Throughout the world women want the freedom to control their bodies, fertility, and lives (López 2008). Yet, no one makes fertility decisions in a vacuum; rather, they do so within specific social and historical conditions that shape and constrain their reproductive options. In examining women’s lives, their reproductive rights, health needs and concerns, and particularly the controversial topic of sterilization, we must account for how women’s individual reproductive options are affected by race, class, gender, sexuality, legal status, colonial legacies, and the politics of reproductive control.

Women’s views from the Global South and the Global North about reproductive freedom vary cross-culturally (Harris Green 2018; López 2008; Petchesky and Judd 1998) and by race and class (Morris and Withers 2018). For example, in the United States during the second wave of feminism in the 1960s, the priorities of White middle-class women and poor racialized women differed at times. Mainstream White middle-class women fought mainly for equal opportunity with men and for reproductive rights, which at that time translated primarily into abortion rights (Baxandall and Gordon 2000; Silliman et al. 2016). In contrast, even though poor racialized women recognized that legal abortions are also essential to their well-being, they fought for access to quality healthcare and education and the right to earn a living wage, and against racism and police brutality (Brown 2019). One of the lessons we have learned from the second wave is that reproductive rights should include and transcend the right of women to have a safe abortion. Reproductive freedom consists of women’s right to legal abortion as well as to have children; access to quality healthcare, education, housing, jobs/careers; and the right to live free of racism, coercion, and violence (Colón-Warren et al. 2001; Colón et al. 1999; López 2008, 1998; Petchesky 2003; Petchesky and Judd 1998; Roberts 1997; Solinger 2001).

My work on sterilization and Puerto Rican women is a case study that illustrates the tension between the complexity of poor racialized women’s desire to control their fertility and the oppressive social conditions that shape and constrain their reproductive options. The primary questions my ethnographic research raises are: What constitutes choice and reproductive freedom in the context of poor women’s lives? In what ways are Puerto Rican women’s experiences similar and unique to other poor and racialized women who have been sterilized in the United States and the world? I draw upon my 25-year study to address these questions and conclude with some directions for reaching full reproductive freedom.
Sterilization, or tubal ligation, is a surgical procedure to block a woman’s fallopian tubes and intended to be a permanent form of birth control. In Puerto Rico, the colloquial term for sterilization is *la operación* and described as the “cutting” or “tying” of the tubes, which is relevant whether the women perceive it as permanent or not. Technically, sterilization is birth control in its most extreme form; however, we need to distinguish tubal ligation from temporary methods of contraception. Birth control is the ability to space children, while sterilization marks the end of a woman’s ability to reproduce. The important distinction is between population control as a state imposition and birth control as a human right. The key issue is not sterilization relative to other forms of contraception per se, but how sterilization is used as population control.

With the globalization of this reproductive technology in the twentieth century, sterilization is currently the most popular form of fertility control in the world (US Department of Health and Human Services, CDC and Prevention 2005). Yet, its widespread prevalence does not expunge its legacy as a form of eugenic population control, nor does it obliterate the significant number of racialized and poor White women who have been subjected to sterilization abuse nationally and internationally. India, China, Puerto Rico, Colombia, Brazil, and El Salvador experienced aggressive programs of sterilization incentives and disincentives that bordered on or were blatantly coercive (Harris Green 2018; Hartmann 2016). Historically, those in power have targeted poor women for birth control and sterilization, particularly in the Global South. For example, the goal of the United States Agency for International Development (USAID) was to sterilize one-quarter of the world’s population by 2020 (Brown 2019; Harris Green 2018; Hartmann 2016; SEJUP 1994).

In the twenty-first century, one of the outcomes we are witnessing is the worldwide medicalization of women’s reproduction (López 1998). Sterilization and cesarean sections are two key interrelated links pivotal in the chain of reproductive processes that are subject to medical intervention. Undesired medicalization (is problematic because it) restricts and, in some cases, takes away women’s control of their bodies and places the control in the hands of the medical establishment and politicians (Caetano and Potter 2004). The lack of access to quality healthcare services directly plays into whether women have access to contraception or whether they are subjected to fertility control.

Despite the high rate of sterilization in Puerto Rico and in different parts of the developing world, there is a dearth of ethnographic data about the daily conditions in which poor racialized women and men are sterilized, and little to no comparative data about the various ways they experience reproduction around the globe. My case study is one of the few ethnographic studies of its kind. I point out ways Puerto Rican women’s experiences with sterilization are both unique and similar to other poor racialized women worldwide. Puerto Rican women have one of the highest rates of sterilization in the world—fluctuating between 40.8 and 45%. My study explains why (López 2008).

The ethnographic methods used to collect the data for this study were participant-observation, oral histories, and a random sample of intensive interviews conducted with 128 Puerto Rican women, 85 of whom had a tubal ligation; 11 of these women had both a tubal ligation and a hysterectomy (N = 96 sterilized, 32 non-sterilized). The data were collected in several stages. The post-doctoral phase of my fieldwork, which spanned from 1986–2006, consisted of undertaking qualitative fieldwork with five households which were comprised of 15 family members; each household consisted of three generations. I refer to these three generations of women as the first, second, and third. This chapter, however, presents an overview of all of the women in my study instead of an analytical intergenerational comparison. In analyzing my data, I use my integral model of reproductive freedom and social justice, built upon an intersectional analysis. This approach transcends the binary construct of choice, on the one hand, as
a personal decision that places the burden on the individual woman while abstracting her from her living relationships, or on the other, the view that social constraints totally determine her decisions. This chapter turns now to an overview of Puerto Rico’s colonial history and the role that population control played in narrowing Puerto Rican women’s reproductive freedom.

**Migration and sterilization**

In 1898, Puerto Rico, Cuba, and the Philippines became colonies of the United States. At the time, Puerto Rico had a subsistence economy, a flourishing coffee industry, and sugar cane haciendas. Colonial measures taken by the US government and sugar corporations such as the appropriation of land, the purchase of Brazilian coffee, and the devaluation of Puerto Rican currency led to the extreme impoverishment of the Puerto Rican people. The specious idea that Puerto Rico’s poverty was due to overpopulation was based in turn on neo-Malthusian and eugenic ideologies. The neo-Malthusians stressed that too many people led to poverty and underdevelopment. The eugenicists believed that some people were genetically inferior and not fit to reproduce.

In the early twentieth century, migration and sterilization were used as the solutions to Puerto Rico’s so-called overpopulation problem. Migration was used as the temporary solution and sterilization as the permanent one. To this day, the Puerto Rican government denies there had ever been an official population control program based on migration and sterilization to lower the island’s birth rate. It regards the decision to be sterilized as a private one made between a woman and her doctor. In 1937, eugenic legislation was transferred to Puerto Rico from the United States. In order to implement the sterilization policy, the Comstock law, which made birth control illegal in the United States, had to be repealed. It was in this eugenic, neo-Malthusian social/colonial climate that Puerto Rico’s birth control program developed. Key players in the establishment of the island’s birth control movement were the Catholic Church, the governments of the US and Puerto Rico, North American public health officials, the Nationalist political party (*Nacionalistas*) that fought for the independence of Puerto Rico, and Puerto Rican women who were both feminists and nationalists. Clarence Gamble, the heir to the Procter & Gamble fortune, had a commercial interest in developing his own brand of birth control on the island, and Margaret Sanger played a significant role in shaping the history of the island’s birth control movement on the island.5

**Puerto Rico’s birth control movement**

The birth control movement in Puerto Rico developed in fits and starts. The Catholic Church and Puerto Rican Nationalists opposed contraceptives and abortion and systematically shut down birth control clinics that were privately funded by individual Puerto Rican philanthropists. To illustrate the experience of Puerto Rican women within this historical context, I divided the sample in my study into three generations: The grandmothers, or first generation; the mothers, or second generation; and the granddaughters and third generation–plus. Each generation had different fertility experiences depending on the members’ access to birth control.

The women in the grandmothers’ generation grew up in an agricultural society. They had large families due to the high rate of infant mortality and the need for children as farm labor. They grew up without consistent access to temporary methods of birth control. The Catholic Church adamantly opposed birth control and frequently shut down clinics offering birth control. Even when they were open, it was difficult for women to obtain birth control because the clinics were located primarily in cities, often far from where the women lived. The clinics were
poorly stocked and often out of contraceptives; they depended on individual philanthropists for support because the Puerto Rican government did not provide federal funding for contraceptives island-wide until 1968. In contrast, tubal ligation, or *la operación*, was readily available and free of charge or for a nominal fee. Although the Catholic Church adamantly opposed birth control, sterilization, and abortion, the Church considered *la operación* the lesser of the three sins. The rationale was that if a woman used temporary methods of birth control she was continually sinning. Abortion was considered an unforgivable crime against God. However, although the Church opposed sterilization as well, it was more acceptable because it took place before conception.

Consequently, while temporary methods of birth control were only intermittently available, *la operación* was consistently accessible. Until 1968 in Puerto Rico, there was extensive reliance on tubal ligation by the government, medical culture, and politicians which gave rise to a culture of sterilization on the island. This was transparent in an election year because, in Puerto Rico, it was a common practice for unethical mayors to exchange a vote for payment of *la operación*.6

Another gross example of the exploitation of poor racialized women is when Clarence Gamble further limited the reproductive options of Puerto Rican women by testing his contraceptive foam on them. In the 1940s, the primary contraceptives available were condoms and diaphragms. Gamble took advantage of this situation by removing diaphragms from the market and testing on Puerto Rican women the contraceptive foam that his company was manufacturing. In this trial run, the failure rate of Gamble’s contraceptive foam was so high that a significant number of Puerto Rican women became pregnant. These unintended pregnancies strongly influenced their decision to get sterilized.

The scandalous testing of the pill on Puerto Rican women

As though all of these other unethical practices were not enough, in the 1950s, Margaret Sanger persuaded the authorities to test the birth control pill in Puerto Rico instead of India because Puerto Rico was a US territory and it would be less politically and legally troublesome (Briggs 2002). The outcome was that a large number of women became ill, which had a long-term negative impact on Puerto Rican women’s perception of the pill and other contraceptives. The irony is some women’s desire to control their fertility was so strong that they consciously participated in this experiment because they desperately wanted to stop having more children (Schoen 2005).

From agriculture to industrialization

Between the 1940s and 1950s, Puerto Rico’s economy shifted from an agricultural to an industrial one. Operation Bootstrap, the name of Puerto Rico’s industrialization program, provided a boost to the island’s economy, generating jobs in the manufacturing industry. In this era, the colonial government enticed North American businesses and corporations to the island with the promise that they did not have to pay taxes for ten years. Once the ten years elapsed, however, these businesses and corporations left the island and moved to other parts of the Caribbean and the world where they could continue to make more profits.

At first, the shift from agriculture to industrialization triggered an internal migration of Puerto Ricans from the rural to the urban areas in search of jobs. The initial job boom created by the manufacturing economy, however, was short-lived. By the 1950s, Puerto Rico’s economy began to shift to light industry manufacturing and by the 1960s, to a service economy. The capital-intensive service industries, which consisted of pharmaceuticals in the northern part of the
island and petro-chemicals in the southern region, created few jobs for the locals and polluted the environment. As unemployment increased island-wide, the government once again invoked the neo-Malthusian overpopulation argument: There were too many people on the island for the number of available jobs. Between the 1940s and the 1950s, approximately one million Puerto Ricans immigrated to New York City in search of jobs in the manufacturing industry, and net outmigration has continued throughout most years, accelerated in the past decade by an economic crisis and most recently by Hurricane Maria and earthquakes.

**New York: La operación continues**

By the 1960s, in New York City, sterilization was branded and marketed as “birth control.” Puerto Rican women in New York were familiar with *la operación* because this reproductive technology was developed and, I argue, tested for birth control purposes on women in Puerto Rico. The high rate of sterilization among women in Puerto Rico was reproduced in New York City, where Puerto Rican/Hispanic women have had one of the highest rates of tubal ligation (New York City Department of Health 1982). In 1985, I recorded in a random survey that 47% of the Puerto Rican women over the age of 21 living in the neighborhood where I undertook this ethnography were surgically sterilized. Identifying the reasons for the persistence of sterilization as women moved from Puerto Rico to New York necessitates that we think about the ways they used elements of agency, resistance, constraints, and accommodations in this social context. In analyzing how Puerto Rican women exercise degrees of agency within constraints, I avoid using the language of agency in a monolithic way.

In undertaking this research, I raised the question: How do we talk about reproductive freedom in the socio-historical context of the legacy of sterilization abuse and population control? Sterilization abuse occurs when an individual submits to tubal ligation or vasectomy without their knowledge and/or consent or because they are pressured to accept sterilization (López 2008). In the 1970s in New York City, it became a persistent problem. In 1975, after a long and harrowing struggle undertaken by women’s groups and health and community activists, sterilization guidelines were implemented in New York City to protect women and men against abuse. Yet, sterilization abuse is only part of the story of Puerto Rican women’s practice of sterilization.

The best way I found to expand on knowledge about Puerto Rican women’s sterilization experiences was to spend time talking to them and their families. By combining quantitative and qualitative fieldwork over 25 years (1981–2006), I found Puerto Rican women’s fertility experiences ranged from those who claimed they were sterilized because it was what they wanted to do to those who considered themselves victims of sterilization abuse. Although sterilization abuse is an important subject, I chose to focus on women who said they wanted to get sterilized since it is challenging to understand what constitutes choice and reproductive freedom in the context of poor racialized women’s lives.

**Agency within constraints: Women’s perceptions of their bodies**

In unraveling the complicated relationship between women’s agency, resistance, constraints, and accommodation, I unpack the ways Puerto Rican women assert agency in the context of *la operación* (López 1998). One way that women use agency is best illustrated through an account of women’s perceptions of their bodies and the question of whom, if anyone, should control them as well as through the circumstances that have led some Puerto Rican women to use sterilization as a way to resist patriarchy and female subordination. Women resisted on a personal
level in their struggle to fight sexism, e.g., not being forced by their male partners to have more children than they desire or getting pregnant when they are not ready to have a child. In some cases, this resistance took the form of getting sterilized. Even though some women in my study used sterilization in this way, it would be misleading to argue that most women use sterilization to resist patriarchy because to do so reduces Puerto Rican women and men to the unit of analysis, ignoring the role that colonialism, population control, racism, sexism, and inequality have played in shaping their reproductive options. Having said that, it is important to reiterate that Puerto Rican women exercise degrees of agency regardless of how their options may be. The integral model, which transcends and includes what women say, but does not reduce the individual, cultural, social, or historical realms to the unit of analysis, is essential in accounting for contradictions as well as in examining and understanding complicated issues that could be argued in a multitude of ways. It is difficult to sustain an integral perspective because it requires taking into account (or holding) multiple elements simultaneously; at first glance, some of these elements may appear contradictory.

“It’s my body and I will do with it as I please”

In addition to the historical and social forces that have coalesced to constrain Puerto Rican women’s reproductive options, if we are to fully understand the nuances of their perceptions of sterilization today, it is important to recognize the variation of their experiences with la operación. Different realities co-exist simultaneously. Depending on the particulars of a woman’s circumstances, tubal ligation may give reproductive freedom to one woman, but it may oppress another. Moreover, a woman may perceive sterilization as empowering at one point in her life because it enables her to control her body and be independent, but at another time, she may wish that she had not been sterilized. She may regret having been sterilized if her child dies, or she remarries and wants to legitimize her marriage by having a child (López 2008). A woman who opts for sterilization because she thought it was a temporary method of birth control may feel oppressed once she learns she cannot reverse her operation (López 1998). In other cases, a woman may get sterilized to resist one difficult situation only to be subjected to another potentially oppressive one. She may choose sterilization as a way to resist forced maternity, only to accept a health practitioner’s patronizing and racist recommendation to get sterilized. Or she may use those recommendations and population control policies in her interest of resisting unwanted maternity.

With the exception of those women who were victims of sterilization abuse, most whom I interviewed adamantly shared the view that sterilization was their decision because it was their body and they would do with it as they pleased. Consequently, many women claimed they did not have to ask their husbands or partners for permission to get sterilized. Women elaborated that most men rarely objected to a woman’s decision to have la operación unless the couple disagreed about the desired number and gender of the children. These women may get sterilized because they have achieved their desired family size and they decide either independently or with their companion/husband that they do not want and/or cannot afford to have any more children. It is a method of fertility control with which they are familiar and, given their socioeconomic condition, with which they may be most comfortable. In these cases, I argue women are doing the best they can with what they have (López 2008).

The age women marry and women’s responsibility for childrearing

There are many factors influencing women’s decisions to get sterilized on an individual and social basis. On average, Latinas marry younger and have children earlier than either White or
Black women. In 2018, the mean age of mothers at first birth in the United States was 24.8 years for Puerto Rican women, 25 for all Hispanics, 25.1 for Black women, and 27.7 for White women (Statista 2018). The age when they begin to have children affects the age when they are sterilized. The tendency to marry or have children while they are young precipitated the women in the mothers’ generation to get sterilized at a younger age: 66% of them were sterilized between the ages of 25 to 29 as compared to White and Black women who were sterilized between the ages of 30 to 34. The factors shaping women’s perceptions of the ideal family size vary intergenerationally and are affected by women’s level of education as well as the cost of living.

**Socioeconomic considerations**

Poverty is one of the most compelling reasons women get sterilized. While most poor women experience difficult socioeconomic situations, households headed by female single parents fare even worse. Two-thirds (66%) of the women in the mothers’ generation in this study were heads of households. In 1985, the median income of the families in this study was $7,000. By 2006, the women in the granddaughters’ generation had an income of $30,000, which reflects the 2005 median income of Puerto Rican households in New York City (New York City Department of City Planning 2005: 15). Given this nominal intergenerational gain, it was not surprising that 35% of Puerto Ricans in New York City lived below the poverty level in 2005 (New York City Department of City Planning 2005: 16).

The employed Puerto Rican women in this study were low-wage workers with little job security. They often worked in tedious jobs under difficult conditions. When they came home, they worked the second shift as mothers and homemakers. Indeed, most of these women did not work outside the home because of the difficulties of coordinating a job and household; most felt it does not pay to work outside the home if they have to spend most of their wages on childcare (Bresge 2018). Eighty percent of the women in my study said their economic circumstances strongly influenced their decision to get sterilized. Forty-four percent felt if their economic conditions had been better, they would not have undergone surgery. The daily grind of living in a poor neighborhood with its inadequate housing and high rates of crime, drugs, and gangs also influenced the women’s fertility decisions. They often claimed one of the reasons why they were sterilized was that it was hard to have children in a dangerous environment where drugs and crime were the norm.

**Lack of access to quality healthcare**

Healthcare policy plays an important role in narrowing women’s fertility choices and directly into whether individuals have access to contraception and/or whether they are subjected to fertility control (Browner and Sargent 2011; also see Browner and Sargent and Andaya in this volume). US federal funding initially covered the cost of abortion, but the Hyde Amendment of 1977 changed this policy by denying women on Medicaid funding for abortions except in narrowly defined therapeutic cases or special circumstances. The state’s refusal to provide public funds for abortion services, while making sterilization readily available, shows it favors sterilization over temporary methods of birth control and abortion (Brown 2019; CARASA 1979; CESA 1976). Even though abortion in the US is legal, women’s reproductive rights are under attack and today it has become more difficult than ever, especially for poor women, to obtain an abortion, reflected in the diminishing number of abortion clinics throughout the country.

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(De Zordo and Marchesi 2014; also see Mishtal and De Zordo in this volume). Consequently, poor women are forced to have children even when they can’t afford to feed them—only to be accused of being a burden on the state for having more children than they are told they can afford (Briggs 2002; Brown 2019; López 2008; Roberts 1997).

On an individual level, a woman’s economic resources strongly influence her health (Mullings 2005) and the quality of healthcare services that she can access, which in turn affects her knowledge of contraception and shapes her reproductive options. The quality of care and information that middle-class women receive in private hospitals expands their choices by enabling them to make informed decisions within the limits of the available contraceptive technology. Conversely, the poor quality of care that poor women receive diminishes their ability to make informed decisions, and in this way, further restricts their already limited reproductive options. For instance, public hospitals have fewer health providers and facilities and a larger patient-to-provider ratio. As I found in this research, one of the ways that health providers in municipal hospitals cope is by counseling women in large groups instead of the one-to-one individual counseling that most middle-class women receive in private hospitals. This compromises the quality of the communication between women and providers. As a result, inadequate family planning counseling in public hospitals diminishes poor women’s reproductive freedom by failing to provide and educate them about the full range of contraceptives available. For example, 90% of the women in this study did not use the diaphragm because they had never heard of it.

Women’s so-called individual choice is also circumscribed by the negative stereotypes that some health providers have of poor racialized women. In some cases, providers believe poor women are not intelligent or responsible enough to use a diaphragm correctly. Consequently, they may prefer to recommend to poor racialized women the use of long-lasting contraceptives such as Norplant and Depo-Provera that the women themselves cannot control. Some national US studies have found adult Black and Hispanic women are more likely to use Depo-Provera and Norplant than White women (Dehlendorf et al. 2010). Almost all of the women in the granddaughters’ generation claimed their doctors offered them Depo-Provera as their contraceptive of choice.

On a national level, studies have found White middle-class women are more knowledgeable about contraceptives and understand how to use them with more success than poor Black and Hispanic women (Dehlendorf et al. 2010). Although myriad factors narrow women’s knowledge of birth control, the quality of healthcare services to which a woman has access plays a primary role in shaping her knowledge of temporary methods of contraception (Rosenfeld et al. 2017). The more limited women’s knowledge of temporary methods of birth control is, the higher the risk of accidental pregnancy and the higher the chances of women getting sterilized because they had more children than they desired (Dehlendorf et al. 2010). The lack of safe and effective temporary methods of birth control that led to unintended pregnancies influenced many women in this study to get sterilized. Although 76% of the women used temporary methods of birth control before getting sterilized, they expressed dissatisfaction with the contraceptives available, especially the pill and the intrauterine device (IUD). Cognizant of the constraints that their economic resources, domestic responsibilities, and problems with contraceptives place on their fertility options, and given the conditions of their lives, many women perceive sterilization as their most feasible option.

Women’s religious views and familiarity with la operación

Historically, Puerto Rico was a Catholic country. Yet, Catholicism does not appear to deter women’s decisions to be sterilized. Eighty-seven percent of the women in the mothers’ genera-
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tion were raised Catholic. Of these women, only 32% felt sterilization goes against their religious beliefs. The prolonged use of sterilization over the generations has imbued la operación with cultural meaning for the Puerto Rican community. Tubal ligation is frequently recommended by a friend or family member as well as a doctor or healthcare provider. Women’s perceptions of la operación are also influenced by the number of women within their own families who have been sterilized and by their desire to control their bodies.

The impact of the consistent availability of sterilization on the island, based on the colonial government’s extensive reliance on sterilization, cannot be underestimated. A sterilization culture was created by the colonial government’s “preference” for la operación and women’s desire for birth control.

Misinformation and regret continued

Eighty-two percent of the women in my study distinguished between the “tying” and “cutting” of the fallopian tubes since they mistakenly believe that “tying” them is reversible. This is a false distinction. In the US, most women, particularly poor women, are misinformed about the permanent nature of tubal ligation. According to a national study carried out on this subject, the rate of misinformation is higher among Black and Hispanic than White women (Rosenfeld et al. 2017). Puerto Rican women in particular have been misinformed about the permanency of la operación. This is an important factor perpetuating the high rate of sterilization, especially among poor women.

Of the 96 sterilized women in this study, a third regretted they were sterilized. Twenty percent were happy about it. Although they felt they made the best decision they could under their given conditions, the remaining 47% claimed they neither regretted their decision nor were happy about it (Hilis et al. 1999; López 2008).

Twenty-first-century concerns

The twenty-first century is witnessing the further medicalization of women’s reproduction worldwide, which in many countries like Puerto Rico is grounded in official as well as unofficial population control policy. There is a strong relationship between the high incidence of cesarean procedures and medically indicated tubal ligations (Barros et al. 2003; Caetano and Potter 2004; Ramirez de Jesus et al. 2014). In many nations, including Puerto Rico and Brazil, the rule of thumb is after a woman has three cesarean procedures, doctors recommend tubal ligation for medical reasons. In the twentieth century, anthropologist Peta Henderson recorded Puerto Rico had one of the highest incidences of both cesarean sections and tubal ligations in the world (Hendersen 1976; López 2008). Similarly, Brazil has the highest combined incidence of cesarean sections and tubal ligations—in the northeast, the country’s poorest part, 44% of the female population is surgically sterilized (Caetano and Potter 2004), and many of these women had cesarean procedures before getting sterilized (Barros et al. 2003). The same phenomenon occurs in Mexico where Indigenous women delivering their babies via cesareans then were recommended postpartum tubal ligation more frequently than other women (Lowenberg 2010). In 1993, US lawyer Nancy Ehrenreich coined the phrase “the colonization of the womb” to refer to motherhood and in particular the court-mandated cesareans of poor women (Ehrenreich 1993). Anthropologists and other social scientists refer to the large number of unnecessary cesareans performed on poor women as obstetric violence. The powerful images that the colonization of the womb and obstetric violence evoke could be applied in a different context to both the unprecedented high rate of sterilization and cesarean sections in Puerto Rico and other post-colonial countries in the Global South.
The colonial solution to Puerto Rico’s poverty was sterilization and migration. While sterilization is declining globally, it is not diminishing in Puerto Rico. According to the last island-wide health survey, the highest rates of sterilization were among women with the lowest levels of education (e.g., a high school diploma or less) (Dávila et al. 1998). Consequently, sterilization and migration have been successful in reducing Puerto Rico’s population growth beyond the government’s expectations. Although other factors such as birth control, women’s participation in the labor force, higher educational attainment, and immigration have contributed to the decline of Puerto Rico’s population growth, there is no doubt that sterilization has also played an essential role (Abel and Deitz 2014). Between 1950 and 2020 Puerto Rico’s fertility rate declined from 5 to 1.2 births per woman. By the 1980s, population growth began slowing down and has been negative since 2005, declining by over 5% over the course of a decade and, intensified by outmigration, by yearly rates approaching 4% between 2017 and 2019, after the island was hit by Hurricane Maria. In 2020, Puerto Rico has a lower population growth than Spain, Italy, Korea, and Japan (Macrotrends 2020).

Today, Puerto Rico’s population decline has shifted the colonial government’s concern from worries about overpopulation to how Puerto Rico’s economy will survive and thrive. This is due to the shortage of young people who will participate in the labor force and pay taxes, as well as the impact of the rising costs of an aging population, and the exodus of professional Puerto Ricans to the mainland since Hurricane Maria (Palloni et al. 2005). More research is needed to investigate the role that sterilization plays in Puerto Rico’s population decline and Puerto Rican women’s reproductive freedom today.

**Conclusion**

In the twenty-first century, sterilization remains the most widely used fertility method in the world and, not surprisingly, the rates are higher in colonial empires (Moss and Isley 2015; Ritu et al. 2015). In order to understand the ways in which Puerto Rican and other poor racialized women experience tubal ligation, I seek to establish a much-needed new paradigm of reproductive freedom that explores, interrogates, and expands on what consent, choice, and coercion mean within the context of their lives. By documenting and analyzing the factors that lead women to sterilization, including their active participation and the degree and quality of agency and resistance in which they engage, I aim to broaden the concept of what constitutes reproductive freedom.

Women actively seek to transform and improve their lives, and controlling their fertility is one of the primary ways they do this. Even though all women’s fertility options are limited by the types of contraceptives available, poor and racialized women’s options are more constrained. The poor women in my ethnography make decisions within a parameter of oppressive conditions. Therefore, the constraints of their lives play an equally significant role in shaping their reproductive options and experiences. It is also important to note while the socioeconomic forces that limit Puerto Rican women’s fertility options are no more constraining for them than for other poor and racialized women worldwide, the historical antecedents that have led to the high rate of sterilization among Puerto Rican women are unique. The issue of sterilization among Puerto Rican women is complex. On the one hand, with the exception of women who are victims of sterilization abuse, the majority in this study claim they made a decision between getting sterilized or continuing to have children under adverse conditions. Because of the limited nature of this so-called choice, however, many women feel they had no other viable alternative but to opt for or accept sterilization. In analyzing Puerto Rican women’s history of sterilization, I deliberately reject the language of choice. Choice invokes ideas of free will.
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based on individual freedom, part of the neoliberal ideology that promotes a binary framework of choice/no choice, voluntary/non-voluntary decision-making, and obscures the interplay between social constraints and women’s desire to control their fertility. As further proof that all women’s decisions are socially mediated, middle- and upper-class women have more viable options from which to choose than poor women.

In the twentieth century, in what ways did Puerto Rican women’s desire to control their fertility intersect with the state’s desire to lower population growth on the island? A woman may decide to get sterilized because she does not want more children. From her perspective, this is a vital decision that gives her more control over her body and her life. Her “individual decision” is encouraged and supported, however, by a state that considers her fertility a burden because it wrongly blames Puerto Rico’s problems of poverty and underdevelopment on overpopulation instead of on colonialism. On an individual level, what may provide women with a degree of agency is simultaneously an expression of her oppression by a state motivated by economics, politics, and unofficial population control policy. Given the drastic reduction in population since 2005, the Puerto Rican government no longer posits population growth as a problem. Yet, the rate of sterilization persists. My analysis describes the history of how and why la operación became a prevalent practice on the island and how Puerto Rican women’s reproductive options have been limited in the individual, cultural, social, and historical realms.

Puerto Rico has a history of social resistance and protest against colonialism and for women’s reproductive rights, and Puerto Rican women have been at the forefront of these struggles for social justice. Throughout the island’s history, feminists and social activist groups have fought heroically for reproductive freedom (Colón-Warren et al. 2001; Colón et al. 1998; Colón-Warren 2003, Colón-Warren 1995). National sister organizations in New York City, such as the National Latina Institute for Reproductive Health formerly directed by Jessica Gonzalez-Rojas, work tirelessly with other activist women around the country for reproductive social justice. They build coalitions with women-centered community organizations and advocate for access to affordable health and reproductive care for Latinx, immigrant, and LGBTQ communities (Zavella 2020). The true decolonizers of women’s wombs are these women who are fighting for reproductive justice in the United States, Puerto Rico, Brazil, and other parts of the world, along with the Puerto Rican women in this study and others who have found their own personal ways to resist having more children than they desire, and who have undergone unnecessary cesareans and unwanted tubal ligations.

In the case of Puerto Rico, the problem with sterilization is not the technology itself, but the way it has been used as a quick fix to solve the problems of underdevelopment and poverty. These were produced by a system of colonization that methodically ravaged Puerto Rico of its resources and profits, decimated the environment, and converted its people into a surplus population in search of jobs. After the sterilization of almost half of Puerto Rican women and the migration of millions of Puerto Ricans, in the twenty-first century, the conditions on the island are worse than ever. After Hurricane Maria in 2018, no doubt remains that Puerto Rico is a colony of the United States (Fícek 2018).

After eight decades in New York, the majority of Puerto Rican US citizens still suffer from the highest rates of poverty, unemployment, high school attrition, health problems, police profiling, and incarceration, and Puerto Rican women still struggle with the dilemma of how to control their fertility. Even though there are more contraceptives today than in the past, after experiencing problems with the pill and intrauterine device (IUD), many Puerto Rican women continue to turn to sterilization after generations of exposure to this reproductive technology. Familiarity with la operación combined with the high rate of misinformation about sterilization procedures further circumscribe Puerto Rican women’s reproductive freedom by limiting their
knowledge about the full range of reproductive options. Although poverty is not attributed to an overpopulation problem as it was in Puerto Rico, in New York City, the narrative is defined as a welfare problem based on the pernicious view that poor racialized women have babies in order to take advantage of public assistance (Briggs 2002; López 2008; Roberts 1997. This narrative demonizes the poor by blaming them for their poverty. The conditions of persistent poverty and the lack of access to safe, effective, convenient, and affordable birth control, legal abortion, and quality healthcare in conjunction with sterilization policies designed to control the rate of population growth among poor racialized women play an equally important role in constraining women's reproductive options worldwide.

Reproductive freedom means having viable alternatives and the proper social conditions that enable one to decide how many or even whether or not to have children. By not offering women alternatives such as quality healthcare services, safe, effective, and convenient temporary methods of birth control for both men and women, affordable daycare centers, and a living wage, Puerto Rican women's fertility options have been effectively narrowed, frequently making sterilization the only viable alternative. Until Puerto Rican women and other poor racialized women achieve equity in society and improve their socioeconomic status, they will continue to have one of the highest rates of sterilization in the world. As long as they continue to have children under inequitable conditions, we cannot talk about Puerto Rican women exercising full reproductive freedom.

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Notes

1 Hysterectomy is considered an extreme form of sterilization when used for birth control purposes. For a detailed ethnographic analysis of these women and their families, see López (2008).
2 In India and other parts of the world, vasectomy camps were pervasive and men were targeted for vasectomies (male sterilization).
3 Between 1995 and 1996, 45.47% of married women on the island between the ages of 15–45 were surgically sterilized. A study on the Zika virus undertaken in 2017 found that 40.8% of sexually active women were sterilized (Ellington et al. 2020). The rate of sterilization in each survey reflects differences in sampling methods. The Zika study was the last survey taken on the island that recorded the prevalence of contraceptive use among Puerto Rican women.
4 For a more detailed account of my methodology see López (2013).
5 For a more extensive account of Puerto Rico's birth control movement, see Briggs (2002); Dávila (1990); López (2008); Ramirez de Arellano (1983); Vázquez-Calzada (1981).
6 The situation in Puerto Rico is comparable to that in Brazil. In their excellent study, Caetano and Potter (2004) document that Brazil has a history of clientelism based on the patronage system of political favors. This unethical, corrupt, and scandalous system needs to be investigated on a global level.
7 Although this is a complicated subject because many middle-class women opt for elective cesareans today, Caetano and Potter (2004) have denounced this unethical practice in Brazil.
8 Among the organizations defending reproductive freedom in Puerto Rico have been: In the 1970s, Mujer Integrar Ahora (MIA); in the 1980s, Taller Salud; in the 1990s, Grupo Pro Derechos Reproductivos (a coalition of feminist organizations and politically progressive organizations) and Asociación Puertorriqueña Pro Bienestar de las Familias (ProFamilias); and more recently, the Movimiento Amplio de Mujeres (a coalition of feminist organizations and individuals) and the Colectiva Feminista (personal communication with Alice Colón–Warren in 2020).
References


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