Getting sterilized in Brazil:
stories of success and failure

Kristine Hopkins

Female Sterilization in Brazil

I already had two children and this was the third and I was wanting to work, wanting to invest in my future. … I wanted to ligar and [the doctor] agreed, took care of everything.

– Berenice, age 26, delivered in a private hospital

So I lost my chance [to get my tubes tied]. … I got screwed out of my ligação. [Dancei com a minha ligação.]

– Úrsula, age 22, two children, delivered in a public hospital

This chapter explores the experiences of women who delivered in public and private hospitals in Porto Alegre and Natal in the mid-1990s. At that time, more than one in four (27%) women aged 15 to 49 in Brazil were sterilized and four out of ten women in union in this age group were sterilized (Remez 1997). Considerably more women were sterilized than used the pill, the second-most popular method of contraception in Brazil; 16% of all women in reproductive age and 21% of women in union used the pill. These national averages, however, masked large regional differences in female sterilization use among women in union: while only 29% of women in the South region were sterilized, 60% of women in the Central-West region were. Thirty-four percent of women in union who lived in São Paulo are sterilized as were 46% of married or cohabiting women in Rio de Janeiro. Likewise, 39% of women in union who live in the Central-East region are sterilized, 44% in the Northeast, and 51% of women in the North region of Brazil.

In August 1997, Law 9263 was passed that regulated surgical sterilization in Brazil. The restrictions imposed under the law were the following: women or men had to be at least 25 years of age or have at least two living children. In addition, the sterilization procedure could not be done

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1 Many seem to have interpreted eligibility under the law, however, as requiring people to be at least 25 years old and having at least two living children, as is the case in the state of Pernambuco (Dalsgaard 2000).
at the same time or soon after delivery, with exceptions for cases of induced abortion, and multiple previous cesarean sections. Potter et al. (2003), argued that “there was hope that regulation would curtail abuses such as demands by employers for certificates of sterilization, coercion, as well as side payments to doctors practicing in public hospitals, and the use of sterilization for electoral purposes” (Potter, et al. 2003: 385; see Caetano & Potter 2004 for more about sterilizations for votes in the Northeast of Brazil).

Before that, neither the public health service (Sistema Único da Saúde, SUS) or private insurance covered the procedure. Before the passage of the 1997 law, the procedure was not only not covered by insurance, it was interpreted as illegal (cutting the fallopian tubes or vas deferens were considered mutilation). Exceptions to this interpretation were if a subsequent pregnancy would put a woman’s life in danger. A history of previous cesarean section deliveries placed a woman in this category because of increased risk of rupture along the uterine scar. Therefore, before the passage of the 1997 law, a substantial proportion of sterilization procedures were performed at the time of a cesarean delivery (Potter et al. 2001). Indeed, 70% of women surveyed in four states in the Northeast who had a cesarean section reported that a chance to get a sterilization on medical grounds was a primary or contributing factor for the surgical delivery (Janowitz et al. 1985).

Dalsgaard (2000) and Hunter de Bessa (2006) use qualitative interviews with poor women living in Recife (Dalsgaard) and Belo Horizonte (Hunter de Bessa) to show what motivates women to get sterilized. They also argue, persuasively, that women seeking sterilizations are not coerced or passive about their fertility, but instead actively pursue an end to childbearing in order to take control of their present lives and to build a better life for themselves and their children in the future. Dalsgaard (2000) also describes clear examples of how women in the northeast setting of her research went about getting their sterilizations in the past as well as reports of those who were unsuccessful in getting them.

Similarly, this study provides an in-depth look at women who were sterilized at the time of delivery or right afterward as well as women who wanted to be sterilized at delivery but were frustrated in their attempts to do so, using both quantitative and qualitative data. Based on a survey of 321 women interviewed postpartum in a southern and northeastern Brazilian city, as well as participant-observation in the research site hospitals and in-depth interviews with women who had just had a baby, I asked the following questions: What are the demographic profiles of the women who got sterilized and how do they differ by where they delivered (hospital type and city of residence)? Who were frustrated in their attempts to get sterilized and why did those sterilizations not succeed? How did a woman manage to get sterilized at the time of delivery when sterilization’s legal status
was, at best, ambiguous? To what lengths did women in these settings go to get sterilized? Finally, before the change in the law, who actually managed to get sterilized and how?

Methodology

Data come from nine months of fieldwork carried out in 1995-96 in the cities of Porto Alegre and Natal. I collected data in three ways: participant observation in the maternity and/or obstetrics wards of a public and private hospital in each city; a postpartum survey of 321 women who had given birth in the research site hospitals; and in-depth interviews with 41 women drawn from the postpartum survey sample. I selected Porto Alegre, the capital of Rio Grande do Sul, Brazil’s southernmost state and Natal, the capital of the northeastern state of Rio Grande do Norte, as research sites because they represent large differences in their economic development and had different rates of female sterilization and of cesarean section, another focus of this study.

The public research site hospitals had each city’s lowest cesarean rate at the time (23% in Porto Alegre and 28% in Natal), while the private hospitals of this research had each city’s highest rate of cesarean section according to 1995 vital statistics information (71% in Porto Alegre and 86% in Natal). Eighty women (81 from the private hospital sample in Natal) were interviewed postpartum, with sampling based on parity and type of delivery, as I have described in detail elsewhere (Hopkins 2000). I interviewed 41 women—ten from each hospital (11 from the Natal private hospital sample)—on average three weeks after she had her baby. The semi-structured interviews were done in confidential settings, tape recorded and transcribed. All participants consented to participate in the research and all names used here are pseudonyms.

Notes on Translation

I use direct quotes in the following pages that I translated from the Portuguese. In some cases, I left the Portuguese word or words intact, or, for more colloquial expressions, I provided the translation and included the Portuguese for reference. Several important words related to childbirth and sterilization are left in the Portuguese, as described below.

In Portuguese, the everyday term for a vaginal delivery is parto normal, literally ‘normal birth.’ Since Brazilians also sometimes say parto natural (natural birth), the much more commonly used expression parto normal is difficult to translate into English. English speakers often use the expression ‘natural birth’ or ‘natural delivery’ or simply ‘childbirth’ to describe a vaginal delivery but none of these seem to capture the idea conveyed in Portuguese that vaginal delivery is the normal, or standard delivery.
Similarly, the technical terms in Portuguese for a tubal ligation is laqueadura or ligadura tubária, though they are seldom used in colloquial speech. Instead, ligadura tubária is shortened to ligadura (cut, ligature) or variations (ligação, ligamento) along with the verb ligar (to tie). Except for perhaps the phrase “to tie one’s tubes,” these words do not have good English equivalents. Eu quero ligar literally means “I want to tie,” but in this context means “I want to get my tubes tied.” A mulher ligada, literally a “tied woman,” translates into a “sterilized woman.” Because these words are a part of everyday speech, they show quite clearly how central a role female sterilization plays in life in Brazil. For these reasons, I usually leave the words describing sterilization in their original Portuguese.

**Sterilization Successes & Failures: Results of Postpartum Study**

As shown in Table 1, 50 (23%) of 171 women with two or more children who wanted no more children in this study were sterilized while still in the hospital postpartum; 47 during a cesarean section and three after a vaginal delivery. (No woman with fewer than two children was sterilized in this sample.) Of these 50 sterilized women, 12 are from the public hospital samples: only 2 in the public hospital in Porto Alegre and 10 in the public hospital sample from Natal. The remaining 38 sterilized women are from the private hospital samples: 14 in Porto Alegre and 24 in Natal. Though the samples are small, these results nevertheless mirrored national figures in the mid-1990s in which fewer women in the south of the country are sterilized compared to women in the Northeast. The proportions of multiparous women who wanted no more children who were sterilized, therefore, vary dramatically in the four hospitals of this research: from a low of 4% who delivered in the public hospital in Porto Alegre to two-thirds who delivered in the private hospital in Natal.

<table>
<thead>
<tr>
<th>Hospital sample</th>
<th>Number sterilized after delivery/N of women *</th>
<th>Means of women who were sterilized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(%)</td>
<td>Parity</td>
</tr>
<tr>
<td>Porto Alegre, public</td>
<td>2/47 (4%)</td>
<td>8.5</td>
</tr>
<tr>
<td>Natal, public</td>
<td>10/47 (20%)</td>
<td>3.2</td>
</tr>
<tr>
<td>Total, public hospital samples</td>
<td>12/94 (13%)</td>
<td>4.1</td>
</tr>
<tr>
<td>Porto Alegre, private</td>
<td>14/41 (34%)</td>
<td>2.5</td>
</tr>
<tr>
<td>Natal, private</td>
<td>24/36 (67%)</td>
<td>2.3</td>
</tr>
<tr>
<td>Total, private hospital samples</td>
<td>38/77 (49%)</td>
<td>2.4</td>
</tr>
<tr>
<td>Total of women sterilized</td>
<td>50/171 (23%)</td>
<td>2.8</td>
</tr>
</tbody>
</table>


*Among those with two or more children and who want no more children.
On average, women who were sterilized in the public and private hospital samples had different demographic profiles. Women averaged 1.7 more children at sterilization in the public hospitals compared to the private hospitals. The two women sterilized in the public hospital in Porto Alegre, though had much higher fertility at sterilization (7 and 10) than sterilized women in the public hospital in Natal (who had no more than 4 children at sterilization). Similarly, age at sterilization differs between the cities. Women in Porto Alegre, in both public and private hospitals were sterilized at older ages than those in the Natal. Indeed, the two women who were sterilized in the public hospital in Porto Alegre were 33 and 39, while the mean age of the women sterilized in the Natal public hospital was 25. Finally, and not surprisingly, given that poorer, less educated women typically only have access to public hospitals in Brazil, the sterilized women in the SUS hospitals of this sample had, on average, 5.5 years less of education, compared to those in the private sample hospitals.

Table 2 shows the distribution of sterilization desires for the 171 women in the sample who wanted no more children and had with two or more children at the time of the interview. A higher proportion of women in both public (64%) and private hospital (46%) samples in Porto Alegre were not sterilized nor had they ever tried to get one, compared to the samples in Natal – 32% in the public hospital and 25% in the private hospital. Still, women in both the public hospital samples had much higher proportions of frustrated attempts to obtain a sterilization (32% in Porto Alegre and 47% in Natal), compared to the private hospital samples (20% and 8%, respectively).

### TABLE 2

<table>
<thead>
<tr>
<th>Sterilization and Attempts</th>
<th>Public Hospitals</th>
<th>Private Hospitals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P. Alegre</td>
<td>Natal</td>
<td>P. Alegre</td>
</tr>
<tr>
<td>Sterilized on first attempt</td>
<td>1 (2%)</td>
<td>7 (15%)</td>
<td>10 (24%)</td>
</tr>
<tr>
<td>Sterilized, made previous attempt</td>
<td>1 (2%)</td>
<td>3 (6%)</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>Not sterilized, made attempt</td>
<td>15 (32%)</td>
<td>22 (47%)</td>
<td>8 (20%)</td>
</tr>
<tr>
<td>Not sterilized, never tried</td>
<td>30 (64%)</td>
<td>15 (32%)</td>
<td>19 (46%)</td>
</tr>
<tr>
<td>Total of women with parity 2+</td>
<td>47 (100%)</td>
<td>47 (100%)</td>
<td>41 (100%)</td>
</tr>
</tbody>
</table>


In fact, 64 women made 73 unsuccessful attempts to arrange a sterilization during their last pregnancy or delivery or during a previous pregnancy or delivery (Table 3). Of these 64 women, 11 eventually succeeded in getting sterilized, four who delivered in the public hospitals and the remainder in the private hospitals. Three-quarters of all unsuccessful sterilization attempts came from women who delivered in the public hospitals in the sample: 49% of the frustrated attempts had
delivered in the Natal public hospital while 26% of the attempts were among women who delivered in the Porto Alegre public hospital.

### TABLE 3

<table>
<thead>
<tr>
<th>Reason sterilization not realized</th>
<th>Public hospitals</th>
<th>Private hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Sites</td>
<td>P. Alegre</td>
</tr>
<tr>
<td>Doctor refused</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Did not deliver by cesarean</td>
<td>63%</td>
<td>46</td>
</tr>
<tr>
<td>Did not deliver by cesarean</td>
<td>10%</td>
<td>7</td>
</tr>
<tr>
<td>Bad luck</td>
<td>10%</td>
<td>7</td>
</tr>
<tr>
<td>Too expensive</td>
<td>10%</td>
<td>7</td>
</tr>
<tr>
<td>Husband refused</td>
<td>7%</td>
<td>5</td>
</tr>
<tr>
<td>“Not possible”</td>
<td>1%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>101%</td>
<td>73</td>
</tr>
<tr>
<td>% of Total frustrated attempts</td>
<td>--</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: *64 women recounted 73 frustrated attempts to get sterilized.

Why were so many women in this sample denied a desired sterilization? The vast majority failed to get sterilized because the doctor they asked refused to do it. Women reported that doctors refused because they were too young (20 cases), had health problems (5 cases), because of the number or sex composition of their children (3 cases), or that sterilizations are only performed after the third cesarean (2 cases) or after the fourth cesarean (1 case). In 15 cases, the doctor refused but gave no reason. Seven sterilization attempts were foiled because the woman did not deliver by cesarean. In seven more cases, women did not succeed in getting sterilized because of bad luck, such as the husband not being in the hospital to sign a consent form, or experiencing labor complications and going to a closer hospital for delivery instead of to the one in which a doctor had agreed to do a cesarean and sterilization (see Ursula’s case, below). Seven attempts were thwarted because the woman could not pay the price the doctor quoted, and in five cases, the woman’s husband refused to allow his wife to get surgically sterilized.

Given that 75% of the frustrated sterilization attempts took place among women who delivered in the public hospitals, it appears clear that these women were less able to realize their contraceptive intentions than were women in this pre-1997 law era who delivered in private hospitals. Also, comparing the public hospital samples, it is interesting to note that more women who delivered at the public hospital in Natal were sterilized compared to the public hospital in Porto Alegre and that more women who delivered in Natal’s public hospital sample were frustrated in their sterilization attempts. In contrast, fewer women who delivered at Porto Alegre’s private hospital were sterilized while more were frustrated in their sterilization attempts, compared to women from the private hospital in Natal.
The Postpartum Survey results presented here show that women in Natal were more motivated to get sterilized, that women in the private sector in both cities were better able to get their desired sterilization, and that a higher proportion of women in the public sector were foiled in their attempts to be sterilized. The next section discusses some of the strategies which women employed to achieve, or try to achieve, their goal of sterilization.

**In-depth Interview & Participant Observation Results: Sterilization Strategies & Stories**

Women I interviewed told numerous accounts of their strong desires for a permanent end to childbearing, as well as sterilization “successes” and sterilization “failures.” In the cases presented below I show some of the strategies women employ in their attempts to get sterilized in Brazil. The most direct—and effective—way that a woman could get sterilized is to arrange for it with her private doctor during prenatal care. Usually she would be required to pay for the procedure out-of-pocket (as health insurance did not cover the procedure), but sometimes the doctor would do the procedure for free, particularly if it were done at the same time as a cesarean operation. Another way women could get sterilized was by chance or luck, as was most common in the public sector. In this way, a woman would encounter a sympathetic doctor during prenatal care, but more likely during labor and delivery, make her plea for a sterilization and the doctor agreed. A third strategy a woman employed in an attempt to get sterilized before the law was changed was to have a more powerful connection, such as a boss or lawyer, contact a doctor on her behalf. A fourth strategy was to try to get sterilized through a political connection, where woman would essentially sell her vote for the chance to be sterilized. Either the politician him or herself, if also a doctor, would perform the sterilization, or the politician contracted a doctor to do the procedure. These last three strategies were employed almost exclusively by women who delivered in the public sector, because many of them could not afford to pay for the sterilization procedure out-of-pocket. But even if a woman managed to arrange for a sterilization using one of these strategies, the outcome was not guaranteed. Something could, and often did, go awry where small mishaps could lead to big consequences so that women were left without their desired sterilization.

The cases below also present other relevant themes in women’s quests for sterilization in Brazil before the change in the law. We will see in these examples that women did not typically receive adequate counseling about the pros and cons of the sterilization procedure, nor were they typically given appropriate information about alternative reversible methods. We will also see how age plays a factor in the sterilization decision (both from the side of the doctors and women) and how what is considered “too young” for a sterilization or “two old” to have another child varies considerably and particularly between those doctors and women in Porto Alegre and Natal.
Case Studies: Stories of Success and Failure

In this section, I present five cases that explore relevant themes in women's attempts to get sterilized in Brazil in the mid-1990s. The first three cases are drawn from women's experiences in the private sector; the remaining two are from women who delivered in the public sector. The first case tells Berenice's story and is an example of an uncomplicated sterilization arranged for during private prenatal care and carried out during a cesarean delivery. Next is Graciela's story, an example of a successful sterilization which nonetheless met the resistance of her doctor and was only agreed upon while Graciela was on the operating table. The third case is Dália's, which relates her indecision about the procedure as well as brings up cost considerations and the lack of information received about alternative contraceptive methods. Rosângela's story, the first of the cases drawn from interviews with women who delivered in a public hospital, provides an example of a series of failed attempts at procuring a sterilization as well as her success (without her knowledge or expressed consent) after the delivery of her fourth child. Finally, Úrsula's case shows to what lengths some women will go to be sterilized and also shows how difficult it can be for women like Úrsula to achieve that goal.

Case #1: Berenice

Berenice, a resident of Natal, got sterilized at age 26 after the birth of her third child at a private hospital. During prenatal care, she arranged for the sterilization with her obstetrician who readily agreed to perform the procedure.

BERENICE: I spoke to [my doctor] during the first prenatal visit (laughter). … I said, ‘I think I’m pregnant doctor and this is the last, not even if you paid me.’ He said, ‘You already want to ligar before you know if you’re pregnant?’ … [So when it was confirmed that she was pregnant,] he said, ‘You really want to ligar?’ I said, ‘Of course I do.’ ‘and I don’t want another normal [birth], I want it to be a cesarean.’ I asked for a cesarean right away, to ligar.

KRISTINE: Did he discuss the possibility of doing a normal birth and afterward doing a ligadura?

BERENICE: He asked, he asked. No, first he asked how many children I had, how old I was, and the possibility that you [sic] wanted more children or not, you know? Because the calculations are like this: with two [kids] you get can already ligar, [but] with three you can ligar with no problem. And about the age, because if you ligar when you’re young, let’s say at 19 or 20 you do a ligação. Then, God forbid, the child dies and you can’t have any more children, you separate and get together with another husband, then you want to have another child with that husband and you can’t, you know? … But I already had two children and this was the third and I was wanting to work, wanting to invest in my future. … I wanted to ligar and [the doctor] agreed, took care of everything.
Berenice’s case shows that her desire for a tubal ligation was so strong that even before her third pregnancy was confirmed, she was already requesting the procedure from her doctor. Approaching her doctor with the subject appeared simple: she said he asked her a few questions about the number of children and her age and then the obstetrician agreed. Berenice is aware of the ways in which women could regret having done the procedure, such as if a child would die or if the marriage dissolves and a new marriage is formed in which a child is desired. Berenice was convinced, however, that even given these possibilities, permanently ending childbearing through sterilization was the most desirable way “to invest in [her] future.”

Case #2: Graciela

At age 31, Graciela’s requests for a sterilization during prenatal care for her second child met with considerable resistance from her Porto Alegre private obstetrician all throughout prenatal care. Graciela reported her doctor as fearful that a patient would later regret the sterilization and then “blame the doctor.” It was only while on the operating table, with the prodding of the assisting obstetrician, that Graciela’s obstetrician agreed to do the tubal ligation.

GRACIELA: … Natália was born at 12:38. (Laughter) Then I… asked [for the tubal ligation] after she was born…, I had already discussed it with my doctor. … [I told her] ‘I don’t want more than two children, you know,’ and she always said ‘No, no, no,’ because she thought I was too young, and that I could regret it afterward. So when she was born and everything was all right, then I asked, I took advantage [of the situation]. … So…her assistant said, ‘Oh, why don’t you do it, she already has two children?’ Then [I’d] be free because taking the pill causes you so much harm. And I didn’t want to put in an IUD, I was going to do it but I didn’t because I know of two or three who got pregnant with the IUD.

The obstetrician sent a nurse to ask Graciela’s husband if he agreed with her getting sterilized. When she returned to report the husband’s verbal consent, the sterilization was performed.

This example points out that even in the private sector, some women meet with resistance in their requests for a sterilization and this is particularly true in Porto Alegre. Graciela’s doctor insisted during prenatal care that at 31, Graciela was too young for a sterilization because she could regret it afterward and then “blame the doctor.” However, the obstetrician’s fears of regret and subsequent blame were not strong enough for her to deny the procedure once she saw that the baby was born healthy, but still only performed the surgery after getting Graciela’s husband’s verbal consent for it.

Finally, Graciela noted her dissatisfaction with other methods of contraception—the pill because it “causes so much harm” and the IUD because she knew of other women who had gotten pregnant while using it. This theme is echoed throughout the in-depth interviews: once a woman
makes the decision to end childbearing, she appears to ask herself why she should fill herself with hormones or risk the possibility of getting pregnant while using another method if she can, instead, get surgically sterilized to permanently end the risk of getting pregnant.

Case #3: Dália

In contrast to Graciela, who was sure she wanted a sterilization but had to convince her obstetrician to do the procedure, Dália, a 32 year old resident of Natal, was not convinced that she wanted a sterilization while pregnant with her second child. She only decided to go ahead with the procedure during the cesarean section of that child. Also, toward the end of Dália’s pregnancy, when her obstetrician decided that a cesarean was indicated (Dália delivered her first child vaginally), it was the doctor who asked if she wanted a tubal ligation, saying she would do it for free “[s]ince I’m already going to do the cesarean, I can ligar you with no problem whatsoever.” The financial incentive appeared to work with Dália. She recounted that her neighbor had paid 300 reais to get an IUD inserted, which was a lot of money for this lower middle class household. And finally, about her age: “I think that my age is pretty advanced to have another child. ... I’m 32 years old. If I were to wait three years [to have another child] I would be 35. I consider myself really old to have another child, you know? ... So I had those doubts, you know: ligar or not ligar, ligar or not ligar, ligar or not ligar?” Still, Dália remained undecided until the last moment.

DÁLIA: ... So, so I was pretty indecisive, you know. Because, but if I don’t intend, if I think that I’m really old to have another child at 35 years old, 36, you know, then what would I keep taking the pill for? Only to ruin my body? And I have a sensitive stomach, so it would be worse for me. And varicose veins are also a [negative] side effect of the pill. ... So I thought, ‘Okay, if I have this opportunity, you know, then I will ligar.’ Sort of like that, sort of anxious, sort of indecisive. So when I arrived in the operating room is when was I told [my doctor to do the tubal ligation].

Dália did not appear to receive adequate information and counseling about alternative methods of contraception and this may have added to her uncertainty and indecision. She relied on sketchy information from her neighbor about the high costs of an IUD insertion to discard that option as a viable long-term reversible alternative method of contraception. From these comments, it seems clear that she had not discussed alternatives with her obstetrician. Her doctor’s offer of a free tubal ligation during the cesarean may have been an additional incentive for Dália to choose to get sterilized.

It is also interesting that although Dália (in Natal) is just one year older than Graciela (in Porto Alegre), Dália’s doctor was so much more open to the idea of sterilization, even to the point of
offering to do it for free. In addition, where the Porto Alegre obstetrician cited Graciela’s *young* age as a reason to not have the sterilization, Dália cites her *old* age as a reason to be sterilized. Recall from the Postpartum Survey results that mean age at sterilization at the private hospital in Porto Alegre was four years more than in private hospital in Natal (34 vs. 30 years, respectively), so these different views on age may reflect regional differences about the ideal ages of both starting and ending childbearing.

*Case #4: Rosângela*

Rosângela managed to get sterilized at age 24 after the birth of her fourth child in the public research site hospital in Natal. Her first three children were delivered vaginally and the last was delivered two months prematurely by emergency cesarean section due to placenta previa, a condition in which the placenta precedes the amniotic sac in the birth canal and can lead to serious complications such as hemorrhaging, as happened with Rosângela. Rosângela had a strong desire to be sterilized and had made several previous attempts to arrange for the procedure, though had failed for a series of reasons. However, perhaps due to the emergency nature of her surgery, she did not request a tubal ligation before or during her cesarean operation. Most importantly, Rosângela consent was not requested before the sterilization was done.

I was present during the surgery and noted that it was a nurse assistant who said Rosângela wanted a tubal ligation. After the baby was safely delivered, the nurse assistant simply said, “She wants to *ligar*.” The lead obstetrician performing the surgery asked the nurse assistant, “She wants to *ligar*?” The assistant nodded and the doctors immediately began to perform the tubal ligation procedure. After the surgery, I spoke to the nurse assistant about her comment. A second nurse assistant was also present during the exchange.

**KRISTINE:** How did you know that the patient wanted a *ligação*?

**NURSE ASSISTANT #1:** Huh?

**KRISTINE:** How did you know that the patient wanted a *ligação*?

**NURSE ASSISTANT #2:** She’s asking you how the doctor knew that she wanted a *ligação*.

**NURSE ASSISTANT #1:** He already knew.

**KRISTINE:** But how did you know?

**NURSE ASSISTANT #1:** It was already her fourth child, wasn’t it? I asked her if she could afford to have more children. It was a medical indication.

This was the extent of my conversation with the nurse assistants because they both hurried away from me. When I interviewed Rosângela at her home several weeks later, I asked her about what happened in the hospital.
KRISTINE: … You didn’t ask that [the doctor] do the ligação?
ROSÂNGELA: No. I didn’t ask for it, but I really appreciate that he did it. It’s what I wanted. I’d also run around like crazy trying to get one.
KRISTINE: And why did he do it? Did he tell you about your problem [placenta previa]?
ROSÂNGELA: He didn’t say anything. He only told me afterward.
KRISTINE: What did he say afterward?
ROSÂNGELA: He said, ‘I tied your tubes. It wasn’t meant to be done, or was it?’ [Não era pra ligar não?] I just nodded my head that it was.

Later in the interview, I asked Rosângela what was the best part about the birth, about her time in the hospital.

ROSÂNGELA: Only when the doctor told me that he did the ligadura was when I was happy, because it really was what I wanted. I ran around like crazy, asking one and asking another [for a ligadura]. A doctor. I’d even asked a politician.

This last comment brings up both Rosângela’s strong desire for a sterilization as well as her series of failed previous attempts to arrange one. During her previous pregnancy she had gone to the university hospital to request a ligadura. Rosângela reported that the social worker told her that she was too young for a tubal ligation and recommended an IUD. When she was denied the tubal ligation, Rosângela said she became so angry that she discontinued prenatal care and only returned to the hospital to deliver her child.

During the most recent pregnancy, Rosângela went to a public health post to try to arrange a sterilization with a doctor there. Rosângela reported that the doctor agreed to do a sterilization but only if Rosângela paid her 250 reais in advance. (Despite the apparent commonness of paying for a sterilization out-of-pocket, it is not legal for public health doctors to request or accept payment for any service.) Given that Rosângela earned very little money selling dishtowels on the street and that her estranged husband offered virtually no financial support, 250 reais was a virtually impossible amount of money for her to raise. Still, she persisted with the doctor, even to the point of agreeing to deliver in what others called a substandard hospital. But because she began hemorrhaging when she was seven months’ pregnant, she went immediately to the closest (and better-equipped) public hospital where she subsequently had the cesarean and got sterilized.

Regarding Rosângela’s attempt to get sterilized through a politician: she explained that she just needed to promise her vote to a politician and he would arrange for the tubal ligation.

ROSÂNGELA: … So [people] arrive there after glasses, license plates, papers, documents. He does everything, but it’s like this: he wants your voter registration number because he keeps a record of who will vote for him, you know? Even ligação too.
But she was unsuccessful in this attempt because she had been unable to locate the doctor to whom she had been referred before she went into premature labor.

Rosângela had tried to arrange a sterilization during her third pregnancy and when the social worker recommended a reversible method because of her young age, she was so angry that she said it made her discontinue prenatal care. Then during the current pregnancy she tried two different ways to arrange for the sterilization: first through a public health doctor who agreed to do it but for an unreasonable—and illegally solicited—sum, and then through a politician. Because her baby was born prematurely, she did not have to seek out the doctor referred to her by the politician. Rosângela's desire for a sterilization was so strong that she had tried for two pregnancies and had employed multiple strategies to get try to arrange one.

Though Rosângela was extremely satisfied with the outcome of her cesarean and subsequent tubal ligation, her case nonetheless raises some important issues about consent and contraceptive counseling. At the time the sterilization was performed, she was not asked whether she wanted the procedure, nor did she receive any kind of counseling about reversible methods. From her experiences at the university hospital, it is clear that Rosângela was not open to hearing about alternative methods of contraception because her mind was set on a sterilization. Still, it is important to be aware that the doctor who did the tubal ligation had no idea of her past history or of her desire for the procedure.

Case #5: Úrsula

Úrsula's case shows just as strong a desire to end childbearing by way of sterilization and it also presents another strategy by which a woman seeks out the procedure: through a more powerful connection. At age 22, Úrsula was pregnant with her second child. She had given birth to her first child less than a year before by cesarean, so she had a strong medical indication for a second cesarean. (A repeat cesarean is almost always indicated in this setting if enough time has not elapsed, e.g., at least two years, between the surgeries to allow the uterine wall to fully heal so as not to risk rupture along the uterine scar.) Before Úrsula tried to arrange for a sterilization through her connection, she first took a more traditional route in which she tried to convince a SUS doctor to do the procedure for which she would pay out-of-pocket. She did find an obstetrician who was willing to do the tubal ligation. She said that the doctor told her that she would have to pay for both the cesarean and the tubal ligation out-of-pocket, because, as he claimed, the public health service would not cover either surgery (which was not true: the cesarean would be covered). He told Úrsula that he would do the surgeries but that it would cost her at least a thousand reais. Given that this total amounted to nearly three months of Úrsula's household income, she gave up on that attempt.
Meanwhile, Úrsula’s was in contact with a lawyer who was helping her sue her former employer for firing her during her first pregnancy. The lawyer asked her if she wanted a tubal ligation. When Úrsula said she did, her lawyer made an appointment with a doctor she knew in Ceará-Mirim, a town about 33 kilometers (20 miles) northwest of Natal.

ÚRSULA: I went by bus to Ceará-Mirim. So [the doctor]…looked at me and said …‘Why do you want to ligar?’ So then I told him about my financial situation, that I already had one [child], that if I had more than two I knew I wouldn't be able to afford it. And I wanted to stop with two. So he said to me, ‘But you don’t think that you’re really young to ligar with two children?’ I told him no, that for me it was the ideal. He said, ‘Okay then. Do those exams and bring them here and we’ll schedule the surgery. Come back next month.’ So I went back the next month and took the [results of the] exams. … Then he scheduled the surgery. Only everything went wrong. Because he set the date for Friday, to give birth there, but I began to feel pain on Wednesday.

Úrsula began to feel labor pains and began to lose amniotic fluid. Úrsula wanted to go immediately to Ceará-Mirim but a neighbor convinced her to go the nearby public hospital in Natal, just for a vaginal exam, because it was the closest hospital. She borrowed ten reais from the neighbor and took the bus to that hospital. But when she got to the hospital, Úrsula saw women in labor about to give birth and said, “I won't stay here now. I'm leaving!” So she went back to the bus stop to wait for the bus to Ceará-Mirim but unfortunately one never passed by. She finally convinced a taxi driver to take her, for two reais, to a more central location where she picked up a minibus to Ceará-Mirim. But when she arrived at the hospital in Ceará-Mirim, she was told that the lights in the operating room were not working. So she and another three women were sent by ambulance back to the large public hospital in Natal (the public hospital research site), where Úrsula had a cesarean and no tubal ligation.

ÚRSULA: And I didn't get a ligação, not anything. … Through the phone call from the lawyer he would have done [the sterilization] for free. So I lost my chance. [A few days after my cesarean] I tried to talk to him… but I didn't manage to. He had just left. Because I was going to see how things were, you know, in case I could still do the surgery now. Because I have two small children at home. How will I manage things with another surgery? [My husband] already took two days of vacation so that he could be home with me now. … I got screwed out of my ligação. [Dancei com a minha ligação.]

Though Úrsula was in labor and losing water she refused to be examined at the nearby public hospital in Natal for fear that they would force her to stay there to deliver. She was so determined to get her ligação that she left the hospital before being seen and went to great trouble to get to the hospital 33 kilometers away. Although her cesarean and tubal ligation had been scheduled for just
two days later, nature and circumstances intervened and Úrsula missed her chance to be sterilized. Her ability to realize her goal to be sterilized was thwarted by broken surgical lights and going into labor sooner than expected. Since Úrsula could only get the sterilization done at the one hospital out of town, when that hospital was not functioning she was out of luck.

Finally, toward the end of the interview, I asked Úrsula to explain to me why she wanted a sterilization. She explained the strength of her desire in the following way.

ÚRSULA: Why do I want to ligar? I can't afford to have more than two children. It's not that I can't afford to have them, I can afford to have them. I can't afford to support more than two children. [Não é porque eu não tenho condições de ter, de ter eu tenho. Eu não tenho condições de manter mais de dois filhos.] ... What's the use of putting three, four children in the world and not have anything to give them?

Úrsula’s case points out some interesting elements in a poor Brazilian woman’s struggle to get the sterilization she desperately wants. She employed multiple strategies to try to arrange the procedure, first through a prenatal care doctor with whom she had no previous connection. When that failed, her more powerful connection, a lawyer, used her connections with a doctor in another town to arrange the sterilization for Úrsula. After just a brief conversation with Úrsula, during which she recounted her reasons for wanting the sterilization, the second doctor agreed. There was no counseling about reversible contraceptive methods nor any discussion of the possible disadvantages of an irreversible method. However, despite the great lengths to which Úrsula went to arrange the sterilization, she was not able to achieve her goal.

Discussion

This paper has attempted to flesh out some of the meaning behind the high rates of sterilization in Brazil in the mid-1990s. I have shown that women in the public sector strongly desire a tubal ligation though are often thwarted in their attempts to achieve that goal. In addition, women in Natal seem to have higher demand for sterilization than do women in the Porto Alegre. A woman, particularly a low-income woman who delivers in a public hospital, can employ a variety of techniques to try to achieve a desired sterilization, from paying for the procedure out-of-pocket—though this is an undesirable option given financial difficulties—to using a more powerful acquaintance to intercede with a doctor upon her behalf, to selling her vote to a politician, to hoping the doctor will take mercy on her and do the sterilization for free. A woman in the private sector is more likely to be able to achieve a desired sterilization, though as we saw in Graciela’s case, it is not necessarily a foregone conclusion that a private doctor will agree to do the procedure, particularly in Porto Alegre.
These data were collected in 1995-96, so apply to the situation for Brazilian women seeking sterilization before the change in the law in 1997. Evidence exists, however, that women continue to have difficulties obtaining their desired sterilization. In a prospective study of women in four cities in Brazil done in 1998 and 1999, Potter et al. (2003) found that there was a high level of demand for sterilizations done postpartum in both public and private sector hospitals. Among women who wanted no more children and who met the age and parity requirements for sterilization, a much higher proportion of those who delivered in the private sector got sterilized postpartum, compared to those in the public sector (33% vs. 12%, respectively). Moreover, over 48% of these women who delivered in public hospitals left the hospital wishing they had been sterilized, compared to only 15% of women who delivered in private hospitals.

Caetano and Potter (2004) also found little evidence, even after passage of the law, that doctors or women were aware of the provisions of the law or even of its existence. Interviews done in 1999 showed that a minority of doctors knew about the provisions of the law and also knew that no licensed hospital was available where they worked for them perform a legal sterilization. While other doctors knew of the law, they were vague about what it entailed. Finally, a number of them were not aware at all that the law had authorized sterilization. “Indeed, by the end of 1999 only five hospitals had been licensed to provide sterilization, all of them in Recife [the state capital]. Only 61 sterilizations were reimbursed by the SUS in 1999 in all of the state” (Caetano and Potter 2004: 97).

Finally, analysis of the recently released 2006 Pesquisa Nacional de Demografia e Saúde da Criança e da Mulher shows that of the approximately 6.8 million women in Brazil who do not want any more children, are 25 or older and who have two or more children, 49% have tried—and failed—to get a sterilization at some time in the past. The main reasons women recounted for not getting the sterilization they wanted were that they tried but the health service did not agree to do it (22%), “tried and didn’t get it” (26%), “gave up” (22%), and “other” reason (21%). While it is unclear if the women attempted and failed to get a sterilization before or after the passage of the law, it is highly doubtful that all of the failed attempts happened more than nine years before the survey took place. Therefore, we can safely conclude that, despite the law which created the provisions to make sterilization available to women, many are still unable to get the sterilization that they desire.

Through a combination of quantitative and qualitative methods, this chapter gives voice to Brazilian women’s experiences of trying to obtain a surgical sterilization. By looking more closely at the strategies that women employed to get the procedure, as well as their determination to obtain one, it is clear that sterilization is a highly desirable commodity. Some of that desire may be the result of a contraceptive method mix that has shrunk to just a few methods, both in people’s minds of the
viable options and in reality based on the services available, for example, the pill for spacing births and sterilization for stopping births (Potter 1999). But no matter the reason that women in Brazil came to strongly want sterilization to end childbearing, it is clearly a commodity they will go to great lengths to obtain. Sadly, poorer women, who are more at the mercy of institutional rules and SUS doctors’ goodwill, are much less likely to get the sterilization they want than are richer women with closer ties to their doctors and the ability to pay directly for the surgery that will free them of the fear of getting pregnant in the future.

References


