

7. What part of the PHMFSS most significantly influenced the ISP process?

Writing the proposal for the ISP really had the most significant impact on the final outcome of my project. Although I had been thinking about this project for a long time and doing lots of library research, writing the proposal was really the first time that I had to think about how the research would be done. That more than anything helped me to organize the project and visualize how I would obtain my data.

8. What were the principal problems you encountered while doing the ISP? Were you able to resolve these and how?

The main problem I encountered was the language barrier. I was working in the interior where the accent is different and most of my subjects were uneducated and spoke with improper grammar and a lot of slang that I could not understand. I recorded all of my interviews so sometimes I was able to go back and understand more than I had during the conversation, but that prevented me from asking the kind of in-depth follow-up questions that I would have liked. I was still able to get sufficient data, but there was little I could do to resolve the problem.

9. Did you experience any time constraints? How could these have been resolved?

I did not experience any time constraints. I was able to complete all my interviews in a week and a half, which then left me plenty of time to analyze the data and write the final ISP monograph.

10. Did your original topic change and evolve as you discovered or did not discover new and different resources? Did the resources available modify or determine the topic?

It wasn't really the resources that were available that modified my topic so much as the responses that I got from the women. Originally I wanted to focus solely on medicalization, but as the interviews progressed I quickly realized that medicalization was only a small part of a much larger and more complicated picture, so the focus of my argument shift as a result.

11. How did you go about finding resources: institutions, interviewees, publications, etc.?

I gained access to all of my interviewees through my adviser Tatiane, the coordinator of the PSFs in

Santo Antonio and the ACSs at The PSF where my research was focused. Library resources were found through the Brandeis University library catalog.

12. What method(s) did you use? How did you decide to use such method(s)?

The main method I used was interviews. I decided to use this method because I thought it was the most appropriate and efficient way to get the information I was looking for.

13. Comment on your relations with your advisor: indispensable? Occasionally helpful? Not very helpful? At what point was he/she most helpful? Were there cultural differences that influenced your relationship? A different understanding of educational processes and goals? Was working with the advisor instructional?

My relationship with Tatiane was good. In a sense it was indispensable because I could not have gained access to my research site without her. As a nurse, she also gave me some very good insights on the state of women's health in Brazil and why doctors often react to women seeking sterilization the way they do. I appreciated her insight a great deal because it was more detailed than the responses I got from the doctors themselves and it was also not something I could have found in a library resources.

14. Did you reach any dead ends? Hypotheses which turned out to be not useful? Interviews or visits that had no application?

As I mentioned before, I had two interviews that were not of use to me, but those were the only dead ends I encountered.

15. What insights did you gain into the culture as a result of doing the ISP that you might not have gained otherwise?

I think the main insight I gained is that as long as you approach people politely and respectfully, they will generally be willing to talk to you about personal details of their lives. Before I started this project I was extremely worried that the I encountered women would not be willing to talk to me about such a sensitive subject, but I quickly realized that this fear was born of American culture where most people would be closed to the idea of being interviewed about their contraceptive decisions and especially such a life-altering decision like sterilization. In Brazil however, everyone is a lot more open and willing to share about themselves.

16. Did the ISP process assist your adjustment to the culture? Integration?

I think I was already well adjusted and integrated before I began the ISP. I would not say that the ISP process influenced my further integration.

17. What were the principal lessons you learned from the ISP process?

Be patient! Things don't work on a schedule in Brazil the way they do in the United States. If something doesn't work out right away the way you had planned, chances are that if you give it some time it will fall into place later.

18. If you met a future student who wanted to do this same project, what would be your recommendations to him/her?

My main recommendation would be to try and have multiple interviews with the same people. Have an initial interview and then go back with follow-up questions to get a more in depth picture of the woman's experiences. My main regret with this project was being able to go back to the same women after I had analyzed there responses and come up with a lot more questions.

19. Given what you know now, would you undertake this, or a similar project again?

Absolutely. I think there is a lot more to learn about the situation that contributes to such high rates of female sterilization in Brazil and I also think that more significant research in the area could help contribute to creating a better sexual education program for women here. In fact, I am planning to spend my summer here to continue this research project and hopefully help give a few sexual education classes to the women in the community where I will be working.