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Mara Saunders

University of Pennsylvania

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Knowledge, Power and Choice: Understanding Women’s Fertility, Contraceptive Use and Sterilization in the Dominican Republic

Mara Saunders

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Dr. Francis Barg

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Abstract
Voluntary female sterilization is the leading contraceptive method worldwide. The Dominican Republic has some of the highest worldwide rates of voluntary female sterilization among certain subgroups of women. This study looks at the historical, political, economic, social and cultural factors that contribute to exceptionally high rates of female sterilization in the Dominican Republic. It explores the shared knowledge, perceptions, beliefs and experiences of women living in a low-income urban neighborhood in the Dominican Republic in an attempt to understand how these multilevel influences interact to shape reproductive and contraceptive choice.

Introduction to the Literature

Researchers suggest that the high incidence of female sterilization in the Dominican Republic is related to the predominance of certain reproductive patterns. It is common for Dominican women to have children at a young age and in rapid succession (Green 1988, Westoff 1988, Loaiza 1995). It is hypothesized that this reproductive

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1 The Dominican Republic has a rate of voluntary sterilization among married women over the age of thirty that is among the highest worldwide.

Westoff, Charles F.

Green, Edward C.

Loaiza, Edilberto
1995 Sterilization Regret in the Dominican Republic: Looking for Quality-of-Care
pattern leads women to choose sterilization at a young age, once they have achieved their desired family size, so as to avoid the economic and domestic pressures of a large family (Green 1988, Lopez 1998).

Traditional Dominican gender norms designate responsibility for birth control, child rearing and other domestic duties to women, and grant decision-making power to men. Traditional norms also discourage discussion or use of certain forms of temporary birth control in a marital relationship. Thus, sterilization may be the best available option for women who would otherwise have to choose between the responsibilities of caring for a large family, or initiating and sustaining temporary contraceptive use for the duration of their reproductive years (Lopez 1998, Stycos 1968).

Poor women may be especially susceptible to pressures that lead them to choose sterilization. Population control programs disproportionately target poor women throughout the world. Pressure to curtail these women’s fertility ranges from direct coercion and financial duress to withholding of information and the use of financial incentives (Lopez 1993). These pressures limit women’s reproductive and contraceptive options.

Poor women’s contraceptive options are also limited by the dearth of resources and staff in public healthcare centers. Poor women may also be under more pressure to limit family size because they lack the economic resources to care for more than a few children. Hazardous substandard living conditions, and the often-unaffordable cost of childcare for mothers who work outside the home, compound the need for these women to limit their fertility. Sterilization may be the only economically viable contraceptive

option for poor women, since it only requires a one-time payment, and has historically been offered free or at low cost in many Latin American countries. [Lopez 1993 and 1998]

Researchers Betsy Hartmann and J. Mayone Stycos study the historical, political, economic, social, and cultural antecedents of high rates of female sterilization in Latin America. They emphasize the value of studying female sterilization in the context of these influences. Both Stycos' and Hartmann's work provide a solid basis for understanding the determinants of contraceptive use and sterilization in the Latin American region. [Hartmann 1987, Stycos 1968]

Anthropologist Iris Lopez (1993, 1998) follows in the footsteps of Stycos and Hartmann. Her work focuses primarily on the macrosocial factors that have contributed to high rates of female sterilization among Puerto Rican women². She asserts that women's decision to become sterilized can only be understood by examining the "dialectical process between culture, history, and social structure" (Lopez 1993). Women's choices are both shaped and constrained by personal, social, and historical forces, so that the decision to become sterilized involves a dynamic interplay between agency and constraint.

Lopez' theory of agency and constraint is one of two key theoretical constructs on which I base my study of contraceptive use and female sterilization in the Dominican Republic. The other, Cognitive Anthropology, is a study of the relationship between human society and human thought (D'Andrade 1995). Cognitive Anthropology seeks to understand how people in social groups perceive the objects and events that make up their world, how knowledge is used in day to day life, and how conventionalized
knowledge becomes part of culture. Strauss and Quinn (1997) identify this as the process of creating "cultural meaning," which they define as the "typical (frequently recurring and widely shared aspects of the) interpretation of some type of object or event evoked in people as a result of their similar life experiences."

Within the framework of Cognitive Anthropology, cognition is not simply an individual's understanding of an object or event. Rather, the terms "cognition in practice" and "situated cognition" are used by proponents of this framework to describe the ways in which individuals' actions are shaped through interactions with their microsocial environments (Strauss & Quinn 1997). Cognitive Anthropology investigates the cultural knowledge embedded in words, stories and artifacts in order to identify the ideas, beliefs and values that make up shared cultural meaning (D'Andrade 1995; Strauss & Quinn 1997). More specifically, cognitive anthropologists search for implicit cultural models of knowledge, or ideas and beliefs that people within a culture share as a result of common experiences.

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2 "macrosocial" refers to large-scale historical, political, economic and social influences
3 "microsocial refers to family- and community-level influences
Community Introduction and Project Background

This study takes place in the barrio (neighborhood) Pekín in Santiago, Dominican Republic. Pekín is one of 24 barrios that make up the area known as the Zona Sur (Southern Zone) of Santiago. The barrios of the Zona Sur belong to a class of low-income periurban settlements, collectively referred to in Spanish as barrios marginados (outcast neighborhoods). Most of these barrios were constructed during the post-civil war years of the 1970's. During this period rapid industrialization spurred massive rural-urban migration, causing the country's urban population to increase from under two million to over four million between 1970 and 1990 (Bobea 1997). A number of quickly constructed settlements sprung up on the outskirts of the country's largest cities to accommodate the burgeoning urban working class. [Guia Autoevaluativa 2000]

The Zona Sur houses approximately seventy thousand inhabitants. Over twenty thousand (nearly 30%) of these inhabitants are women between the ages of 15 and 44 (Guia Autoevaluativa 2000). As is common in many barrios marginados, Zona Sur inhabitants lack access to a number of basic public services, including electricity, potable water and a modern sanitation system. Houses and streets are often poorly constructed, and in various states of disrepair.

What the Zona Sur does have to offer inhabitants, however, is a unique community-based health network known as Project UNISUR. Project UNISUR began in 1996. It is the product of a tripartite effort which includes the Secretaria de Estado de Salud Pública y Asistencia Social (Secretariat of Public Health and Social Assistance-

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4 "periurban" refers to settlements built peripheral to urban areas
5 Data from 1996 survey- it is likely that the population count has increased, though population composition has presumably stayed relatively constant. Women between the ages of 15 and 44 are of reproductive age.
SESAS), the community organization Consejo de Salud (Health Council- CODESA), and the Pontificia Universidad Católica Madre y Maestra (Catholic University of Santiago- PUCMM). Financial support for Project UNISUR comes from the W.K. Kellogg's foundation. [Guia Autoevaluativa 2000]

The goal of Project UNISUR is to address the high incidence of infectious diseases and preventable illnesses in the Zona Sur. It aims to "promover acciones en salud y en el fortalecimiento del liderazgo comunitario haciendo énfasis en el papel protagónico de la comunidad como objeto y sujeto de la atención que requiere, y en la autogestión como forma idónea de sostenibilidad de todo proceso" [promote actions in health and the strengthening of community leadership, emphasizing the primary role of the community as object and subject of the attention that it requires, and self-evaluation as a suitable form of sustainability for the whole process] (Guia Autoevaluativa 2000:2).

In order to realize these goals Project UNISUR developed the Juan XXIII Model to guide development of its community healthcare infrastructure.

Primary Care Center Juan XXIII is the hub of this infrastructure. The Center is dedicated to "ofrecer servicio de salud humanizado, con alta calidad y calidez a la población de la Zona Sur" [offering humanized health services of the highest quality to the population of the Zona Sur] (Guia Autoevaluativa 2001:2). The Center is only one part of a large healthcare network, however. This network also includes two peripheral clinics, Unidades Básicas de Salud (Basic Health Units- UBAS), located at strategic sites within the region; and 22 hogares comunitarios/Unidades de Rehidratación Oral Comunitarias (Community Oral Rehydration Units- UROCS), which house the promotoras and supervisoras de salud (health promoters and supervisors). Promotoras
and supervisoras are trained community members who supervise and attend to the health of families living within an assigned area, giving priority to education and prevention of sickness. In total, there are 19 supervisoras, and 131 promotoras⁶. [Guia Autoevaluativa 2000:2]

Promotoras and supervisoras are charged with the responsibility of garnering community members’ support and cooperation for Project UNISUR and its various undertakings. Since community participation is the central tenet of Project UNISUR, the role of the promotoras and supervisoras is vital to the project’s existence. The promotoras and supervisoras also play the crucial role of intermediaries between community members and other components of the healthcare network. They hold the keys to the community.

My work in the Zona Sur was made possible by the enduring support of one woman, Ana Silvia Peralta. Ana Silvia is one of the 19 supervisoras in the Zona Sur. Her modest family home in the barrio Pekín also serves as one of the 22 hogares comunitares, and so, in essence, she is always at work. Her extraordinary determination is embedded in a quiet, unflappable persona, but her commitment to the community is clearly evidenced by her constant interactions with fellow community members, promotoras and supervisoras.

I was first introduced to Ana Silvia and the Zona Sur in January of 2002. My work in the community began as part of a community service class at the Catholic University, quickly became an independent study and then slowly evolved into a senior thesis over the course of a year. For the first four months I took on the role of a public health educator in the Zona Sur. With the help of Ana Silvia, a fellow university

⁶ Data from October 2000. Numbers may have changed.
exchange student and I gave charlas (chats/educational talks) throughout the Zona Sur. We talked about subjects like domestic violence, teen pregnancy, family planning, HIV/AIDS, Leptospirosis (a disease spread by contamination of food and water with rat urine), and prenatal and infant care.

Those four months were an invaluable opportunity for me to become familiar with the community. I observed community members in various settings and learned about the daily rhythms of their lives. I interacted with community members on individual and groups bases and began to pick up on the mannerisms and styles of communication that make up the social fabric of the community. I listened to people talk about their life experiences and gained insight into the social and economic realities that shape community members’ beliefs and perceptions. Though I had not yet been formally introduced to the theories of Cognitive Anthropology, I sought to find cultural meaning in the patterns I observed.

Since the majority of my charlas focused on issues of reproductive health and the majority of community members who came to the charlas were women, I had ample opportunities to learn about the reproductive health of women in the Zona Sur. On one of my first trips into the Zona Sur, I accompanied a Peace Corps volunteer as she conducted a health census in Pekín. The census was directed towards caretakers of young children, so most of the respondents were women of reproductive age. After the census experience I made the following observations:

First, I noted for a number of women, their first birth was fairly young. I asked Angie about this, and she said it varied with people’s economic status. She did say, and I observed, that many of the women who had kids young (and had the resources) were sterilized.7

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7 Notes from personal field journal (February 5, 2002).
Compiled data from the Peace Corps health census reports that only 52% of respondents claimed to use some form of birth control, and the majority of contraceptive users were women between the ages of 25 and 29. Sterilization was the method chosen by 49% of contraceptive users\(^8\). [Fujioka 2002]

This data suggests that temporary contraceptive use is not common among Zona Sur women, and that many women resort to sterilization as a permanent means of fertility control at a young age, after having their desired number of children\(^9\). During my four months working in the community I became interested in learning more about women's lives and the reasons they decide to adopt this pattern of early childbearing and sterilization. When I returned to the University of Pennsylvania in the Fall of 2002 I decided to embark on a yearlong senior thesis project to explore the issues of reproduction, contraception and female sterilization in the Dominican Republic.

**Methodology and Study Sample**

I began with an extensive search of academic literature and census data from Latin America and the Dominican Republic. Unfortunately, the body of literature on voluntary female sterilization is limited, and very few studies deal specifically with female sterilization in the Dominican Republic. I began to identify common themes in the literature about macrosocial determinants of contraceptive choice in Latin America. I also observed that Lopez and other researchers often refer to locally shared knowledge, beliefs and experiences in their populations of study. These shared cultural models are important determinants of contraceptive practice in a community of women.

\(^8\) For more information, see Appendix B: Tables 2.2 and 2.3

\(^9\) "Temporary contraceptive" refers to any reversible, non-surgical method of fertility control
I decided to return to the Dominican Republic in December of 2002 to conduct my own primary research on the microsocial determinants of contraceptive choice in the Zona Sur. I designed a semi-structured qualitative interview to explore the shared knowledge, perceptions, beliefs and experiences of women in the Zona Sur, with regard to reproduction, contraceptive use and sterilization.\(^\text{10}\)

I conducted interviews with 11 Zona Sur women during a one-week period from the 20\(^{th}\) to the 27\(^{th}\) of December 2002. All 11 women were full-time residents in the barrio Pekin. Women ranged in age from 16 to 51, and had between one and five living children. Seven participants were married at the time of the interviews, and four classified themselves as single. At the time of the interviews, five women were involved in some form of economically productive activity. Three of these five women worked in the neighborhood. One “sold food,” another ran a beauty salon out of her house, and the third worked as a promotora. The other two women were factory workers the Zona Franca (Free Zone) on the outskirts of Santiago. Of the six women who were not gainfully employed at the time of the interview, only one claimed to have recently worked outside of the house. The other five were always “en la casa” (in the house/involved in domestic duties).

Each interview took approximately fifteen to twenty minutes, and was conducted either in participants’ homes or in the home of the overseeing promotora, Ana Silvia. Ana Silvia was present for all of the interviews. She served as a witness and translator, but more importantly as a sort of “cultural broker.” As a recognized and respected community member, Ana Silvia was able to not only recruit participants, but also to

\(^{10}\) For more information, see Appendix A: Documents 1.1 and 1.2
legitimize my entry into the community and into the lives of the women who I interviewed.

The participants in this study were not randomly selected, and do not represent an average cross-section of the Zona Sur population, or of the Dominican population in general. I do not believe that this weakens the legitimacy of my study. I do not claim to understand the specific determinants of any individual woman’s reproductive and contraceptive decisions, nor do I believe that each of the influential factors that I identify is directly relevant to every woman in the Zona Sur.

The goal of this study is to provide a framework for understanding how multilevel influences can shape patterns of fertility, contraceptive use and sterilization in a community of women. I examine the interplay between macrosocial and microsocial influences on women’s knowledge, power and choice in order to gain a comprehensive understanding of the ways in which these factors shape fertility and contraception in my study population. My hope is that this framework can be used in other communities of women to foster a better understanding of the influences on their knowledge, power and choice.
Foreword ~ Knowledge, Power and Choice Vs. Knowledge, Attitude and Practice

The framework that I propose for thinking about women’s fertility and contraceptive use stands in opposition to the standardized models that are used by the population control establishment to implement family planning programs in the Third World.

Since the 1960s, United States policymakers and international development agencies have collaborated to bring family planning to the Third World. Hartmann (1995) asserts that these efforts are driven by fears about overpopulation, poverty and instability, and are not based on concerns about women’s well-being.

The population control model for bringing about lower birth rates in the Third World is based on what Donald Warwick calls the “machine theory of implementation” (Hartmann 1995:63). This theory proposes a standardized model for implementing family planning programs. Hartmann describes this model as consisting of “mechanical delivery systems on the one hand and program clients who are ‘receptacles for the services delivered,’ on the other” (1995:63).

According to Hartmann, this model is based on the assumption that “there is already a large demand for family planning services among recipient populations and that people are prepared to use them right away, regardless of social, economic, and cultural conditions” (1995:60). The Knowledge, Attitude and Practice (KAP) Survey is an example of how this false assumption was converted into faulty practice by the population control establishment.

The KAP Survey was used in the early days of the population control movement to assess the demand for modern contraception among a population of women. Based on
this Survey, a woman was thought to be a candidate for contraception if she answered yes to questions of whether she was either interested in contraception or already had enough children (Hartmann 199:60). In his published criticism of the population control establishment, Warwick points out that the KAP Surveys were faulty measures of potential acceptance because they “ignored the cultural context of fertility decisions in which women often have no authority, have never viewed themselves or their husbands as able to determine family size, or may change their minds over time” (Hartmann 1995:60).

I argue that the KAP Survey represents the fundamental shortcoming of population control-driven family planning programs in the developing world. The “imported” and standardized nature of these programs divorces them from the women who they target. The result of this rift is a long history of family planning in the developing world that acts against, rather than for women. By targeting women instead of serving them, target, population control-driven family planning programs constrain women’s ability to make reproductive and contraceptive decisions that are appropriate to their needs and demands.

I propose that reproductive and contraceptive decisions can be better understood by questioning the Knowledge, Power and Choice that exists within a community of women. It is important to consider not only whether women know about contraception, but also what type of knowledge about reproduction and contraception exists in their community and where that knowledge comes from.

One must also consider the power dynamics that exist within a community of women. That is, who has the power to make recommendations and decisions about
women's fertility? If women have the power to decide their own fertility and contraceptive use, do they also have the power to fully realize their decisions in practice?

All of this relates to choice. When women choose between their reproductive and contraceptive options, do they really have a choice? These questions provide a framework for understanding the ways in which women's decisions about fertility and contraceptive are constrained. I believe that identifying constraint is the first step towards promoting agency.
Part One:

Women’s Fertility, Contraceptive Use and Sterilization in Latin America and the Dominican Republic
Women’s Fertility: Latin America and the Dominican Republic

Numerous historical, economic and social factors play a role in shaping fertility patterns in Latin America. Traditional economic structures and social norms have historically limited women’s ability to control their own fertility. In recent decades, social and economic changes have caused a decline in fertility rates throughout the region. However, there is evidence that many factors continue to limit women’s fertility control.

Changing Fertility Trends

Traditional Patterns of Fertility:

Researchers writing about traditional patterns of fertility in Latin America describe the following trend: “women have traditionally married early, had their first child at a young age and given birth to a large number of children over the course of their reproductive lives” (Hartmann 1987, Stycos 1968, Weinberger et al. 1989, Wulf and Singh 1991). Green (1988), whose work focuses on the Dominican Republic, links this trend to the high incidence of female sterilization. He reports “the typical pattern is for women to have about four children in rapid succession at an early age and then to become sterilized while still in their 20s.” Since both early and rapid childbearing seem to be linked to the high rates of sterilization in the Dominican Republic, it is important to consider the factors that have lead Latin American women to adopt these fertility patterns.

Researchers J. Mayone Stycos (1968) and Blanca Ortiz-Torres et al. (2000) explain that the preference for large families was shaped by traditional agrarian economic
structures in many Latin American countries. In traditional agrarian societies, having many children conferred both an economic benefit and future security for aging parents. As Latin American countries have become increasingly urbanized, there has been a shift in women's attitudes and aspirations, accompanied by a decline in fertility.

Researchers attribute this decline to growing participation of women in the labor force, the introduction of national family planning programs in a number of countries, increasing acceptability of contraception, and improvements in women's education (Ortiz-Torres et al. 2000, Weinberger et al. 1989, Wulf and Singh 1991). Despite the fact that fertility declines are nearly universal among women Latin America, a number of social and economic factors continue to limit women's fertility control. Studies indicate that certain groups of women, including adolescent, less-educated and poor women, are particularly limited in their ability to control their own fertility.

Adolescent Fertility

In some countries, such as the Dominican Republic, young women are particularly disadvantaged in their ability to control their own fertility. Despite a notable recent decline in the number of women marrying and initiating sexual intercourse before the age of 20, teenage childbearing is still on the rise. The persisting link between first union, first intercourse, and early childbearing indicates that many women who enter a first union before the age of 20 are either already pregnant, or become pregnant shortly afterwards. [Magnani et al. 2002, Wulf and Singh 1991]

Women who start having children at a young age tend to have more children over the course of their reproductive lives than women who initiate childbearing at a later age. Researchers attribute early and rapid childbearing to lack of contraceptive use, high rates
of contraceptive failure, and shortened periods of breastfeeding among younger
generations of Latina women. [Blanc and Way 1998, Weinberger et al. 1989, Wulf and
Singh 1991]

Lopez (1998) asserts that early childbearing precipitates the decision to become
sterilized. Women who achieve their desired family size at a young age tend to choose
sterilization as a preferable alternative to relying on temporary methods of birth control
for their remaining years of fertility. According to a study by Philliber and Philliber
(1985) women who become sterilized have an average of ten to twenty years of fertility
left at the time of the operation. This is a considerable amount of time to rely on a
temporary method.

**Education and Fertility**

Weinberger et al. (1989) study women’s education and fertility decline by
comparing data from the 1970’s United Nations World Fertility Studies (WFS) and the
more recent Demographic and Health Surveys in four Latin American countries
(including the Dominican Republic). They attribute rapid fertility declines in all four
countries to dramatic increases in women’s educational attainment. This relationship is
especially pronounced among the least educated groups of women. Their study reveals
that women’s desired family size has decreased in all four countries and at all educational
levels. Data from the two studies also indicates that the reproductive aspirations of
women with different levels of educational attainment have become similar.

However, researchers demonstrate that women in the more educated group are
more likely to achieve a total fertility rate (TFR) that is close to their desired family size
than are the less educated. This data indicates a persisting disparity between women with
high and low educational attainment. The former tend to marry later, have fewer children and practice some form of modern contraception, and the latter are more likely to experience unwanted fertility (Weinberger et al. 1989).

Weinberger et al. (1989) present compelling evidence of the association between education and fertility, but fail to pose a hypothesis as to why this association exists. Surely, education is not directly related to fertility decline, but rather serves as a proxy for other determining factors. Stykos (1968) and Yabour de Caldeira (1974) suggest that access to information is a link between education and fertility control. Women in many developing countries demonstrate both an awareness of the economic burden of large families and a desire to limit their family size, but lack information about how to control their fertility. Women who have limited access to information about fertility control may be more vulnerable to pervasive social and cultural messages about reproductive expectations and norms.

Poverty and Fertility

There is a lack of consensus among researchers as to the effects of poverty on fertility. Some researchers claim those poor women are motivated to limit family size because they lack the economic resources to care for more than a few children. Substandard neighborhood conditions threaten children's safety, while economic shortages limit living space and the amount of resources that women have to provide for their children. For women who work outside the house, the costs of childcare are often economically unfeasible. Thus, low-income women are generally under more pressure to take definitive action to control their fertility. [Henderson 1976, Lopez 1998]
Other researchers suggest that poor women are motivated to bear children in order to gain greater economic security. In the Dominican Republic, where consensual unions are more prevalent than legal marriages and women are often dependent on men for economic security, children may be an assurance of continuing financial support and marital stability (Lopez 1998, Weinberger et al. 1989, Zelaya et al. 1996, cite census data).

Population control advocates view childbearing among poor women as a primary cause of overpopulation and underdevelopment in Latin America. The perception that poor women are unable to control their own fertility has been used to justify various levels of regulation by governments and international agents.

Beliefs about poor women’s lack of fertility control are often perpetuated at the societal level. Henderson records the testimonies of middle-class women in Puerto Rico:

Family planning must continue, especially for the low income families. The middle class usually plans, but the poor are egoists.

There is a lack of family planning. Many families are irresponsible. The Government should take responsibility for these at all education levels but especially the poorest class. They lack education and orientation.

The children come from those poor people. They are women who have different husbands....

[Henderson 1976:240]

These beliefs shape not only social perceptions about poor women, but also the types of contraceptive methods and family planning interventions that are made available to poor women\textsuperscript{11}.

\textsuperscript{11} For more information, see “Economic Influences on Contraceptive Use”
Sociocultural Influences on Fertility

Gender Roles and Sexuality:

Much of the writing about sociocultural influences on sexuality in Latin America focuses on the concepts of “machismo” and “marianismo.” These concepts are derived from traditional Catholic, Protestant and colonial values, and were also shaped by the paternalistic structure of traditional agrarian societies. Traditional societies placed a high premium on women’s virginity and fidelity. Roman Catholic doctrine defines sex as a “necessary evil” that should only be practiced between men and women in a civil union for the purposes of reproduction (Stykos 1968).

According to Ramirez, machismo, which defines the male social role, stresses the qualities of “virility, independence, physical strength, and sexual prowess.” Stevens explains marianismo as the “complement” of machismo, and Gil and Inoa-Vazquez define it as “the role of the ideal woman, modeled after the Virgin Mary” which is based on “chastity, abnegation, and sacredness, while reinforcing obedience and virginity.” [Ortiz-Torres et al. 2000]

Within the context of these influences women’s sexual practices are dictated by men’s sexual desires and the social obligation to fulfill their reproductive duties. From a traditional viewpoint, marriage and motherhood define Latina women’s status. These roles are the “pinnacle of success” and the “ultimate fulfillment” in a woman’s life. Thus, traditional social norms encourage a young courting age and prize early and closely-spaced childbearing as a promising sign of fertility in a civil union. [Erickson 1998]
According to Stykos (1968), social norms that encourage early marriage and rapid childbearing are barriers to reproductive control. Men and women who are eager to initiate childbearing because of social pressures are less likely to make reproductive decisions based on the goal of achieving their desired family size. Instead, men are motivated by a desire to prove their virility and to ensure wives' fidelity by tying them down to domestic responsibilities. Women may simply be motivated by a desire to achieve the acceptance and social status that comes with motherhood. These social pressures ultimately undermine women's ability to control their fertility.

In the context of these social pressures, it may be difficult for women to communicate with their partners about fertility control. Lack of ability to communicate with a partner about fertility control may be a key precipitating factor in a woman's decision to become sterilized. Sterilization can be performed without a male partner's knowledge, participation or consent. This makes it an appealing option for women whose partners are unwilling to agree to contraceptive use. [Lopez 1993 and 1998, Zelaya et al. 1996]

Lack of communication between partners is only one of many barriers that can limit women's ability to use temporary contraceptives. In the next section, I will review the factors that have historically limited use of temporary contraceptives in Latin America.
Temporary Contraceptive Use: Latin America and the Dominican Republic

Factors that limit knowledge about temporary contraceptives, restrict their availability, reduce their effectiveness and decrease their social acceptability create barriers to effective use. In Latin America a number of historical, political, economic, social and cultural factors create barriers to effective use of temporary contraceptives.

Historical and Political Influences on Contraceptive Use

National Family Planning Programs:

National family planning programs are the primary example of political influence over fertility control. These programs have a powerful influence on knowledge, availability and social acceptability of temporary contraceptives in a particular country. National family planning programs have varying impacts on effective use of temporary contraceptives depending on the overall strength of the program, the breadth of their policies, and the types of reproductive control that they sanction.

Yabour de Caldera (1974) outlines the following determinants of effective family planning programs: 1) availability of clinics to provide contraceptive services 2) provision of effective and inexpensive birth control devices or methods 3) development of community programs to reach potential acceptors through personal contact or public information campaigns. She also emphasizes the importance of public education and communication about contraceptive use. However, she cautions that this information must be targeted to local audiences. In order to be effective, family planning programs must take into account key characteristics of target audiences, such as socioeconomic conditions, social practices and cultural beliefs.
The Dominican national family planning program was not developed until well
after the fall of the Trujillo regime in 1961. During his 31-year dictatorship, Trujillo
advocated a strongly pronatalist official policy, which hindered the development of a
comprehensive family planning program. The private sector was first to fund family
planning in 1962 after the fall of the dictatorship. In 1966, after four years of isolated
family planning efforts, the private non-profit Dominican family planning organization,
Asociación Dominicana Pro-Bienestar de la Familia (Dominican Association for the
Well-Being of the Family- PROFAMILIA) PROFAMILIA was funded in affiliation with
the International Planned Parenthood Federation (IPPF). [Población y Desarrollo 1988]

Public family planning services were first offered in 1967, under the maternal and
child division of the Dominican Secretariat of Public Health and Social Assistance
(SESPAS). The inception of the Dominican national family planning program, El
Programa Nacional de Planificación Familiar (PNPF) was finally realized in 1968 by
the Consejo Nacional de Población y Familia (National Council of Population and
Family- CONAPOFA). During the next five years, the number of urban family planning
clinics in the country grew from eight to fifty-seven. However a major disparity existed
between rural and urban family planning availability until 1976. [Población y Desarrollo
1988]

The development of national family planning programs in many Latin American
and Caribbean countries was driven by 1960’s population control fervor in the U.S.
Widespread fear that overpopulation was causing poverty and instability in the
developing world obliged policymakers to develop and “import” a standardized model of
family planning in many Third World countries (Hartmann 1995)\textsuperscript{12}. The programs based on this standardized model are often elitist and culturally inappropriate. According to Hartmann:

Standard models have been developed and applied irrespective of different cultural contexts, with authority centralized within the national government and passed down through a rigidly defined hierarchy of officials. Success has typically been evaluated solely in terms of numbers of acceptors and of targets met, not in terms of people's satisfaction with the services delivered. [Hartmann 1995:63]

Stykos (1968) suggests that many Latin American family planning programs share certain shortcomings that limit their effectiveness. He identifies excessive reliance on clinics to dispense contraceptive supplies and information, lack of non-medical commercial and communal distribution of information, failure to consider socioeconomic factors and overemphasis on females as program targets as common shortcomings.

Another commonly noted shortcoming of Latin American family planning programs is their overwhelming bias towards hormonal and surgical methods, such as the intrauterine device (IUD), oral contraceptives, injectable contraceptives and contraceptive implants. Widespread availability of a variety of contraceptive methods is extremely important. In order for potential users to find the contraceptive method that best suits their needs they must have equal access to a range of options. In a worldwide study of contraceptive use in developing countries Ross et al. (2002) found that use of a particular contraceptive method was directly related to its availability. The more widely available a contraceptive was, the more frequently it was used. The existing bias towards hormonal and surgical methods limits the range of contraceptive options available to women throughout the region, and causes a high incidence of unmet need for contraception. [Brown and Moskowitz 1997, Ross et al. 2002, Ross and Stover 2001]

\textsuperscript{12} For more information, see Foreward
It is likely that delayed development of national family planning programs in countries such as the Dominican Republic, and the influence of the population control movement in the region, have contributed to these shortcomings. Delayed development of national family planning programs created a space for the population control movement to import its standardized models. These models clearly do not meet Yabour de Caldera’s (1974) criteria for effectiveness. Standardized models fail to take into account important characteristics of the target population. Moreover, population control focuses almost solely on increasing contraceptive acceptance, and does not work to improve education and foster communication about contraceptive use.

The population control movement also overemphasizes use of hormonal and surgical contraceptives, to the exclusion of discussion about natural and barrier methods, such as the rhythm method, breastfeeding, and condom and diaphragm use (Hartmann 1995). In this way, population control has contributed to the predominant biases towards hormonal and surgical contraceptives that exist in many Latin American family planning programs.

Economic Influences on Contraceptive Use

Contraceptive Testing:

The population control movement is largely funded by subsidies from international donors, such as the US Agency for International Development (USAID) and other international development agencies. As a result, international development agencies have considerable influence over family planning programs in much of the developing world. [Brown and Moskowitz 1997]
A major goal of international development agencies, in the area of family planning, is to promote use of contraceptive methods that are “appropriate” for women in developing countries. Efforts in the 1960’s focused on research to develop an “ideal” contraceptive method with the following characteristics:

- long-acting
- fully reversible application, not coitus-related
- highly effective
- no need for continuing supplies
- producing few or no side effects
- low cost
- little or no need for action in the part of the user, after initial acceptance

[Brown and Moskowitz 1997:381]

International development agencies commonly enlisted major pharmaceutical companies to develop new contraceptive methods and test them in Third World populations. Pharmaceutical companies capitalized on the opportunity to implement contraceptive in developing countries, where there was little or no government regulation. Women in these countries also tended to be less informed and have less access to legal recourse than women in the U.S., making them more easy targets for manipulative research practices. [Brown and Moskowitz 1997, Hartman 1987]

One example of an exploitative study funded by an international development agency was the Population Council’s “field acceptability” study of a contraceptive vaginal ring among poor populations in the Dominican Republic and Brazil. The Population Council advertised the Ring as “a contraceptive method as effective and safe as the pill... which could be used in basic health systems without direct medical supervision” (Hartmann 1995:183-184) During the study, women were not informed about potential disadvantages of the Ring, despite the fact that it was known to produce a number of side effects, including a high rate of vaginal discharge. [Hartman 1987]
As a result of pervasive negligence, misinformation and lack of regulation in contraceptive testing and distribution markets, contraceptive users in the developing world often experience a high incidence of negative side effects and contraceptive failure. Women who experience side effects and contraceptive failure tend to discontinue use at a higher rate than those who have not had a negative experience. Thus, rates of effective contraceptive use in the developing world are diminished (Polanco 1994, Porter 1984). These factors likely contribute to the fear and distrust of contraceptive methods that is expressed by many women in the Dominican Republic (Brown and Moskowitz 1997, Hartman 1987, Henderson 1976)

Private Sector Funding:

The private sector is an important source of funding for family planning programs in Latin America. In the Dominican Republic private sector-funded family planning efforts, which mainly fall under the auspices of PROFAMILIA, still represent a significant percentage of the total family planning services nationwide (Ross and Stover 2001, Polanco 1994). Thus, the private sector exerts considerable control over availability of contraceptive supplies and information.

Contraceptive social marketing (CSM) is an interesting example of the private sector’s ability to influence contraceptive options. CSM programs subsidize sales and advertisements of certain contraceptives in developing countries. This social marketing program was developed to target young, lower-middle-class women of low parity who were too poor to buy commercial products, but were not being reached by public distribution programs.
CSM programs commonly rely on USAID for their contraceptive supply. However, the CSM program in the Dominican Republic obtains its supplies directly from a commercial pharmaceutical company. PROFAMILIA serves as an intermediary in this transaction. In 1985, PROFAMILIA signed an agreement with IPPF and Schering Dominicana (a local subsidiary of the Schering pharmaceutical company). The agreement enables PROFAMILIA to buy Microgynon oral contraceptives from Schering at an IPPF discounted price, and to resell them to Schering Dominicana at a lower price than they would be charged by their own parent company. The contraceptives are then marketed to local pharmacies at a lower price, which enables pharmacies to offer the product to consumers at nearly half the normal commercial rate for oral contraceptives in the Dominican Republic. [Green 1988]

In order to ensure that the program reaches its target population, PROFAMILIA uses a share of their profit from the transaction to pay for advertising. Their original advertisement was a 30-second television commercial featuring a popular Dominican model/singer. The commercial aired two or three times a day for just under four weeks. This proved to be an effective means of reaching potential consumers; sales of Microgynon increased drastically between the months before and after the original advertisement aired. [Green 1988]

Through the CSM program PROFAMILIA not only determines which contraceptive methods will be available at an affordable price to low-income Dominican women, but also controls the information that women receive about these methods through advertising (Green 1988, Hartmann 1987). According to data from the 1991 and 1996 Demographic and Health Surveys, the pill continues to be the single most
commonly adopted contraceptive method among women in the Dominican Republic (Demographic and Health Survey 1991, 1996). Contraceptive social marketing has likely contributed to this trend.

Public Medical Services:

Economic factors can directly limit temporary contraceptive use at the individual level. Economically disadvantaged women often can’t afford to purchase monthly supplies of modern reversible contraceptives. When there is not enough money to cover both the cost of birth control and the necessary costs of living, the latter must take priority. [Zelaya et al. 1996]

For the same reason, economically disadvantaged women often have limited access to private family planning services. The result is a necessary reliance on public services (Bertrand et al. 2001). Given the importance of private suppliers in Latin America, women who use public services are often at a disadvantage.

Lack of staff and contraceptive resources at institutions serving low-income populations contribute to that disadvantage. Medical providers in public institutions generally have limited time and resources to offer individual women in contraceptive consultations. Therefore, they are not able to fully inform women about available contraceptive methods, nor to provide adequate training for contraceptive use. This may predispose providers to prescribe methods that don’t require extensive instruction. Moreover, studies show that providers are influenced by stereotypical perceptions of poor women as “irresponsible” with regard to fertility control and unwilling to accept certain types of contraception. [Henderson 1976, Lopez 1998]
Lopez (1998) reports that many Puerto Rican health care providers attribute limited diaphragm use among poor women to the belief that it is a "culturally unacceptable method of birth control for the poor." This belief deters providers from prescribing the diaphragm to poor women. Instead, providers overwhelmingly recommend mechanical and surgical methods to poor women because of a belief that "they do not have sufficient initiative or responsibility for controlling their fertility."

Lopez (1998) proposes that providers perpetuate limited diaphragm use among poor women. Providers observe limited diaphragm use among poor women and attribute this phenomenon to a "cultural aversion." This prevents providers from recommending the diaphragm to poor women. Many poor women do not use the diaphragm because their providers never inform them about it.

Selective provision of information effectively limits women's ability to access a wide range of contraceptive options. Lack of access to safe and effective temporary contraceptives, dependence on provider-controlled methods, and contraceptive failure are all factors that contribute to high rates of dissatisfaction and low social acceptability of certain contraceptives among low-income women. [Brown and Moskowitz 1997, Lopez 1998]

**Sociocultural Influences on Contraceptive Use**

**Social Stigma:**

The Church has a significant social influence on reproductive control. The Catholic Church has historically condemned the use of all "artificial" contraceptives. While many women claim that their religious beliefs do not have an impact on their
decision to practice contraception, Church doctrine may contribute to the social stigma surrounding contraceptive use. [Henderson 1976, Lopez 1998, Ramirez de Arellano and Seipp 1983, Stycos 1968, Zelaya et al. 1996]

The Church influences contraceptive use by perpetuating traditional machista gender roles. Traditional Roman Catholic ideology supports male control over sexual interactions and discourages use of condoms in a marital relationship. Women are expected to be modest and subordinate. They may only engage in sexual intercourse for the purpose of reproduction in the context of a marital relationship. [Stycos 1968]

Studies of contraceptive use among Latino populations attribute low rates of condom use in marital relationships to this traditional ideology. As a result of the ideological restrictions on sexuality in marital relationships, men turn to prostitutes for sexual pleasure and experimentation. Condom use is common and accepted in casual relationships. Condoms thus become associated with prostitution and infidelity, and their use in a marital context is seen as a degradation of a “sacred” and “pure” relationship. A woman’s suggestion that her husband use a condom might be construed as a questioning of his fidelity. [Stycos 1968]

Other researchers have noted that the stigma surrounding extramarital sexual relationships negatively affects contraceptive use among adolescents. Most family planning programs target older women in civil or common-law unions (Bongaarts and Bruce 1995, Zelaya et al. 1996). Westoff (1988) suggests that this bias may result in a concentration of unmet need for contraception among certain groups of women in the Dominican Republic. He identifies adolescents as one group of women with a high level of unmet need. Westoff goes on to suggest that the Dominican family planning program
contributes to this unmet need by failing to provide adolescent women with safe and effective pathways through which to obtain contraceptive information and supplies.

Lack of access to information also contributes to high rates of contraceptive failure among adolescents. Researchers have found that, among adolescents, the rate of contraceptive failure is directly related to contraceptive discontinuance and non-use (Blanc and Way 1998, Magnani et al. 2001, Wulf and Singh 1991). In this way, the social biases embedded in many Latin American family planning programs can be said to limit adolescent women’s ability to control their fertility.

Communication:

Traditional Latino culture places sole responsibility on women for all domestic and reproductive matters, including fertility control (Lopez 1993 and 1998, Stykos 1968). Social stigma surrounding condom use and cultural ideals of feminine modesty, create barriers to discussion about contraception; a topic which is considered “shameful” and “unladylike” (Stykos 1968). Sociocultural barriers to discussion about contraception between couples impede women’s ability to control their fertility.

A study of contraceptive use in Nicaragua revealed significant differences between the contraceptive practices reported by men and women. This indicates a lack of communication about contraception between couples (Zelaya et al. 1996). Moore et al. (1995) demonstrate the importance of communication between couples: in their sample of Dominican, Puerto Rican and Mexican women, likelihood of condom use was partially based on the level of openness and communication between partners. Women who communicated more with their partners were less likely to expect negative reactions in

\[13\text{ For more information, see "Sociocultural Influences on Fertility"} \]
response to requests for condom use. Not surprisingly, these women were more likely to use condoms than were women who did not communicate openly with their partners.

Power inequality in sexual relationships limits open communication about contraception. In their study, Ortiz-Torres et al. (2000) found that Puerto Rican and Dominican women identified male partners’ unwillingness to use a condom, verbal criticism (blaming women for ‘spoiling the moment’ with their demands, chastising women for ‘doubting’ them), and accusations (questioning women’s faithfulness) as the primary barriers to condom use. These studies indicate that women’s ability to negotiate contraceptive use with their partners is often limited.

Informal interpersonal communication is another important form of social influence on temporary contraceptive use. Interpersonal communication between members of a community can influence women’s decision to initiate and continue use of a contraceptive. According to Yabour de Caldera (1974), positive (favorable) communication about fertility control reduces the stigma surrounding contraceptive use. It creates a climate in which contraception is no longer considered embarrassing or shameful, but is instead common and respectful. Thus, communication legitimizes the decision to initiate contraceptive use. Positive interpersonal communication between members of a community can also support continuing contraceptive use among new acceptors. It provides an assurance of the social acceptability of contraceptive use.

Evidence suggests that negative (unfavorable) communication about contraceptives influences decision-making more than positive communication. New contraceptive acceptors are particularly influenced by negative communication during the months following adoption. [Porter 1984] Porter’s (1984) review of contraceptive...
communication and discontinuance studies reports that negative communication about contraceptives is common in many Latin American countries. For example, in Mundigo and Stycos' sample of 200 Dominican women, every woman claimed to have heard negative comments about at least one family planning method (Porter 1984).

Interpersonal communication is not the only source of negative information about contraceptives. Negative perceptions of contraceptives are also shaped by personal experiences, observations of problems experienced by other women, religious propaganda and cultural beliefs. Negative perceptions are often a result of pervasive misconceptions and misinformation. The belief that oral contraceptives cause cancer and disease, and the belief that diaphragms can become trapped inside the vagina and require surgery for removal are two examples of misinformation commonly transmitted to women through informal interpersonal communication. There is also a pervasive cultural belief that condoms reduce physical and psychological pleasure for both men and women. Negative information can cause women to dislike, distrust, and even fear temporary contraceptives. [Henderson 1976, Lopez 1998, Stycos 1968, Zelaya et al. 1996]

The effects of limited and negative communications about contraception are significant. Studies show that many sterilized women do not try to use another form of birth control before undergoing the operation, and a substantial number claim to have never received information about temporary contraceptives (Landry 1990, Loaiza 1995, Ramirez de Arellano and Seipp 1983, Stycos 1968). The decision to become sterilized is often based on more than just a lack of alternative contraceptive options. In the next
section I will explore the prevalence of Latina women’s preference for sterilization over temporary methods of contraception.
Female Sterilization: Latin America and the Dominican Republic

Many political, economic, social and cultural factors influence sterilization rates in Latin America. These multilevel influences have historically made sterilization an easily accessible and socially acceptable form of fertility control. The result is a predilection for sterilization among contraceptive users throughout the region.

Historical and Political Influences on Sterilization

Population Control and Government Support:

Colonialist development programs and the population control movement are key historical and political antecedents of sterilization practices in the developing world. These programs have historically promoted female sterilization as the most effective method for controlling fertility.

Population control fostered the advent of sterilization in Puerto Rico and the Dominican Republic during the 1930’s and 40’s. The population control movement identified overpopulation as the primary cause of economic underdevelopment in Puerto Rico. Population control advocates promoted sterilization as a solution to the problem of economic underdevelopment. [Henderson 1976, Ramirez de Arellano and Seipp 1983, Stykos 1968]

Researchers have since pointed out that most women become sterilized after they have given birth to their desired number of children. Data suggests that women who become sterilized have more children, on average, than those who do not. These data stand in opposition to the population control movement’s endorsement of sterilization as a preferred means of population control. [Loaiza 1995, Lopez 1993 and 1998, Philliber and Philliber 1985, Stykos 1968]
Despite this argument, political actors and medical institutions in many Latin American countries continued to support sterilization. In Puerto Rico government officials historically kept a low profile with respect to sterilization policy. However, they demonstrated their tolerance of the procedure through legalization and lack of regulation (Henderson 1976). The Dominican government did not initially support sterilization as a part of its national family planning program (PNPF). However, in 1977 the government responded to growing popular demand for sterilization and included the operation as an official contraceptive option in the PNPF. (Población y Desarollo 1988).

Researchers also assert that strong legal sanctions against abortion in Puerto Rico and the Dominican Republic have contributed to the growing prevalence of sterilization. Article 317 of the Dominican Penal Code states that abortion is a criminal act regardless of the circumstances under which it takes place. Violators are subject to severe legal sanctions, which can include anywhere from five to twenty years of community service. Women who already have their desired number of children may be more motivated to ensure against unplanned pregnancy by becoming sterilized than they would be if abortion were an option. [Henderson 1976, Lopez 1993 and 1998, Población y Desarollo 1988, Población y Sociedad 1983, Ramirez de Arellano and Seipp 1983]

Medical Support:

Medical institutions played a key role in promoting sterilization. The medical profession in Puerto Rico initially supported sterilization only in cases of medical need. However, as the popularity of the procedure increased, many institutions began to relax their criteria. Public institutions were unable to meet growing demand for sterilization. This led to a proliferation of private sterilization clinics and medical entrepreneurs
dedicated solely to performing the operation for profit. These institutions fostered the growing prevalence of sterilization in practical terms by making the operation more accessible to women, and ideologically by contributing to the medicalization and commodification of women’s fertility. [Henderson 1974, Lopez 1998, Ramirez and Seipp 1983, Stylos 1968]

Lopez (1998) asserts that medicalization of women’s fertility in Puerto Rico subverted community-based knowledge and caused women to become overly dependent on medical providers for information. Medical elitism and a continuing façade of medical justification for sterilization restricted communication between patients and medical providers. This perpetuated fear, misconceptions and a general lack of information about contraceptive use among Puerto Rican women. As a result, women were often vulnerable to the coercive tactics used by medical entrepreneurs to increase acceptance of sterilization. Entrepreneurs persuaded women by urging acceptance of the operation immediately postpartum or by offering it as part of a “package deal” during a caesarian section (c-section). [Lopez 1998, Rodriguez-Trias 1978]

Association of the operation with childbirth and c-sections continues to be a key determinant of the predominance of sterilization in many Latin American countries. In Brazil, where sterilization is illegal, many women obtain the operation clandestinely by having it performed in conjunction with a c-section. This not only protects women from legal and social repercussions, but also reduces the financial burden associated with the operation since medical insurance will cover c-sections. [Hartmann 1987, Veira and Ford 1996]
In countries where sterilization is legal, association with the medical profession lends the procedure an aura of legitimacy, prestige, and safety. This association has historically augmented the social acceptability of sterilization throughout Latin America (Henderson 1976, Lopez 1998, Ramirez de Arellano and Seipp 1983, Stykos 1968).

**Socioeconomic Influences on Sterilization**

Population Control Targets:

Historically, population control programs have targeted individuals from “less desirable” segments of the population for sterilization. Population control pressure has been focused on groups such as “the mentally and morally degenerate.” (Rodriguez-Trias 1978) In Puerto Rico, many medical professionals originally supported sterilization as the preferred form of contraception for all but the “more intelligent” members of the population (Henderson 1974). Minorities and the poor are frequently targets of population control pressure (Hartmann 1987).

Population control advocates use various forms of pressure to promote acceptance of sterilization among poor and minority populations. In some cases this pressure is exerted through overtly abusive means, such as force and economic duress (Hartmann 1987, Lopez 1993, Rodriguez-Trias 1978). Such direct forms of sterilization pressure are outside the scope of this paper.

**Economic Pressure and Employment:**

Indirect forms of pressure are extremely pervasive and equally significant in increasing sterilization acceptance. Government sanctions of sterilization and withholding of contraceptive information by medical authorities are examples of indirect
political and social pressure. Many indirect forms of economic pressure promote sterilization in Latin America. These pressures disproportionately affect economically disadvantaged women.

Sterilization is often more economically viable for poor women than temporary methods which require repeat payments. In Puerto Rico, public subsidies and market competition among private medical entrepreneurs have historically driven the price of sterilization down. As a result, the operation has been available inexpensively or at no cost to women since the 1930’s (Hartmann 1987, Henderson 1976, Lopez 1998, Ramirez de Arellano and Seipp 1983). In the Dominican Republic, the operation became available at low cost in public hospitals and clinics after its legalization in 1977. The advent of public financial support for sterilization contributed to a drastic increase in the number of sterilized women by 1984\textsuperscript{14}. [Población y Desarrollo 1988]

Women who work outside of the house to support their families may experience increased pressure to become sterilized. Henderson (1976) and Ramirez de Arellano and Seipp (1983) describe the changing economic situation in Puerto Rico in the 1950’s. Traditional home employment opportunities for women began to decrease and job prospects in the service and industrial sectors increased. This transition led to a shift in traditional gender roles, as many women became primary providers and began to exercise more decision-making power in their families. Increasing participation in economically productive labor caused many women to consider the economic implications of childbearing.

\textsuperscript{14} Sterilization rates in the Dominican Republic increased from 3% to 34% of all contraceptive users between 1977 and 1984.
In the competitive Puerto Rican job market of the 1950's, pregnancy posed a threat to ongoing employment. It was widely acknowledged that employers were more willing to hire a woman if she was sterilized. This contributed to economic pressure for working-class women to become sterilized (Ramirez de Arellano and Seipp 1983). The Family Planning Association (FPA) of Puerto Rico capitalized on the opportunity to promote contraceptive use in the workplace. Many employers signed agreements with the FPA to promote various contraceptive methods (including sterilization) in the workplace. In some cases, private employers subsidized contraceptive supplies for their employees (Henderson 1976, Ramirez de Arellano and Seipp 1983).

Ramirez de Arellano and Seipp (1983) demonstrate how social perceptions of women's fertility are embedded in common Spanish vernacular. The word embarazada (pregnant) denotes the idea that pregnancy was a source of embarrassment to female employees. The metaphor cerrar la fábrica (close the factory) is used to refer to sterilization. These terms demonstrate the pervasiveness of messages about fertility, and the ongoing conflict between women's productive and reproductive roles.

**Sociocultural Influences on Sterilization**

Church Doctrine:

There is a lack of consensus among researchers as to the Church's influence on sterilization rates in Roman Catholic countries. Many assert that the Church's condemnation of artificial fertility control contributes to social stigma surrounding contraceptive use and sterilization\(^\text{15}\). [Henderson 1976, Lopez 1998, Ramirez de Arellano and Seipp 1983, Stycos 1968, Zelaya et al. 1996] Henderson (1976) and

\(^{15}\) For more information, see “Sociocultural Influences on Contraceptive Use”
Ramirez de Arellano and Seipp (1983) point out that the Church's disapproval of contraceptive use forced the Puerto Rican government to maintain a low profile with regard to sterilization policy.\(^{16}\)

Other researchers claim that the Church's public criticism of contraceptive use actually bolstered sterilization rates. Stylos (1968) cites the example of a pastoral letter condemning a new sterilization clinic in Puerto Rico. The letter was read at a number of churches in the vicinity of the new clinic. As a result, women throughout the region learned of the clinic's existence and became interested in the procedure.

Hartmann (1987) asserts that the Church did not publicly condemn sterilization as much as they did temporary contraceptives and abortion. Thus, sterilization was thought to be a more tolerated form of fertility control. According to Ramirez de Arellano and Seipp (1983), Catholic women felt that sterilization was more acceptable than continuous use of temporary contraceptives, since the former necessitated only a single "violation" of Church doctrine.

Social Acceptability:

Female sterilization is also a more socially acceptable form of fertility control in the face of persisting machista gender relations in Latin America. According to Lopez (1998), many Puerto Rican women feel they have the right to make an autonomous decision about sterilization. However, evidence suggests that most women consult their partners before undergoing the operation, and partners rarely oppose the decision (Henderson 1976, Landry 1990, Lopez 1998, Philliber and Philliber 1985). This

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\(^{16}\) For more information, see "Historical and Political Influences on Sterilization"
increases the likelihood that women will choose sterilization since other forms of contraception commonly elicit unfavorable responses from male partners\textsuperscript{17}.

Many Latina women report a preference for sterilization over temporary contraceptive use. Women describe the operation as "therapeutic and effective" (Henderson 1976), "effective and easy," and not "dirty" (Stykos 1968). It is less socially stigmatizing for a woman to undergo postpartum sterilization in a hospital than to make a separate trip to a family planning clinic. Sterilization is a morally neutral form of fertility control. It is not directly associated with a sexual act and does not require contact with sexual organs. This makes the operation more socially acceptable than many temporary contraceptives. [Stykos 1968]

Socially transmitted messages are a key determinant of sterilization acceptance rates. Philliber and Philliber (1985) study the worldwide prevalence of sterilization. They state "societies provide people with a rationale for sterilization, which they then cite." In this way, society legitimizes the decision to become sterilized.

Societal acceptance of sterilization is transmitted to women in a variety of forms. Lopez (1993, 1998) suggests that the historical commonality of sterilization in Puerto Rico has made it a part of the country's "cultural repertoire." According to Henderson (1976), most women who become sterilized have received information from other women who have been sterilized. She found that Puerto Rican women who had been sterilized tend to have more female acquaintances that are sterilized than acquaintances that are not.

Landry (1990) claims that informal interpersonal communication is the most important source of information about sterilization. Testimonies from women who have undergone the operation shape local knowledge and belief models. Thus, communication

\textsuperscript{17} For more information, see "Sociocultural Influences on Contraceptive Use"
about sterilization is a key determinant of sterilization acceptance among women in a community. In communities where there is a lot of positive communication about sterilization, the rate of sterilization acceptance tends to be high.

Informal communication can also perpetuate dangerous misconceptions about sterilization. Iris Lopez (1998) demonstrates the prevalence of misinformation about the permanence of sterilization among Puerto Rican women. Lopez specifically discusses the fact that 82% of women in her study population make a false distinction between "tying" and "cutting" fallopian tubes as forms of sterilization. Women understand tying to be a less-permanent form of sterilization than cutting, which a woman should not consider until she is sure that she does not want any more children:

I feel that if a woman is not sure if she wants anymore kids, then she should have her tubes tied. Because of birth control pills, women get cancer or veins on their legs. It's a different situation when you get your tubes tied. At least then you can feel relatively safe that you will not have any more children until you want to. If a woman really has decided she absolutely does not want to have more children, then she should have her tubes cut. [Lopez 1998:255]

This "tying vs. cutting" model creates a false perception of agency among women. It fosters the belief that women can choose between a permanent and a semi-permanent form of sterilization. Lopez asserts that this model of thinking about sterilization is dangerous. Since the distinction between tying and cutting does not actually exist, it is not likely that women initially receive this idea from medical providers. The pervasiveness of this model demonstrates how misconceptions are perpetuated at the community level. However, it also reveals that medical providers often fail to correct misconceptions due to limited communication with women. Lopez claims that these misconceptions maintain and perpetuate a high rate of sterilization in Puerto Rico. [Lopez 1998]
Part Two:

Women’s Fertility, Contraceptive Use and Sterilization in the Zona Sur
Women's Fertility: Zona Sur

This group of Zona Sur women seems to share a pattern of early marriage, followed by rapid childbearing and late initiation of contraceptive use\textsuperscript{18}. Most respondents began their first marital relationship at or before the age of 23\textsuperscript{19}. All but two women had their first child within one year of their first marital relationship. The two exceptions are also two of the three women who initiated contraceptive before their first childbirth.

Data from this Zona Sur population does not definitively indicate whether this common fertility pattern is directly related to the incidence of sterilization. However, a number of shared experiences, perceptions and beliefs emerge from these women’s testimonies in the form of commonly expressed themes. These common themes offer insight into the determinants of reproductive and contraceptive choice in the Zona Sur.

La situación económica and limiting family size

It is clear from respondent’s testimonies that scarce economic resources are the prevailing motivation for these Zona Sur women to limit their fertility. Every respondent either specifically cites or makes a clear reference to la situación económica (the economic situation) as a reason to limit family size.

Some respondents talk about la situación económica in an abstract sense. They use this phrase to indicate the experience of economic hardship, but do not identify the particular ways in which it affects childbearing. They simply allude to the difficulties of

\textsuperscript{18} For more information, see Appendix B: Tables 1.1, 1.2 and 2.3
\textsuperscript{19} It is assumed that respondents’ first sexual relationship also refers to first marital relationship. See “No sex or contraceptive use outside of a marital relationship” for more information.
having limited economic resources and a large family. In response to the question of how many children she would like, one woman states:

The three [children] I have, no more. In la situación económica, having a lot of children...ay no! Three, y ya21!

More often, respondents specify the aspects of la situación económica that make childbearing difficult. The two most commonly described causes of economic hardship are low pay and the rising costa de la vida (cost of living).

Women feel it is important for a couple to consider both total income, and whether or not both partners are working outside the house, in order to decide how many children they should have. Women who work in the informal sector, or as unskilled laborers often must limit their fertility because of the threat that pregnancy poses to job security21.

Employment opportunities for Zona Sur residents are mostly limited to low-wage professions. According to 1996 census data, the most common occupations among residents are ama de casa (female homemaker) and obrero/peon (manual laborer). Approximately six percent of Zona Sur residents are employed in the informal sector, and 23% percent are unemployed. [UNISUR 1996]

Women typically work in the home, and many take part in the large informal employment sector by selling household goods and cosmetics products and services. Some women work as unskilled laborers in the nearby Zona Franca (Free Zone) factories. For women who can’t depend on a friend or family member to provide free childcare, however, the cost of hiring a care provider may negate the economic benefits

20 Common Dominican expression: ya [already, enough, finally]
21 For more information, see “Economic Influences on Sterilization”
of working. Economic hardships also arise when only one partner works to earn money.

One woman describes this situation:

Where am I going to get with so many children? When one doesn’t work, and your husband, tu sabe, is working in La Zona earning so little...no es fácil [it is not easy].

Respondents allude to a recent change in la situación económica that has made it difficult to “maintain” lot of children. They preface statements about limiting fertility with the phrase “como está la situación ahora” [given the current situation]. Many respondents worry about their ability to provide children with a good upbringing. The costs of food and education are common sources of concern. One woman worries that the ambiente (environment) is not good for raising children.

This Zona Sur mother is justified in her concerns about the environment. Infections and diseases of contamination are common in the region, and children are at a high risk for these health problems. Children run around partially clothed and barefoot in the streets, which are full of agua negra (black water) caused by poor drainage and sewage. Another source of environmental disease is the contaminated cañada (river) that runs through the Zona Sur. During my time in the Zona Sur I witnessed an outbreak of Leptospirosis, a disease that originates in the cañada and is spread through contamination of food, water and household items with rat urine.

These environmental health hazards are one example of how la situación económica can adversely affect the health and well-being of children in the Zona Sur. Given the difficulty of raising children under these circumstances, one can understand why these women are motivated to limit their fertility.

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5 Common Dominican expression: tu sabe [you know/you see].
Difficulty of raising children and obligation to use temporary contraceptives

These Zona Sur women recognize not only the basic challenges of raising children under adverse circumstances, but also the difficulty of caring for many young children at once. Respondents generally acknowledge the importance of using temporary contraceptives to space births. These ideas are expressed in two different ways. Respondents give personal accounts of the difficulties related to childcare and make general endorsements of temporary contraceptive use.

Two respondents who were present for one another's interviews begin an impromptu discussion about the difficulties of caring for many young children:

Respondent 1: What happens is that one gets tired. As much as the man helps...
Respondent 2: Exactly!
R1: ... your partnership, it's never the same. The man takes a...
R2: Yes!
R1: ... (inaudible) the children that one has in the Dominican Republic, and this is why one always says—this is the typical phrase... "se vuelvo viejo" [I'm becoming old].
R2: From a lot of childcare... from the sun.
R1: At least with this one I can now [sleep] the entire night—because my little daughter is not a problem, thank God. *Tu sabe,* she goes to sleep and yo! (inaudible) but *tuve* C- that with M- I never had [problems]... thank God! But those [children] who (inaudible) you like that, girl...
R2: And when there are many... with one it doesn't matter, but when you have three and four little ones... Look, I'll tell you all, for me it hasn't been very [easy]. There have been many nights when I have to start the day sitting [with child] in a bed.

Even though the first woman talks about having a relatively easy experience with her one child, she can relate to the second woman's experience. They both understand the difficulty of having many children. These respondents agree that not all women share an understanding of the burden of childcare:

R1: ...you see those pretty professional women who look like young girls, when they go out as if (inaudible) they have...
R2: Yes! But they give... how do they say? The nanny is the one who cares [for the children].
R1: Yes!
R2: You see them and [they make] it [having kids] look like nothing.

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21 Common Dominican expression: *tuve* [you know/you see]
Respondents’ testimonies and evidence from the Zona Sur suggest that women shoulder the majority of childcare responsibility\textsuperscript{24}. This responsibility defines many women’s lifestyles. One woman who has recently had the operation to become sterilized explains why the operation has not changed her lifestyle. Being sterilized does not alleviate the burden of caring for her four young children:

[My lifestyle] hasn’t changed much because, like I already told you, I have four little girls and I am tired. I live with them harassing me from the time I awake until I go to sleep. [I wish] that the girls were already grown so that they could feed themselves, and bathe themselves, and change their own clothes. But while they are like this [young], and [I] have to bathe them and nurse them…what kind of lifestyle change could [I] have?

Temporary contraceptives use can potentially alleviate the burden of childcare. Women can use temporary contraceptives to space their births and avoid the possibility of having to care for many young children at once. In the words of one woman:

It is recommended that one use family planning so that one can watch one’s children grow a little more. \textit{Osea que}\textsuperscript{25} it isn’t easy to attend to a lot of little [children].

It is not clear whether the recommendation that this woman refers to is literal or figurative; Has she explicitly been told to use contraceptives, or is her decision self-motivated? Another respondent explains that her decision to use contraceptives is not self-motivated. When asked which contraceptive method she prefers she replies, “Ninguno, lo que pasa es que hay que usarlo por obligación…” [None of them, the fact is that one has to use them out of obligation].

These Zona Sur women demonstrate both an understanding of the social and economic benefits of family planning, and a motivation to limit their own fertility. Most respondents agree with the idea that women should use temporary contraceptives to space their pregnancies. Evidence suggests that this idea is not easily converted into practice.

\textsuperscript{24} For more information, see Appendix B: Tables 1.3 and 1.4
\textsuperscript{25} Common Dominican expression: \textit{osea que} [that is]
Lack of control over fertility

Lack of fertility control is a pervasive theme in these women's testimonies. Many women describe a lack of control over their total number of children. For example, one woman uses the conditional phrase "si se puede" [if possible] to express her desire to have three children. Although use of the conditional is common in the Spanish language, it implies a level of uncertainty that is noteworthy in this context; this woman is not saying "I plan to have three children," but "I would like to have three children, if possible." The implication is that the number of children she will have is not entirely within her control.

Two respondents who have completed their childbearing indicate that they gave birth to more than their desired number of children. One woman simply states, "Yo quería dos y tengo tres" [I wanted two, and I have three]. The second woman describes her experience:

After it [childbirth] went so badly with the first one I said, "bueno" (ok, enough), but what happened was that I had... after the first I had three more. I had four without wanting to! But now that is what I have and... imaginate26 that is my life, verdad27?

The first woman does not express unhappiness about having more than her desired number of children. Although she later acknowledges the economic difficulty of having more than two children, she also claims that three is the preferred number of children for women in the Dominican Republic. The second woman, however, clearly conveys regret in the above statement. She goes on to describe her childbearing years as a seemingly constant series of pregnancies:

I always had a big belly in December! Por suerte (by luck/bys chance) I got pregnant almost every year.

26 Common Dominican expression: imaginate [you can imagine/you see].
27 Common Dominican expression: verdad [right/true]
She has recently been sterilized, and says that she is now “feliz de la vida” [happy with life] because she knows that she will not have any more children. This woman’s use of the phrase por suerte implies that she did not have control over the timing of her pregnancies.

Her sentiment is echoed by a third woman who says, “Yo no decidi usarlo porque, como yo estaba predestinada cada dos años quedo embarazada, yo no usaba nada” [I decided not to use (contraceptives) because, since it seemed like I was predestined to become pregnant every two years, I didn’t use anything]. This woman goes on to talk about the length of time that she spent nursing each of her children. Based on her report, it seems likely that her breastfeeding activities largely determined the two-year intervals between her pregnancies. The fact that she discusses breastfeeding immediately after birth spacing suggests that she recognizes the relationship between the two. However, her use of the word predestinada implies lack of agency in the timing of her pregnancies.

Two commonly expressed sets of ideas offer explanatory models for women’s lack of fertility control. The first model explains reproduction as a phenomenon that is controlled by a higher power. A number of respondents refer to the belief that God ultimately determines the number, timing and sex of one’s children, as well as the time that one will naturally stop bearing children.

One woman who did not want to have the operation to become sterilized talks about waiting for God to sterilize her; which is presumably a reference to menopause. A woman who had the operation after having four boys indicates that she would return to her childbearing years if she could. However, she says, God gave her four boys because he wanted her to have four boys. Thus, she decided to have the operation rather than
keep trying to have a girl. Another woman who been sterilized says that she is happy with her decision to have the operation and emphatically states that she does not want to have more children. She goes on to say that God will determine whether or not she will have more children:

_‘Ay no my friend! Ay no! Ay no. I am done with that [childbearing]. I have four [children] here. If God wants...it’s up to God, but...’_

The third woman’s statement implies a near complete lack of control over fertility. Even though this woman has gone to an extreme measure to prevent childbearing, she is still not confident in her ability to control this phenomenon. This seems to be the prevailing sentiment among respondents who refer to God as the ultimate regulator of fertility. The religious implications of this mode of thought are beyond the scope of this paper. However, the idea that God’s omnipotence negates women’s agency over reproduction is disempowering. This disempowerment is not cause for a fatalistic attitude about fertility control. Most respondents who accept this explanatory model still use some form of contraception. Sterilization is generally acknowledged as the most effective form.

In contrast to the lack of agency implied in first explanatory model, the second commonly expressed set of ideas blames poor women for their lack of fertility control. This set of ideas describes an explanatory model that distinguishes between poor women and upper- or middle-class women.

Two respondents draw distinct comparisons between poor women and _mujeres profesionales_ (professional/upper-class women). Poor women have numerous children in rapid succession while upper-class women use their intelligence and do not give birth to

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28 Breastfeeding is a natural contraceptive
more than two or three children. One respondent gives a particularly vivid image of this phenomenon, describing the difference between upper class women and women who are part of la masa pobre (the poor masses):

[Upper-class women] drive around in their nice cars with [their] two children. If they have two boys, they have two boys. If they have two girls, they have two girls... You only see people loaded down with children among la masa pobre. When you go to el centro (central market) you see the [poor] women with two or three little children... One doesn't see this in the [upper] class.

These Zona Sur women's words echo the population control propaganda discussed in Henderson (1976). Their testimonies support the idea that poor women are unable to control their own fertility. Notably, one respondent's use of the word inteligencia (intelligence) when referring to upper-class women's fertility control echoes the statement of one Puerto Rican woman, recorded by Henderson, that poor women are unable to control their fertility because they lack "education and orientation." Also significant is the use of the phrase la masa pobre when referring to poor women.

These words suggest an internalization of population control advocates' belief that poor women are unable to exercise control over their own fertility, and must be collectively regulated by an outside agent. By internalizing these ideas, Zona Sur women effectively deny themselves agency over their own fertility.

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29 For more information, see "Socioeconomic Influences on Fertility"
Temporary Contraceptive Use: Zona Sur

Census data suggest that most Zona Sur women lack access to a wide range of contraceptive options. Respondents’ personal accounts confirm that they have limited access to accurate information about temporary contraceptives and are often influenced by social norms, which define acceptable contraceptive methods and practices. As a result of these influences, these women are limited in their ability to identify, obtain and sustain effective use of a temporary contraceptive that is appropriate to their needs.

Women’s inability to be active participants and the commonality of provider-controlled methods

Lack of fertility control is related to the idea that women are unable to be responsible for sustained use of temporary contraceptives. Respondents frequently discuss contraceptive failure in the context of women’s inability to be responsible for fertility control. User-controlled methods, such as the birth control pill and the condom are made less effective by improper or inconsistent use.

Only one respondent talks about condoms. She explains that her use of this method was provisional (provisional) however, because condoms are uncomfortable and break often. She also states that even provisional use is difficult because men often don’t want to wear condoms.30

Many Zone Sur women use the birth control pill31, though respondents often claim that this method is also problematic for some women:

> There are always people who [claim to] get pregnant while on the pill, and that is a lie. They [actually] forget to use it, or they have sexual relations right before menstruation, verdad, which one shouldn’t do. Those [women] get pregnant and they say “I got pregnant while I was on the pill,” and that is a lie.

30 For more information, see “Sociocultural Influences on Contraceptive Use”
31 For more information see Appendix B: Tables 2.1 and 2.2
I would recommend that [injection] more because using the pill every day is tiring, and it is riskier too because if you forget [to take it] one day. There are many women who [have gotten] pregnant because they forgot [to take the pill], tu entiende. Then they start taking it again the next day, and then they start to feel physical symptoms of pregnancy, and they say “but I was taking the pill!” But it is because they forgot it for a day. But with the injection they give you one shot every month, and then you don’t have to worry about pregnancy, tu entiende?

The idea that women need help to sustain contraceptive use is extremely pervasive. One woman attributes her successful long-term pill use to the fact that she was given free supplies at each of her monthly visits to the local health center. Despite its easy accessibility, a number of respondents prefer to avoid the pill. They feel that the daily nature of pill use increases the risk for contraceptive failure due to human error.

Long-acting provider-controlled methods, such as contraceptive injections, subdermal implants and the IUD are generally thought to be more effective because they do not require frequent attention. The following conversation between two respondents illustrates the idea that provider control is necessary to ensure effective contraceptive use:

Respondent 1: It [birth control pill] is the one [contraceptive method] that is used the most; More than the...injections, because there are injections that [last] for a month. But sometimes...one doesn’t know when to go back to get the next [injection]. This is bad...[A woman] came here and said to me, “C- I’m afraid that I might be pregnant again!” I asked why, [and she replied] “because they [doctors] told me that they had to give me an injection, and I haven’t [gotten it yet].” Tu sabe, that can happen. So sometimes the pill is better than the injection.

Respondent 2: Yes, but let me tell you something. There is a thing [that comes with] the injection [chart/written reminder?]. If it [injection] is monthly, the woman [should get injection] one day after her menstrual period ends. It clearly says [to get injection] after the five days [of her period]. And on the fifth day, when the [woman’s] menstrual period should be over...if, for example, it is the twentieth [of the month] when it happens, it [chart/written reminder?] says “the twentieth of the month.” And that injection [date] has to be set so that you don’t [forget/get pregnant].

Although the birth control pill is the most commonly adopted temporary contraceptive method among Zona Sur women, it seems that there is also a high rate of pill discontinuance. A number of respondents describe a preference for long-acting provider-controlled methods.
Respondents articulate a shared perception about women's inability to control their own fertility. This perception contributes to a set of social norms, which define the contraceptive methods that are appropriate for women in the Zona Sur. Widespread endorsement and use of provider-controlled methods diminishes women's agency in both contraceptive choice and practice.

No sex or contraceptive use outside of a marital relationship

Another significant influence on effective temporary contraceptive use is the stigma surrounding extramarital sexual relationships. This social norm defines when contraceptive use is appropriate for Zona Sur women. Respondents commonly allude to the belief that sexual relationships, and thus fertility control, are only appropriate for married women.

This belief is embedded in the language that Zona Sur women use to describe romantic relationships. I originally translated the following interview question using the word novio (boyfriend) to describe women's first sexual relationship:

At what age (approximately) did you become involved in your first relationship?

I soon discovered that the use of this word was confusing to my respondents. According to my first respondent, I had to use the word esposo or marido (husband) if I wanted to ask women about their first sexual relationships. In her words:

Here [in the Dominican Republic] we say, "novios besan, nada más besan" [boyfriends and girlfriends only kiss]. They don't have sexual relations.... I had sexual relations with my esposo when I was twenty-eight.

After this first interview, I changed my question to use the phrase relaciones sexuales (sexual relations) without making any reference to the type of union that these...
sexual relations took place in. I became very attentive to the ways in which respondents referred to their first sexual relationships.

Respondents frequently convey the social norm of sex and contraceptive use only in the context of a marital relationship. A few women make a direct connection between sex and marriage, referring either to their age at first sexual relationship as the age at which they became married, or to their first sexual partners as their husbands. More often, respondents explicitly relate contraceptive use to marriage. A few respondents talk about discontinuing contraceptive use when they separated from their husbands:

[After having my third child] I used the pill again. Then I left my husband and I am still single.... I am not using anything.

This social norm conflicts with persisting social pressures for married women to fulfill their traditional reproductive duties\textsuperscript{32} and the barriers to initiating contraceptive use in a marital relationship\textsuperscript{33}. Traditional reproductive expectations and pervasive power inequality in marital relationships may make it difficult for women with no prior contraceptive experience to initiate use after marriage.

One woman had initiated her first sexual relationship at the age of 13. After having a child at the age of 15 her doctor recommended that she use birth control pills because, "...era la más fácil que tenía para mi edad" [this was the easiest (method) that they had for (someone) my age]. She also tells me that her husband is the one responsible for buying her contraceptive supplies.

This is an anomalous situation given that majority of respondents conform to the traditional norm of female responsibility for fertility control\textsuperscript{34}. Respondents typically

\textsuperscript{32} For more information, see "Sociocultural Influences on Fertility"
\textsuperscript{33} For more information, see "Sociocultural Influences on Contraceptive Use"
\textsuperscript{34} For more information, see "Sociocultural Influences on Contraceptive Use"
obtain contraceptive supplies themselves, and occasionally receive assistance from their mothers. A probable reason for this young woman’s dependence on her husband to obtain birth control pills is the stigma she would likely face as a result of her age.

The stigma surrounding extramarital sexual relationships creates a barrier to unmarried women’s access to contraceptive information and supplies. One respondent alludes to the barriers that unmarried women face when trying to obtain contraceptive information. She claims that there are various sources of contraceptive information, but if a woman is not married “tiene que buscarla” [she has to search for it (information)].

Although it is not clear whether this woman has personally experienced these barriers, her statement sets up a notable contrast with the testimonies of other respondents. Respondents commonly give accounts of receiving family planning advice from medical providers after marriage:

_Bueno_\(^{35}\) the doctor [gave me the information] because after I got married I... didn’t know about taking the pill..., I didn’t know how to use it [the pill], I didn’t know anything, _tu me entiendes_\(^{36}\)? After I got married I went to the doctor and got family planning.

Respondents’ testimonies demonstrate a dependence on medical providers for contraceptive information and advice. The stigma surrounding contraceptive use outside of marriage contributes to this dependence by subverting informal communication about contraceptives. These Zona Sur women tend to have no experience with, and very little knowledge about contraceptives before they are married. After marriage, women typically receive family planning consultations at clinics or from other medical providers. Promotoras are another commonly mentioned source of contraceptive information. Only one woman cited a family member as her primary source of contraceptive information.

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\(^{35}\) Common _Dominican_ expression: _bueno_ [well]

\(^{36}\) Common _Dominican_ expression: _tu me entiendes_ [understand]
Sources of contraceptive information: medical providers and the legitimacy of local knowledge

Among respondents who have used some form of temporary contraception, all but one cite a medical provider as their primary source of contraceptive information and advice. Women receive information and advice from doctors, nurses, gynecologists and promotoras. Providers have a significant influence on women’s contraceptive decisions. When asked why she decided to use the pill instead of another contraceptive method, one woman replies:

Because, *imaginete*, that is what they gave me when I went to get family planning.... I never used anything else.

This woman’s testimony indicates that medical providers often do not present Zona Sur women with a full range of contraceptive options. Since most Zona Sur women consult public medical providers, it is likely that the scarce resources that characterize public institutions limit their access to contraceptive supplies and information\(^37\).

Dependence on medical providers for contraceptive information also diminishes women’s ability to choose a method that is most appropriate to their needs.

The birth control pill is the leading contraceptive method among Zona Sur women. Besides female sterilization, the pill is the method that most respondents know of and have used\(^38\). The popularity of the pill is self-perpetuating, in the sense that high rates of local pill use predispose Zona Sur women to select this method.

\(^37\) For more information, see “Economic Influences on Contraceptive Use”

\(^38\) For more information, see Appendix B: Tables 2.1 and 2.2
Respondents often cite widespread use as a reason they decided to choose the pill.

In response to the question of where she learned about contraceptives, one woman declares:

*Imaginate* from the others...the people. Women talking to one another, because *casi todo el mundo usa* [almost everyone uses the pill].... I said, “bueno vamos a ir a eso también” [I’m going to use that too] For one because it is one of the cheapest [methods], although now it is no longer [the cheapest] because the price has gone up, but even so women said, “…a la Microgynon” y yo sigue usar a esta” [I will continue to use Microgynon].

This is a prime example of the way that local transmission of contraceptive knowledge affects contraceptive choice. It is also a good example of the way that macrosocial economic influences shape local contraceptive knowledge and practice. Informal communications with other women influenced this woman to choose not only the method, but also a specific brand of contraceptive to use.

**Contraceptive cost and the effects of Contraceptive Social Marketing**

Respondents do not cite contraceptive cost as a major consideration in their decision-making process. However the contexts in which respondents mention contraceptive cost offer some insight into the ways that economic factors influence contraceptive access in the Zona Sur.

A number of respondents’ testimonies indicate that Contraceptive Social Marketing (CSM) has a significant impact on contraceptive use in the Zona Sur. Respondents frequently identify Microgynon as the brand of pill that they know of and have used. In some cases, respondents use the brand name Microgynon interchangeably with or in place of the word *pastilla* (birth control pill). This use of a brand name to describe a product is comparable to the North American use of the word Kleenex to refer

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39 "Microgynon" refers to a brand of birth control
to toilet tissue, or the Dominican use of the word *gile* (Gillette) to refer to shaving razors. The significance of this linguistic tendency is that it implies widespread and long-standing use of the brand.

Microgynon is the brand of pill marketed to low-income Dominican women through the national Contraceptive Social Marketing program. Many Zona Sur women fall within the CSM target group, in that they cannot afford contraceptive supplies at market cost, are not poor enough to be receiving supplies through public distribution programs, and are easily accessed through commercial media channels.

Zona Sur women are prime candidates for commercial contraceptive advertising. According to 1996 census data, approximately 86% of Zona Sur households have a television. This is greater than the number of households that have either a phone (73%) or a refrigerator (66%). Zona Sur women often watch popular *telenovelas* (soap operas) and talk shows while doing household chores. CSM marketing clearly caters to this audience:

The 30-second spot shows Vickiana [a popular Dominican singer and model] sensually embracing a handsome man who has just stepped out of a shower and is clad only in a towel wrapped around his waist. During the embrace, Vickiana holds up a pill and confides, "This is my little secret for enjoying love every day of the month." The scene shifts to a doctor who endorses Microgynon as a safe, reliable, and effective product, then shifts back to a final few seconds of Vickiana holding up a pack of Microgynon and telling about its low price. [Green 1998:110]

Respondents also receive information about Microgynon from their doctors and from women in their community. Endorsements from at least one of these two sources are an important factor in women's acceptance of the product. However, it does not seem that either of these sources offer Zona Sur women information about other available oral contraceptives. Thus, a woman’s choice to use Microgynon is not based on preference but is a result of market constraints that limit her options.
The economic impact of CSM on Zona Sur women is small but significant. A number of respondents state that the price of Microgynon has increased in recent years:

*Bueno, Microgynon used to be extremely cheap. It used to cost...I believe that is was twenty-nine pesos, and afterwards it went up to thirty-five....*

None of the respondents indicate that this price increase has prohibited their ability to sustain contraceptive use. It is significant, however, that respondents express an implicit acceptance of this price increase. They do not talk about protesting the increase or switching brands. Women who receive their contraceptive supplies through CSM are not able to exercise market control or agency as contraceptive consumers. The consequences of this economic constraint are potentially devastating. One woman talks about receiving a recommendation to use Microgynon from her doctor and suffering negative physical side effects as a result of her compliance:

*Yes I used the pill, like I told you, because the doctor told me to use that...Microgynon. But then I was beginning...* *tu sabe,* *I was gaining a lot of weight. I got very fat, and it [Microgynon] also left marks on my face, *tuve?* It left marks on my face that are still visible. You [interviewer] can see them, *tuve?*

Rather than recommend another brand of oral contraceptive, this woman’s doctor told her to use contraceptive injections. When I asked about her experiences with the injections, she replied, “Es un poquito cara, pero no me ha hecho nada hasta ahora, *tuve*” [It’s a little expensive, but it hasn’t done anything (bad) to me yet]. This woman’s experience suggests that medical providers’ contraceptive recommendations may not be based on considerations of what is most appropriate for their patients. This is partly a function of the social and economic constraints that public medical providers face41. Negative side effects are a possible outcome of inappropriate contraceptive recommendations.

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40 For more information, see “Economic Influences on Contraceptive Use”
Contraceptive side effects and negative communication

Many respondents report a fear of contraceptive side effects. For some respondents, this fear is based on a past personal experience. Side effects experienced by women who have used the birth control pill include weight-gain, discoloration of facial skin, nausea and dizziness. One woman who used Norplant hormonal implants suffered bruising of the arm and prolonged menstruation.

Women who have not personally experienced a contraceptive side effect base their fear on information from various outside sources. One woman identifies the media as a specific source of information:

Also, I just saw a report on the television that contracept- the pill...eh...can cause breast cancer, tu sabe, and it [pill] is very risky.

For others, fear of side effects is based on information that they have received from informal interpersonal communication with other women. Respondents make reference to a general body of knowledge about possible side effects. This suggests that women share a cultural model of knowledge and belief about contraceptive side effects:

I [didn’t use contraceptives] because, for one, I can’t use the pill because it will bother my stomach, and I am afraid of the injection and the implant too.

As they say, sooner or later all those contraceptives can cause a problem, me entiendo?

Yes, I know that after one has used them [contraceptives]...one hears a lot of [talk], “C- uses this one [contraceptive], C- used that one...” tu sabe, because there are many [contraceptives] that can do harm.

Fear of contraceptive side effects is evident even in respondents’ accounts of positive contraceptive experiences. There is a tendency among these women to use define a positive contraceptive experience as the absence of a negative experience. In other words, a contraceptive method is good as long as it hasn’t done any harm:

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41 For more information, see “Economic Influences on Contraceptive Use”
The pill? It was good because it didn’t do me any harm.

*Bueno,* like I told you...the pill does [harm] to some people. It has never done anything to me.

I have only been using the injection for three months, *tuve,* and I haven’t felt any physical problems, *tuve?* We’ll see if that continues, *tuve.*

Because of this shared fear of side effects, respondents are often hesitant to identify themselves as sources of contraceptive information for other women. When asked whether or not they would recommend a contraceptive method that they have used to a friend or family member, many respond that the method they used may not be appropriate for other women:

*Ah no!* I wouldn’t recommend it [birth control pill]... Because I don’t know how...if it would do harm, or what would happen, *tuve?* I would only recommend it to myself, no one else.

No, [I would not] recommend the pill. I would recommend the injection because it is only once a month...[but] everyone is different; Everyone responds differently. What is good for me [contraceptive] may not be good for you, *tu sabe*.

In contrast to the medical providers, these women base their contraceptive recommendations on considerations of what is appropriate for other women. However, they are unwilling to convey their contraceptive knowledge in an authoritative manner. Local communication about contraceptives is typically informal and negative. Though informal, this negative communication has a significant impact on knowledge and belief models in the *Zona Sur.*

Negative communication about contraceptives contributes to the idea that contraceptive side effects are common. This idea diminishes the social acceptability of many temporary contraceptives, and limits *Zona Sur* women’s ability to sustain effective use of a temporary contraceptive that is appropriate to their needs. The idea that temporary contraceptives are harmful contributes to a preference for sterilization over prolonged use of temporary contraceptives.
Female Sterilization: Zona Sur

Respondents rarely plan to sustain use of a temporary contraceptive for the duration of their reproductive years. All respondents were familiar with sterilization as a method of fertility control. Five out of eleven respondents were sterilized either at or before the age of 34. Of the remaining six women, three express a desire to be sterilized in the future, and the other three women specifically say that they don’t want to have the operation.

Respondents’ ideas about sterilization are clearly shaped by a cultural model of knowledge and belief that create a predilection for the operation. Those who choose not to have the operation typically do not refute this cultural model. Instead, they agree with the basic tenets of the model and offer personal explanations for their deviance from the normative practice. None of the respondents explicitly contest the idea that sterilization is the preferred method of fertility control for most Zona Sur women.

Sterilization is simple, safe and effective

The widespread belief that sterilization is not harmful contributes to women’s preference for the operation. Respondents’ testimonies generally support the idea that sterilization carries less risk than prolonged use of temporary contraceptives. One woman talks about contraceptive side effects as a precipitating factor in the decision to become sterilized:

If contraceptives are doing you harm I think it is better [for you to have] an operation [become sterilized]. . . . Because even after they have operated on you, your body is still the same.

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42 For more information, see “Sociocultural Influences on Contraceptive Use”
43 For more information, see Appendix B: Tables 1.1, 2.1 and 2.2
44 For more information, see “Social Influences on Sterilization”
Despite the invasive nature of the operation, many of these Zona Sur women share the idea that sterilization is a simple and safe procedure. This shared idea seems to come mainly from two sources within the community. The primary source of information is informal communications between women in the community. All of the respondents who have not been sterilized know of at least one woman who has been sterilized. One woman who is not sterilized describes her understanding of the procedure, based on what she has heard from other women:

No, they have told me that it is una tontería (a silly/simple thing)... that it is a simple operation.... You go and then they give you a few little stitches.... There are women who, after they become sterilized, say, “Mire que gorda estaré porque se preparo- porque hizo la operación!” [Look how fat I am getting because I was sterilized- because I had the operation!]. And there are others who lose weight, tuve, and others say that it causes back pain...it [operation] can cause these side effects].... There are others who [say] that they haven’t felt anything...that they feel the same [as before the operation], and their ritmo de vida (rhythm of life/daily life) is the same, tuve. That is what I have heard.

Information from promotoras also contributes to these women’s ideas about sterilization:

According to what I have heard, [the operation] is easy. I went to Juan XXIII and the promotoras gave charlas (chats/educational talks) to tell us about sterilization. The promotoras told us that one can return home the same day [as the operation], that one can have sexual relations as long as she feels comfortable, that there is no discomfort [after the operation]...there is only a small cut right afterwards.

This description of the operation makes sterilization an appealing option, especially for women who have experienced difficulties or side effects with temporary contraceptives. Neither the promotoras, nor the sterilized women in the community strongly caution potential acceptors about negative after-effects or side effects associated with the operation. Women who have experienced negative physical effects as a result of the operation tend to downplay the significance of these experiences. These women rarely cite their negative experiences as a reason not to recommend the operation to other women.
A possible reason for lack of recognition about negative after-effects of the operation is the fact that many women have become sterilized postpartum or in conjunction with a c-section\textsuperscript{45}. Some women who had this type of joint procedure attribute their physical discomfort more to the childbirth than to the sterilization. In response to my question about her experience of becoming sterilized, one woman replies:

*Bueno* I don’t know how to tell you because I...I basically felt ok.... I had also given birth that day and, well, I felt strange also...like they had done a c-section. It was, well, it was the same.... They, how shall I say...they sterilized me and they did a c-section all at the same time, and I felt, how shall I say...like it was a normal birth...

Other women attribute negative physical effects to individual or anomalous circumstances, and not to fundamental risks associated with the operation. An interesting example of this comes up in a few of the interviews. One woman talks about having her bladder accidentally pierced during her sterilization. A few other respondents recount this woman’s story, but none of them specifically refer to the incident as a disadvantage or a risk of sterilization. One woman shares her views on the matter:

For example, with P- you know that they pierced her bladder, but I say that this is...perhaps carelessness on the part of the doctors.... You can know your profession very well, but anything can happen because we are human.... [Perfection] is Godly and error is human. Anyone can commit an error, *tu entiende*, anyone can make a mistake.

Most respondents imply that the benefits of being sterilized outweigh the possible risks associated with the operation. Respondents generally acknowledge that sterilization is the most effective method of fertility control. One woman illustrates this by talking about the risk of becoming pregnant while using various contraceptive methods:

*Imaginate*... when one goes to the doctor- to the [Health] Center, he/she tells one about all the risks, and with all of the methods there are always women who...out of a hundred [percent] this many can get pregnant...with all of the methods. And with sterilization, no one.

\textsuperscript{45} For more information, see “Historical and Political Influences on Sterilization”
Respondents commonly express the idea that sterilization is *lo unico seguro* (the only sure) method of fertility control. Sterilization is the only method that can free women from the fear of pregnancy.

**Sterilization as freedom from fear of pregnancy and the “tying vs. cutting” model**

Freedom from the fear of pregnancy is clearly a shared desire among these Zona Sur women. Sterilization can offer women this freedom. Respondents seem to understand the permanent nature of sterilization in principle; Women talk about becoming sterilized when they don’t want to have any more children. When asked specifically about the amount of time that sterilization prevents pregnancy, however, many respondents suggest that sterilization is not always permanent.

These Zona Sur women make a false distinction between two different types of sterilization. Respondents distinguish between doctors who *amarrar* (tie) and those who *cortar* (cut) the fallopian tubes. This model for understanding sterilization is similar to the one noted by Lopez (1998) in her study of Puerto Rican women. In contrast to the model described by Lopez, however, the Zona Sur tying vs. cutting model does not offer women a perception of greater agency. These Zona Sur women don’t believe that they have a choice between tying and cutting. Instead, tying is discussed as a worst-case scenario of sorts. Women who want a permanent sterilization must contend with the possibility that they received the semi-permanent operation. One woman discusses the uncertainty of this situation:

> There are a lot of [women] that they [doctors] *amarran*, and after a while they become untied.... They come untied, like when you tie a knot. And after a while that knot comes untied.... It happens just like that, and women say, ‘I came untied,’ and they get pregnant. And [this happens

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46 For more information, see “Sociocultural Influences on Sterilization”
to] many women, oye47 thousands of women, oy Dios mio! I saw this woman who was preparada [sterilized] and she came united and got pregnant.... There are many who last five years [before coming united], but the ones that they [doctors] cortan [sterilized].... After they operate there is no fear that you will get pregnant... as long as they don't tie you, tu entiende?

The tying vs. cutting model is based on pervasive misconceptions that are perpetuated at the community level. In the Zona Sur, the body of misinformation about sterilization also seems to be fed by the promotoras.

Three of the respondents explicitly identify promotoras or charlas (which are typically given by promotoras) as their sources of information about the tying vs. cutting idea. During a number of interviews Ana Silvia, the overseeing promotora engages in discussion with women about this idea. Some women discuss tying vs. cutting independently and look to Ana Silvia for validation, while others are prompted by her to discuss this distinction during the course of their interview.

Medical providers fail to dispel the tying vs. cutting idea in their interactions with these Zona Sur women. Respondents' testimonies verify the pervasive lack of communication between medical providers and sterilization acceptors. Most respondents who have undergone sterilization say that the operation was not fully explained to them by doctors. As a result, they do not know whether they were tied or cut. One woman discusses this problem with me during her interview:

Interviewer: Are you more or less familiar with the operation; Do you know how is it done?
Respondent: no
I: You aren't familiar with the operation?
R: Yes...I have been sterilized.
I: Yes, but you don't know how it [operation] is done, more or less?
R: Eh...they didn't tell me anything.... I went to [a clinic] where they were going to give me [the operation in which] they cut, but she [Ana Silvia] told me that they don't- that they tie.
I: mmhm
R: I don't know if that is true.... A lot of people talk about this...that they don't cut; They tie [fallopian tubes].... I don't know the truth. One has to say something and ask the doctor.

47 Common Dominican expression: oye [listen]
There is a shared body of local knowledge about which type of operation different medical institutions perform. It seems likely that body of knowledge has developed to allay the uncertainty associated with the tying vs. cutting idea. For example, it is generally acknowledged that the hospital cuts and does not tie. Thus, respondents who were sterilized in the hospital state with some confidence that they had their tubes cut.

Despite persisting uncertainties about the permanence of the operation, these women agree that they would only recommend sterilization to a woman once she has had her desired number of children. One woman discusses the need to exercise caution when recommending the operation to another woman:

It [recommendation] depends because if a woman is young, even though she might have a couple of kids, she has to try to use [temporary] contraceptives…. Because no woman knows whether she will decide to have more children after a while, and [if she is sterilized] she won’t be able.

Once a woman has had her desired number of children, however, it is generally acknowledged that she should become sterilized to avoid the risk of pregnancy.

Women should become sterilized after their desired number of children or after a certain age

Respondents talk about two different circumstances under which a woman should make the decision to become sterilized. The first, when she has her desired number of children, is based on personal choice. Respondents stress that only women and their partners can determine the number of children that is appropriate for them. One woman who was sterilized after having four children asserts that it would be wrong for her to tell another woman how many children to have:

I'm not going to tell you that you should have four or five [children] because every person knows
how many children they can have. I can’t tell a woman, “but *morena*⁴⁸ have three [children], have four because I have four”…. The woman and her husband [are the ones who] know how many [children] they can have, *tu me entiende*?

Although these women agree that desired number of children is a personal choice, it seems that a few women’s desires have been shaped by advice from medical providers. One woman talks about her desire to have three children. Later in the interview, when asked whether or not she plans to become sterilized, she replies in the affirmative, “Cuando tenga mis tres hijos, sí” [When I have my three children, yes]. This statement suggests that this woman’s plans are shaped by her reproductive desires. When I ask her why she plans to become sterilized instead of continuing to use a temporary contraceptive, she replies that she can’t have more than three children because her first birth was a c-section.

Clearly, a medical provider’s recommendation has influenced this young woman’s reproductive plans. Her experience calls into question the amount of agency that women actually exercise in planning their own fertility.

A few respondents agree that a woman should decide to become sterilized after she has passed a certain age, regardless of the number of children she has. In contrast to the decision about desired number of children, the age at which a woman should become sterilized is generally defined by a set of social norms.

According to these norms, there is no specific age at which a woman should begin to consider sterilization. However, there is a life stage at which it becomes socially inappropriate for a woman to continue bearing children. One respondent explains that the end of a woman’s childbearing stage begins when her children reach their childbearing stage:

⁴⁸ Common Dominican expression: *morena* [nickname for a dark-haired or dark-skinned woman]
A woman should try to have all of her [children] by a certain age, *tuve*, because once one passes the age of forty, one [should] say, “Ay no! Eso lo solo dejo a mis hijos” [No more! I will leave this (childbearing) to my children]. Because the daughter, *tuve*, is already [seventeen years old], and many [women] have their first child when they are seventeen. So now you often see that the mother is giving birth and the wives of her sons are also giving birth, *tu entiende?* For example, let’s say I have a daughter who is fifteen, and she is also having children...my grandchild and my child [would be] the same age! That is what I’m saying, *tu entiende.* Osea que it wouldn’t look good.... I think that after a certain time- at a certain age a woman should say “Bueno ya! Ya me prepare, ya! Ya tuve mis hijos, ya ya!” [It is time for me to be sterilized. I already had my children, and that is it!]. That way she can pay attention to her grandchild!

Two other women attest to the social appropriateness of becoming sterilized after a certain age. Conversely, a few women mention that it is important for women to wait until they have passed a certain age before becoming sterilized. In other words, it is equally inappropriate for a woman to end her childbearing years prematurely.

These social norms undoubtedly influence women’s decisions regarding childbearing and sterilization. However, respondents who have been sterilized commonly claim that their decision was not based on outside influences.

**Sterilization is a woman’s decision**

Similar to the women in Lopez’s (1998) study population, these Zona Sur women assert their autonomy in the decision sterilization. One woman talks about how she initially encountered resistance from her husband and a female friend or family member. Although this woman clearly listened to their opinions, she says that in the end she decided to become sterilized because she already had three children and did not want any more.

Even when it is clear that external influences are a factor, these women tend to emphasize that the final decision to become sterilized was their own. One woman’s experience exemplifies this tendency. This woman was recently sterilized after having
her fourth child by c-section. She made the decision to have the joint procedure because she neglected to follow through with her plan to be sterilized after birthing both her second and third child:

It is terrible when you have to have two operations because you gave birth with a c-section. Maybe most people, tuve, wait for a little while [after childbirth] and then become sterilized, but I did both things at once to get it over with! Because the problem was that when I had the second [child], someone said to me, “Vete preparate, o con la tercer, no tenga mas muchacho” [Go be sterilized (either now), or after having a third (child). Don’t have any more children]. I made an appointment to be sterilized at the hospital and then I didn’t go because I was afraid.... Then, with the third [child], I had made an appointment, morena, to be sterilized...and I got scared and didn’t go. But... [then] I decided that I couldn’t have any more children...

Given this woman’s initial fear of sterilization and her mention of the advice she received after the birth of her second child, I wonder how much of her decision to become sterilized was based on this advice. I ask her who told her that she shouldn’t have more children. She replies:

¿Quién más que yo? (Who else but myself). Even though my mother fought with me a lot because she doesn’t want [a house] full of children, tu entiendes?

This woman also mentions financial shortages that made it difficult for her to have more children, and the fact that her husband already had two other children from a previous relationship. In the end, though, she says that she was the one who made the decision to stop having children. She recounts her horrible three-day stay in the hospital, during which she suffered a number of negative after-effects of the joint operation:

I was there in that situation [and] I said, “¡Dios a mi! ¿Quién me mandó a mi prepararme?” [Who sent me to be sterilized]. I said, “¡Yo!” [I did].

Despite all of the pressures and difficulties she describes in her testimony, this woman maintains that the decision to become sterilized was her own.

Lopez (1993, 1998) notes that many women view the decision to become sterilized as an act of self-determination and resistance. She asserts that the decision to

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49 For more information, see “Sociocultural Influences on Sterilization”
be sterilized does not free women from the sociocultural constraints on their reproductive control. Rather, when women decide to be sterilized, they are essentially accepting the conditions that have limited their contraceptive alternatives. In Lopez’s words:

...there are elements of resistance in women’s decisions to get sterilized as well as a degree of accommodation. That is, women resist to the degree that they can and also acquiesce to the multiple forces constraining their options. [Lopez 1998:249]

When women become sterilized because of a lack of options, they perpetuate the cycle of constraint that led them to become sterilized. By “acquiescing” to existing constraints, they fail to set a precedent for other women to exercise greater agency in their reproductive and contraceptive decisions. Without a proven cultural model of resistance, other women are more vulnerable to the constraints that frequently lead them to become sterilized. Thus, high rates of sterilization are perpetuated at the local level, and this maintains high rates of sterilization throughout the nation and the region.
Conclusion ~ Promoting Agency

The Consequences of Constraint:

Given the commonality of sterilization, it is important to consider whether or not women suffer negative after-effects as a result of their decision to become sterilized. Researchers tend to focus on regret as a possible consequence of sterilization. Studies of sterilization regret are usually inconclusive, however, and attempts to compare study data are confounded by lack of a standardized measure of regret.

Risk of regret seems to be based on a number of factors, including age, parity, divorce rate, infant mortality, quality of family planning services, and economic circumstances. There is a general among researchers that the risk of regret is higher when women are sterilized at a young age or have less than their desired number of children. Women who experience pressure or coercion to become sterilized, have not used other forms of contraception prior to having the operation, or do not understand the permanence of the operation also tend to experience a higher incidence of regret. The experience of regret can range from feelings of sadness and loss to prolonged depression. [Hartmann 1987, Henderson 1976, Landry 1990, Lin et al. 1996, Loaiza 1995, Lopez 1998, Philliber and Philliber 1985, Ramirez de Arellano and Seipp 1983, Veira 1996]

Based on these findings, it seems that regret is related to constraint. According to Lopez, “regret is a barometer of the constraints and social coercion involved in the decision-making process” (1998:256). In situations where women’s decision-making power and options are restricted, risk of regret is higher. A woman’s decision to become sterilized is not truly an exercise of agency unless she has access to a range of reproductive and contraceptive options, and the power to make choices that are
appropriate for her. If the decision to become sterilized is made in this context, sterilization can have a positive impact on a woman's life.

It is difficult to understand how these multilevel factors interact to influence women's knowledge, power and choice. It is even harder to untangle agency and constraint from the complex interactions that determine women's reproductive and contraceptive decisions. One cannot assume that the decision to become sterilized is always related to constraint. Lopez explains:

Sterilization may give one woman freedom, but be oppressive to another. A woman may perceive sterilization as empowering at one point in her life because it gives her a degree of independence, but at another point in time she may perceive it as oppressive. [Lopez 1998:257]

Thus, it is important to understand the ways in which constraint influences knowledge, power and choice in a community of women. By recognizing the types of constraint that pertain to these women's fertility and contraceptive use, it is possible to identify avenues through which to promote agency.

Empowering Knowledge in the Zona Sur

The Zona Sur's unique health infrastructure offers a promising opportunity to promote agency. I believe that Zona Sur women's knowledge, power and choice are largely constrained by a lack of access to accurate and culturally relevant forms of information about fertility, contraceptive use and sterilization. Information about these subjects exists in a hierarchical form, which privileges medical providers as authorities. This hierarchy of knowledge is perpetuated by a lack of communication between women and health providers, and the pervasive misconceptions that exist at the community level.

I believe that promotoras in the Zona Sur are the key to shifting the knowledge hierarchy. Promotoras are in a position to bridge the gap between medical and local
knowledge. They can serve as agents to make accurate knowledge about fertility, contraceptive use and sterilization accessible to women in a culturally relevant form.

It is important to ensure that promotoras do not become another mechanism by which knowledge is privileged in the Zona Sur. It is also essential that promotoras have access to medically accurate information so that they don’t continue to be a source of misinformation in the community.

Promotoras can help to make local knowledge an authoritative source of information for women in the Zona Sur. They can counter the constraints that have historically limited women’s knowledge and power by working to empower local knowledge. I believe that empowering local knowledge is a promising way to promote women’s agency in the Zona Sur.
Appendix A:

Research Documents
Gracias por su participación en esta entrevista. Tengo interés en aprender más sobre sus ideas con respecto a la reproducción, y al control de la natalidad. También quiero saber de sus experiencias con algunos anticonceptivos.

Thank you for agreeing to participate in this interview. I am interested in learning about your ideas regarding reproduction, and family planning/birth control, and your experiences with some methods of family planning/birth control.

1) ¿Cree ud. que hay un numero preferido de hijos para las mujeres en la República Dominicana? ¿Cuántos?
   - ¿Cuántos hijos quiere Ud.? ¿Por qué quiere Ud. ese numero de hijos?
   First, I'd like to know what you think is a preferred number of children for a woman in the Dominican Republic to have in her family.
   - How many children would you like to have in your family? What are some of the reasons why you would like to have this many children in your family?

2) ¿Cuáles anticonceptivos y métodos de planificación familiar conoce Ud.?
   - ¿Dónde aprendió Ud. de esos anticonceptivos y métodos de planificación familiar, y quién le dio esa información?
   Can you please list all of the methods of family planning/birth control that you know about/have heard of.
   - Where, and from whom did you hear about these methods?

Possible probing questions:

¿Ha recibido algún tipo de información sobre los anticonceptivos o los métodos de planificación familiar de...? ¿Qué tipo de información ha recibido de estos fuentes?
   - miembros de su familia
   - amigos o otras personas conocidas que no son parte de su familia
   - los médicos, las enfermeras, o otras personas que trabajan en un hospital o en una clínica
   - promotores de salud, o otras personas que trabajan en la comunidad
   - maestras
   - los anuncios o algunos programas en la televisión
   - otras fuente de información

What kind of information, if any, have you received about family planning/birth control from the following?
   - Family/relatives
   - Friends or other non-familial acquaintances
   - Doctors, nurses, or other health workers in a hospital or clinic
Entrevista #

-Health educators in the community (such as health promoters)
-Teachers in school
-Commercials or advertisements
-Other

3) ¿Cuáles anticonceptivos o métodos de planificación familiar Ud. ha tratado de usar?
   - ¿Cuántos años tenía Ud. (aproximadamente) cuando trató de usar por primera vez un anticonceptivo o método de planificación familiar?
   - Entre los anticonceptivos/métodos de planificación familiar que Ud. ha tratado de usar, ¿cuál es el más preferido, cuál es el menos, y por qué?

Which methods of family planning/birth control have you ever tried to use?
- At what age (approximately) did you first try to use a method of family planning/birth control?
- Which of the methods that you have tried to use do you most prefer? Why?

Quiero saber un poco más de sus experiencias con los anticonceptivos y los métodos de planificación familiar que Ud. ha tratado de usar.
I'd like to know a little more about your experiences with the family planning/birth control methods that you have tried to use.

4) ¿Por qué decidió Ud. usar (method)?
   What were some of the reasons that you decided to use (method)?

5) ¿Cómo obtuvo Ud. este anticonceptivo?
   Please describe the experience you had obtaining (method)

   Possible probing questions:

   ¿Fue fácil o difícil obtener (method)?
   ¿Dónde lo obtuvo?
   ¿Cuánto costaba- fue barato, caro, o precio razonable?
   Was it easy or difficult to obtain (method)?
   Where did you obtain (method)?
   What was the cost of (method)- low, medium, high?

6) Por favor, describame cuál fue su experiencia al usar (method)
   - ¿Por cuánto tiempo usaba Ud. (method)?
   - (Si no está usando ahora) ¿Por qué decidió Ud. dejar de usar (method)?

   Please describe the experience you had using (method)
   - For how long did you use (method)?
   - (If no longer using method) What were some of the reasons you decided to stop using (method)?
Possible probing questions:

¿Fue fácil o difícil usar (method)?
¿Cuáles eran las ventajas y desventajas?
¿Prevenía bastante bien el embarazo? ¿Había algunos problemas con el anticonceptivo respecto a la prevención del embarazo?
Was (method) easy or difficult to use?
What were some of the benefits of using (method)? What were some of the drawbacks?
Did (method) work well as a way to prevent pregnancy? Did you have any problems with (method) as a way to prevent pregnancy?

8) ¿Recomendaría Ud. (method) para una amiga o para una mujer en su familia? ¿Por qué?
Would you recommend (method) to a friend or family member? Why or why not?

Ahora quiero hablar específicamente sobre el método de planificación familiar llamada “la operación para preparar a la mujer.”
Now I would like to talk to you specifically about the family planning/birth control method known as “preparación para la mujer”

7) ¿Conoce Ud. el método de planificación familiar llamada “la operación para preparar a la mujer”?
Have you ever heard of the method of family planning/birth control known as “preparación para la mujer”?

8) ¿Qué Ud. entiende por “operación para preparar a la mujer”? 
Please describe to me what you know about preparación para la mujer

Possible probing questions:

¿Cómo hacen la operación para preparar a la mujer?
¿Por cuánto tiempo previene el embarazo?
¿Es fácil o difícil la operación?
How does a woman become sterilized?
For how long does sterilization prevent pregnancy?
Is it easy or difficult for a woman to become sterilized?

9) ¿Fue Ud. operada para no concebir/tener más hijos? 
Are you preparada?
If yes, ask questions 10-13; If no, ask questions 14-18

10) ¿Cuántos años tenía Ud. cuando le hicieron la operación?
How old were you when you became preparada?

11) ¿Por qué decidió Ud. hacerse la operación para no concebir/tener más hijos?
Entrevista #__________

What were some of the reasons that you decided to become preparada?

Possible probing questions:
¿Cómo influyeron las cosas siguientes a su decisión de hacerse la operación para no concebir/tener más hijos?

i. Su numero preferido de hijos
ii. El numero de hijos preferido por su novio/marido
iii. El costo de tener más hijos
iv. La dificultad de cuidar más hijos
v. El consejo de una amiga u una mujer en su familia quien está preparada (se ha hecho la operación)
vi. La recomendación de un médico, una enfermera, o otra persona quien trabaja en un hospital o en una clínica
vii. La recomendación de una promotora de salud u otra persona en la comunidad
viii. La dificultad de obtener otros anticonceptivos/métodos de planificación familiar
ix. El costo de otros anticonceptivos/métodos de planificación familiar
x. La dificultad de usar otros anticonceptivos/métodos de planificación familiar
xi. Si no le gusta otros anticonceptivos/métodos de planificación familiar
xii. La aceptación de su novio/marido a otros anticonceptivos/métodos de planificación familiar
xiii. Los otros anticonceptivos/métodos de planificación familiar no previenen bastante bien el embarazo
xiv. Ud. tiene que trabajar o asistir a un programa educativo fuera de la casa
xv. Otra razón

How, if at all, did the following factors affect your decision to become preparada?

i. Your preferred number of children
ii. Your partner’s preferred number of children
iii. The cost of having more children
iv. The difficulty of caring for more children
v. Advice from a friend or family member who was preparada
vi. The recommendation of a doctor, nurse, or other health worker in a hospital or clinic
vii. The recommendation of a health worker in the community
viii. Difficulty obtaining other methods of family planning/birth control
ix. The cost of other methods of family planning/birth control
x. Difficulty using other methods of family planning/birth control
xi. Your dislike of other methods of family planning/birth control
xii. Your partner’s dislike of other methods of family planning/birth control
Entrevista #

xiii. Other family planning/birth control methods’ ineffectiveness at preventing pregnancy
xv. Work or school outside the home
xv. Other

12) Por favor, describame cual fue su experiencia al hacerse la operación para no concebir/tener más hijos?
- ¿Cómo ha cambiado su estilo de vida después de la operación?
Please describe the experience you had with becoming preparada
- Please describe the experience of being preparada

Possible probing questions:

¿Cómo fue la operación?
¿Cuáles son algunas ventajas y desventajas de estar preparada?
¿Ha tenido algunos problemas como consecuencia de haberse hecho la operación para no concebir/tener más hijos?
What was the operation like?
What have been some benefits of being preparada? What have been some drawbacks?
Have you had any problems as a result of being preparada?

13) ¿Cómo se siente Ud. sobre su decisión de hacerse la operación?
- ¿Recomendaría la operación para una amiga o para una mujer en su familia?
- Si pudiera Ud. deshacer la operación, lo haría?
How do you feel about your decision to become preparada?
- Would you recommend preparación para la mujer to a friend or a family member?
- If you could reverse the operation, would you?

14) Por favor, digame, ¿Qué opina Ud. sobre la operación como un anticonceptivo/método de planificación familiar?

Please describe to me what you think of preparación para la mujer as a method of family planning/birth control

15) ¿Conoce Ud. una mujer quien se ha hecho la operación?
- ¿Qué le han dicho a Ud. sobre la operación?
Do you know anyone that is preparada?
- What are some of the things they have told you about preparación para la mujer?

16) En su opinión, ¿Por qué decidiría una mujer hacerse la operación?
Entrevista 

What do you think are some of the reasons that a woman might choose to become preparada?

17) ¿Cuáles son algunos riesgos de hacerse la operación? What are some of the risks of becoming preparada?

18) ¿Piensa Ud. en hacerse la operación? ¿Por qué? Do you ever plan on becoming preparada? Why or why not?

Quiero saber un poquito más sobre su vida ahora. Tengo algunas preguntas básicas para Ud.

Now, I would like to know a little more about your current situation. I have a few more basic questions that I would like to ask you.

1) ¿Cuántos años tiene Ud.? What is your current age?

2) ¿Cuántos hijos biológicos Ud. ha tenido, y cuantos están vivos? a. ¿Cuántos años tenía cuando dio a luz por primera vez? How many living, biological children do you have? a. At what age (approximately) did you give birth to your first child?

3) ¿Cuántos niños tienen menos de 18 años y están viviendo en su casa en este momento? How many children under the age of 18 are currently living in your household?

4) ¿Quién tiene la responsabilidad de cuidar los niños en su casa? Who is responsible for caring for the children living in your household on a regular basis (at least four days a week)? (list all household members that apply)

5) ¿Tiene Ud. alguna pareja en este momento? a. ¿Es Ud. casada? b. ¿Cuántos años tenía (aproximadamente) cuando tuvo su primera pareja? Are you currently involved in a sexual relationship? c. Are you married? d. At what age (approximately) did you become involved in your first sexual relationship?

6) ¿Está Ud. trabajando o asistiendo a un programa educativo fuera de la casa con regularidad? Are you currently working or regularly attending school outside of the house?
Entrevista #

_Esto concluye la entrevista. Muchas gracias por hablar conmigo hoy. Si Ud. tiene algo más que quiere decir sobre los anticonceptivos o de la planificación familiar, por favor digamelo ahora. También, Ud. puede hacer preguntas y comentarios ahora, si quiere._

That concludes the interview. Thank you very much for speaking with me today. At this time, please add anything else that you would like to mention about family planning/birth control or reproduction. Also, feel free to ask any questions, or make any comments about the interview.
Document 2.1: Consent Form (English)

University of Pennsylvania

Mara Saunders, Health and Societies- Principal Investigator
Fran Barg, PhD Anthropology- Faculty Advisor
Day Telephone Number: (local phone number)
24-Hour Emergency Number: (215) 662-6059
(Ask for Dept. Resident on Call)

Reproduction and Family Planning/Birth Control in the Dominican Republic
Consent Form

Invitation to Participate and Study Purpose
You are being asked to participate in an interview, as part of research study, because I am interested in learning more about the perceptions, beliefs, and experiences that women in your community have regarding reproduction and family planning/birth control. Your participation in this research study will help me to learn more about what it is like to be an adult woman in your community, so that I can work with health promoters and other health workers in the community can design better programs and charlas for you.

Decision to Participate and Procedures
Your participation in this interview is completely voluntary, and you are free to refuse participation. Some of the questions in this interview may seem personal, or may deal with sensitive issues. If you feel uncomfortable, you may choose to stop the interview at any point. If you decide to stop the interview, you may request that none of the answers you provided be used in the research study. There will be no cost to you for participating in this research study, nor will there be any financial compensation or direct benefits to you for your participation.

If you agree to participate in this research study, you will be asked to sit with a health promoter and myself, either in your house, or in another nearby location of your choice, for approximately half an hour, and answer a series of interview questions. The questions will ask you about your own perceptions, beliefs, and experiences regarding reproduction and family planning/birth control. After the interview, you will have an opportunity to ask any questions, and make any comments about the research study or the interview.

I will be using an audio voice recorder to make a tape of the interview. The health promoter and myself may also take notes during the interview. After the interview, the audiotape will be transcribed for use in the research study. The audiotape and the transcription of your interview will not be accessible to anyone, other than the project staff. No one will know which answers you, as an individual, provided. After the interview, you will not be asked to participate in any further activities related to this research study. If you have any questions or concerns regarding the research study, you may call Mara Saunders, Principal Investigator, at (local number), or Ana Silvia Peralta, health promoter, at (809) 582-3785. To report any complications or problems that arise
as a result of this study, please call the University of Pennsylvania's 24-hour emergency contact number for research subjects, at (215) 662-6059, or the University's Director of Regulatory Affairs, at (215) 898-2614.

Thank you for your help.

Participant's Authorization

I agree to participate in an interview for the research study described above. I understand that my participation in this interview is completely voluntary, that I may choose to discontinue my participation at any point, and that, after the completion of this interview, I will not be asked to participate in any further activities related to this study. I understand that my answers to all questions will be kept confidential. I understand that I will not receive any form of compensation for my participation in this research study. I have had the opportunity to ask questions regarding my participation in this study, and I have been provided with contact numbers to call in the event that any questions or problems arise as a result of this study.

(All participants will be provided with a copy of this consent form, subsequent to its completion)

Name of participant __________________ Signature of participant __________________ Date __________________

Name of person obtaining consent __________________ Signature of person obtaining consent __________________ Date __________________

(If necessary)

Name of witness to participant mark or consent __________________ Signature of witness to participant mark or consent __________________ Date __________________
Document 2.2: Consent Form (Spanish)

Universidad de Pensilvania

Mara Saunders, Salud y Sociedad- Investigadora Principal
Fran Barg, PhD Antropología- Directora

La Reproducción y la Planificación Familiar en la República Dominicana
Forma de Autorización

Invitación a Participar y el Propósito del Trabajo de Invesitgación
Me interesa saber más de las percepciones, creencias, y experiencias de las mujeres en su comunidad, con respecto a la reproducción y a la planificación familiar. Como parte de mis esfuerzos, estoy entrevistando a mujeres que viven en la Zona Sur. Quiero entrevistarte a Ud. Hoy. Su participación en este entrevista me ayudará a entender mejor las vidas de las mujeres en la Zona Sur, para que pueda trabajar con los promotores de salud aquí en la comunidad a desarrollar charlas y programas educativos para Uds.

La Decisión a Participar y la Entrevista
Su participación en este entrevista es completamente voluntaria, y tiene la alternativa de no participar. También se puede negar a responder a cualquiera pregunta que Ud. desee. Algunas de las preguntas se tratan de asuntos personales. Si Ud. Quiere dejar de participar durante la entrevista, solo tiene que avisarme. Si Ud. decide dejar de participar, también puede decirme si no quiere que yo use sus respuestas en el trabajo. Si Ud. me de la autorización para hacer la entrevista, vamos a sentarnos en su casa, o donde quiera, por aproximadamente media hora para completarla. Las preguntas en la entrevista se tratan de la reproducción y de la planificación familiar. Después de la entrevista, Ud. va a tener la oportunidad de hacer preguntas o comentarios sobre la entrevista o el trabajo.

Voy a hacer una grabación de la entrevista. También voy a escribir apuntes durante la entrevista. Nadie, aparte de la directora del trabajo y yo, va a tener acceso a las cintas, ni a los apuntes. Nadie va a saber cuales respuestas fueron suyos. Después de la entrevista, no voy a pedirle a Ud. que participe en ninguna otra actividad. Si Ud. tiene alguna pregunta o preocupación sobre el trabajo, se puede llamar por teléfono a:
Mara Saunders, Investigadora Principal a 581-1265,
a Ana Silvia Peralta, promotora de la salud, 582-3785
o, en caso de urgencia a la Universidad de Pensilvania a (215) 662-6059

Gracias por su ayuda.
Autorización de la Participante

Yo le da mi autorización a participar en este trabajo de investigación. Yo entiendo que puedo negarme a participar en este trabajo y que puedo retractar mi autorización y descontinuar mi participación sin penalidad alguna.

Yo entiendo que la investigadora hará todo lo posible para que toda la información recolectada en este entrevista se mantenga de manera estrictamente confidencial. Si se produce presentaciones o alguna publicación como parte de esta investigación, no seré identificada por nombre.

Yo entiendo y estoy de acuerdo con la información previamente mencionada. He tenido la oportunidad de hacerle preguntas a la Investigadora Principal y a la Promotora de la Salud. También tengo los números de teléfono para llamar si tengo algunos problemas o preguntas como resultado de este trabajo de investigación.

<table>
<thead>
<tr>
<th>Nombre de la participante</th>
<th>Firma de la participante</th>
<th>Fecha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre de la investigadora</td>
<td>Firma de la investigadora</td>
<td>Fecha</td>
</tr>
<tr>
<td>Nombre del testigo (Promotora de la salud)</td>
<td>Firma del testigo</td>
<td>Fecha</td>
</tr>
</tbody>
</table>
Appendix B:

Data Tables
Figure 1.1: Respondents’ Age, Fertility and Contraceptive Use

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
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<tbody>
<tr>
<td>Current age</td>
<td>35</td>
<td>33</td>
<td>34</td>
<td>25</td>
<td>31</td>
<td>51</td>
<td>35</td>
<td>32</td>
<td>47</td>
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<td>16</td>
</tr>
<tr>
<td>Age at first sexual</td>
<td>28</td>
<td>~27</td>
<td>17</td>
<td>20</td>
<td>19</td>
<td>X</td>
<td>23</td>
<td>18</td>
<td>23</td>
<td>18</td>
<td>13</td>
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<td>relationship</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at first birth</td>
<td>29</td>
<td>26-27</td>
<td>20-21</td>
<td>21</td>
<td>20</td>
<td>21</td>
<td>24</td>
<td>19</td>
<td>24</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Age at first contraceptive use</td>
<td>30</td>
<td>X</td>
<td>17</td>
<td>20</td>
<td>NA</td>
<td>36</td>
<td>X</td>
<td>20</td>
<td>25</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>Number of children</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Age at sterilization</td>
<td>NA</td>
<td>32</td>
<td>34</td>
<td>NA</td>
<td>~26</td>
<td>NA</td>
<td>NA</td>
<td>X</td>
<td>30+</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

~ = approximate age  
X = information not available  
NA = Respondent has not used method

Figure 1.2: Average Number of Children by Age Group in the Zona Sur

<table>
<thead>
<tr>
<th>Age Group</th>
<th>15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>40-70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of children</td>
<td>1.33</td>
<td>1.63</td>
<td>2.52</td>
<td>3.33</td>
<td>3.5</td>
<td>2.5</td>
<td>5.6</td>
</tr>
</tbody>
</table>

N=113

*Data from Fujioka (2002)

Figure 1.3: Respondents’ Childcare Responsibilities

| Number of children under the age of 18 who are currently living in respondent's house (average) | 2.64 |
| Number of respondents who are sole caretakers | 5 |
| Number of respondents who receive help from family members | 5 |
| Number of respondents who share caretaking responsibility with hired helper | 1 |

N=11

Figure 1.4: Primary Caretakers in the Zona Sur

<table>
<thead>
<tr>
<th>Number of female caretakers</th>
<th>Number of male caretakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>3</td>
</tr>
</tbody>
</table>

N=113

*Data from Fujioka (2002)
Figure 2.1: Respondents’ Contraceptive Knowledge and Use

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of women who know of contraceptive method</th>
<th>Number of women who have used contraceptive method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth control pill</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Subdermal contraceptive implant</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Intrauterine device (IUD)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Contraceptive injection</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Contraceptive foam</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Condom</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

N=11

Figure 2.2: Contraceptive Knowledge and Use in the Zona Sur

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage of women who know of contraceptive method</th>
<th>Percentage of women who have used contraceptive method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth control pill</td>
<td>84.5</td>
<td>40.7</td>
</tr>
<tr>
<td>Subdermal contraceptive implant</td>
<td>50</td>
<td>3.4</td>
</tr>
<tr>
<td>Intrauterine device (IUD)</td>
<td>4.5</td>
<td>0</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>34.5</td>
<td>49.2</td>
</tr>
<tr>
<td>Contraceptive injection</td>
<td>46.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Contraceptive foam</td>
<td>5.5</td>
<td>0</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>8.2</td>
<td>0</td>
</tr>
<tr>
<td>Condom</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

N=113

*Data from Fujioka (2002)

Figure 2.3: Zona Sur Contraceptive Use by Age Group in the Zona Sur

<table>
<thead>
<tr>
<th>Age Group</th>
<th>15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>40-70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of contraceptive users in age group</td>
<td>33.3</td>
<td>48.7</td>
<td>81.8</td>
<td>58.3</td>
<td>70</td>
<td>50</td>
<td>26.3</td>
</tr>
</tbody>
</table>

N=113

*Data from Fujioka (2002)
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