



Access to tubal ligation: An analysis of women's trajectories and experiences in the public health subsector of Santa Rosa, La Pampa, Argentina

Acceso a ligadura tubaria: análisis de las trayectorias y experiencias de las mujeres en el subsector público de salud de la ciudad de Santa Rosa, La Pampa, Argentina

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ABSTRACT Tubal ligation access in the province of La Pampa is regulated by Provincial Law 2079 and National Law 26130. Although the only legal requirements are to be over 16 years of age and to sign an informed consent form, in practice there are barriers stemming from institutionalized heteronormativity. This normative framework privileges certain profiles of women while resisting the procedure for others, despite their status as rights-holders. This study aims to describe and analyze the trajectories and experiences of women who requested a tubal ligation — whether or not they ultimately obtained the procedure — in the public health subsector of the city of Santa Rosa, La Pampa. The research adopts a qualitative theoretical-methodological approach based on grounded theory. A total of 18 in-depth interviews were conducted between 2022 and 2023. The findings reveal the effects of the social valuation of motherhood within health services, which places women in a subordinate position regarding their autonomy and their right to make decisions about their reproductive functions in the face of medical authority.

KEYWORDS Reproductive Rights; Tubal Ligation; Accessibility to Health Services; Gender; Argentina.

RESUMEN El acceso a ligadura tubaria se encuentra regulado en la provincia de La Pampa por la Ley Provincial 2079 y la Ley Nacional 26130 y, si bien el único requisito legal es ser mayor a 16 años y la firma de un consentimiento informado, en la práctica se evidencian barreras derivadas de una heteronormatividad institucionalizada, que privilegia algunos perfiles de mujeres, mientras se mantienen resistencias a realizarla a todas las solicitantes en tanto titulares de derecho. Este estudio se propone describir y analizar las trayectorias y experiencias de las mujeres que solicitaron una ligadura tubaria —accedieran o no a su realización— en el subsector público de salud de la ciudad de Santa Rosa, La Pampa, a través de un enfoque teórico-metodológico cualitativo basado en la teoría fundamentada. Se realizaron 18 entrevistas en profundidad durante 2022 y 2023. Los resultados muestran los efectos de la valoración social de la maternidad en los servicios de salud, que sitúa a las mujeres en posición de subordinación de su autonomía en tanto derecho a tomar decisiones sobre sus funciones reproductivas frente al poder médico.

PALABRAS CLAVES Derechos Reproductivos; Ligadura Tubaria; Accesibilidad a los Servicios de Salud; Género; Argentina.

INTRODUCTION

Access to tubal ligation falls within the broader context of the recognition of sexual and reproductive rights, an area in which the province of La Pampa has been a pioneer. It was the first province to enact a law on reproductive rights⁽¹⁾ and also preceded national legislation in establishing the right to surgical contraception. In 2003, it passed Law 2079 on the Practice of Health Activities,⁽²⁾ which included tubal ligation in Article 17 as a human right and, therefore, a responsibility of the State.⁽³⁾

At the national level, the enactment of Law 26130 on Surgical Contraception⁽⁴⁾ in 2006 marked the beginning of a series of public policies aimed at ensuring access to the procedure. In this context, the Ministry of Health published a guideline on tubal ligation in 2008, standardizing its contents to provide health professionals with clear directives regarding the procedure. The only requirements stated to access the practice are the signing of an informed consent form and having reached the age of majority, which, following the 2015 amendments to the Civil and Commercial Code, was set at 16 years of age. Furthermore, the guideline explicitly states that, as this is a personal decision, spousal or partner consent and judicial authorization are not required, except in cases involving individuals declared legally incapable, a provision that was amended in 2021 by Law 27655, which enabled people with disabilities to provide consent.

However, the available evidence consistently points to the existence of accessibility barriers rooted in institutionalized heteronormativity,⁽⁵⁾ which manifests in gender biases associated with femininity and motherhood. These biases favor certain profiles of women – particularly those who are perceived to have “fulfilled” the role of motherhood and have multiple children –⁽⁶⁾ while institutional resistance persists against providing the procedure to all women who request it, despite their legal entitlement to it as rights holders.⁽⁷⁾ Along these lines, a 2010 report by the National Consortium for Reproductive and Sexual Rights (CoNDeRS),⁽⁸⁾ which included La Pampa in its monitoring, identified power dynamics within the medical consultation space as key obstacles. These dynamics limit or prevent women’s autonomous decision-making by imposing informal requirements, such as minimum age or a certain number of children. Another study conducted in the Autonomous City of Buenos Aires,⁽⁹⁾ which analyzed public complaints submitted to the Office of the Ombudsperson regarding access to tubal ligation, underscores the need for justification imposed on women, primarily due to pre-existing or pregnancy-related physical conditions, high-risk obstetric histories, and, to a lesser extent, economic hardship as a reason to limit family size.

This study draws on the conceptual frameworks of experiences and trajectories, understood as singular

ways of navigating social space, shaped by the dispositions of the *habitus*,⁽¹⁰⁾ to analyze access to tubal ligation from the perspective of women who choose to undergo the procedure. It adopts a relational gender approach,⁽¹¹⁾ which, when applied to health-related phenomena, sheds light on how the social valorization of motherhood places women in subordinate positions. Because tubal ligation is an irreversible contraceptive method, it poses a significant challenge to hegemonic heteronormativity, which privileges reproductive heterosexuality over other non-reproductive expressions of sexuality. This normative framework, embedded in health institutions, becomes a decisive factor in shaping the limits and possibilities of access to tubal ligation.

According to Castro and López Gómez,⁽¹²⁾ this somewhat “pedagogical” role assumed by health professionals stems from the professional autonomy prevalent in the medical field, where scientific-technical knowledge intersects with cultural and moral authority, and where external regulation based on norms and consensus is virtually absent. Revisiting the concept of *habitus*, the agent of practice is culturally reproduced as a subject of their profession, legitimizing ideological or religious assessments about women as if they were technical judgments. These assessments operate as moral evaluations which, when intertwined with clinical judgment, result in care decisions that reflect a “slippage” from a technical-scientific approach to one that is personal and moral in nature.

More than fifteen years after the law was enacted, the lack of knowledge about how users of public health services in the province of La Pampa experience barriers to accessing this right – and the impact this has on their overall health and reproductive decisions – continues to obscure the challenges they face in fully exercising their reproductive rights. The general objective of this study was to describe and analyze the trajectories and experiences of women who requested a tubal ligation – whether or not they ultimately underwent the procedure – within the public health subsector of the city of Santa Rosa between 2010 and 2020 (a period that ended when surgical appointments were suspended due to the onset of the COVID-19 pandemic). Using a qualitative theoretical-methodological approach, the study aimed to recover women’s perspectives on the accessibility of this right, explore how they experienced the process, and identify the barriers and/or facilitators they encountered, in order to contribute with evidence for the design of public policies that guarantee access.

MATERIALS AND METHODS

The study was conducted using a qualitative theoretical-methodological approach, with a flexible design based on grounded theory methodology.⁽¹³⁾ The units of analysis were women who requested a tubal ligation

in the public health subsector of the city of Santa Rosa, province of La Pampa, between 2010 and 2020. The sample included women aged 18 to 45, regardless of whether or not they ultimately underwent the procedure. Exclusion criteria included women who made the request outside the defined time period, those who accessed tubal ligation through the private health subsector, and –for ethical reasons– women who were under the medical care of the researcher.

The study setting was the city of Santa Rosa, whose public health network consists of 13 primary health care centers (comprising the Programmatic Area of Santa Rosa), the “Evita” Community Hospital, which provides outpatient care, and the “Dr. Lucio Molas” Hospital, the only facility equipped to perform the surgical procedure.

Fieldwork was conducted between December 2022 and October 2023. A theoretical sampling strategy was employed, following the principles of theoretical purpose and relevance. Participant selection was non-probabilistic and intentional, continuing until theoretical saturation of the study's dimensions was reached. A snowball sampling technique⁽¹⁴⁾ was used, beginning with contacts within women's networks. Initial contacts were established through various community and social organizations with whom the researcher had established relationships of trust, including the Villa Germinal Breakfast Center, the Network of Health Professionals for the Right to Decide, the feminist collective *Todas Somos Andrea*, and the Fuerza Joven Soup Kitchen in Villa Parque. These organizations facilitated additional contacts with women from different geographic areas of the city. Among the main challenges to participation were the caregiving responsibilities of the women contacted, and to a lesser extent, work-related constraints that required the researcher to offer flexible scheduling.

For data collection, in-depth interviews were conducted to reconstruct women's trajectories and understand their experiences. This qualitative technique fosters dialogue with participants to explore their universe of meanings.⁽¹⁵⁾ At the beginning of each interview, a short questionnaire was completed to gather sociodemographic information. The following variables were considered: age, relationship status, educational attainment (highest level completed), employment situation (formal/informal-unemployed), reproductive history (pregnancies, abortions, vaginal deliveries, cesarean sections), and type of health coverage (public, social security, or private insurance).

Although the interview guide served as a general framework, the discussion was organized around four main themes: the processes of information-seeking, motivations, and decision-making (including reasons for seeking tubal ligation, access to information, and support received in the decision); the medical trajectory

and the role of the health care team (consultation sites and responses from health professionals); perceived barriers and facilitators throughout the process; and life after undergoing or not undergoing tubal ligation, considering physical, sexual, emotional, and social dimensions in order to assess the impact of access or lack thereof.

A total of 18 interviews were conducted. These took place in various settings, including public health facilities within the Santa Rosa Programmatic Area, participants' homes, and community spaces such as the aforementioned soup kitchens and breakfast centers. In all cases, the purpose and scope of the study were explained to the participants, and informed consent was obtained. The average duration of the interviews was 40 minutes. Interviews were audio-recorded with participants' authorization. Both the research project and the informed consent form were reviewed and approved by the Provincial Bioethics Council of the Ministry of Health of La Pampa. To preserve participants' anonymity, pseudonyms are used in the presentation of results.

Given the qualitative nature of the approach, data processing was carried out concurrently with fieldwork. The interviews were transcribed, forming the empirical corpus upon which content analysis was conducted, structured in the following stages: an individual analysis of each interview to reconstruct the case (horizontal dimension), followed by manual coding using a chart to develop emerging categories. For the comparative analysis (vertical dimension), the constant comparative method⁽¹³⁾ was employed. Two matrices were constructed, one based on the initial questionnaire and the other on the emerging categories from the interviews. This process made it possible to identify both the shared patterns and the unique characteristics of women's trajectories and experiences, and to develop new analytical categories and properties. Finally, the results were progressively integrated with the study's theoretical framework for the final analysis.

Given the researcher's ties to the field of study, the process required continuous methodological reflexivity,⁽¹⁶⁾ involving a critical awareness of the effects arising from that positionality.

RESULTS

The sample consisted of 18 women from various geographic areas of the city of Santa Rosa. Participants' ages ranged from 29 to 45, with an average age of 36. With the exception of one participant, all women were either unemployed or working in the informal sector; in two cases, they received a state pension for mothers of seven or more children. Only three women were single

at the time of the interview, while the others were cohabiting with a partner.

In terms of educational attainment, the majority (15 women) had completed primary education and started secondary school but were unable to finish it. One participant had completed secondary school, and two had not completed primary education.

Regarding their reproductive histories, all participants had children, with the number of pregnancies ranging from three (in two cases) to eight (in two other cases). On average, participants had between four and five pregnancies, including births, cesarean sections, and abortions. All of the women received care exclusively through the public health subsector and did not have any social security or private health insurance coverage.

Although the women's narratives reveal various points of contact with health services throughout the period under study, two distinct types of trajectories can be identified:

- 1) Women who requested tubal ligation during their first or second pregnancy, without medical complications affecting the gestation, and who encountered difficulties or barriers in accessing the procedure. This group includes 12 women –some of whom ultimately accessed the procedure after navigating a “series of obstacles,” while others were never able to do so. These women were categorized under Trajectory 1 (T1).
- 2) Women whose access to tubal ligation was guaranteed due to multiparity and/or the presence of pre-existing or pregnancy-related health risk factors, and who did not experience barriers to the procedure. This group includes six women and was categorized as Trajectory 2 (T2).

These trajectories are described using the following analytical categories:

- 1) Decision-making process
- 2) Access pathways
- 3) Access to information
- 4) Perceptions of the process
- 5) Impact of access or lack thereof

Decision-Making Process

In analyzing the decision to request a tubal ligation, three aspects were considered: the motivations behind the request, the role of the partner or other affective relationships, and the influence of health professionals.

Regarding motivations, the primary reason cited by women for wanting to undergo the procedure was the overwhelming burden of care associated with mother-

hood. The lack of support networks for child-rearing, the experience of paternal absence during pregnancy, and the uneven distribution of caregiving responsibilities during early childhood were described as distressing situations that shaped a shared feeling of not wanting to become mothers again. Some illustrative statements include:

“It takes time to raise a child, feed them, take care of them, it all takes time, and you have to take care of one baby and then another, it’s all the time. And also time for myself; I’m a mom 24 hours a day, so when am I going to think about myself?” (Marcela, 36 years old, T1)

“First, I was very young to have so many kids all at once, and second, because I didn’t have a job or a stable partner. I was alone, I mean, at that time I only had social assistance, imagine that.” (Olga, 43 years old, T1)

In many cases, the burden of caregiving is compounded by socioeconomic difficulties, which limit women's participation in the labor market and increase domestic expenses, as described by several participants:

“Because, like I told you, there are already three kids, and nowadays everything is very hard. You can’t just bring a child into the world, you have to be able to give them a good life. As I said, I’m alone with them, and it’s not easy... I’m telling you, I ended up alone with them, and it’s tough.” (Daniela, 29 years old, T1)

“I want to have the surgery because nowadays things get complicated. You have to have a job, a place to live, you have to be okay because bringing kids into the world and having them starve or not being able to clothe them or something like that is complicated. That’s what I was thinking about too.” (Natalia, 29 years old, T1)

Other reasons cited by the women include challenges with the use of other reversible contraceptive methods. Experiences of method failure were frequently reported and motivated many to opt for more definitive reproductive decisions, in order to feel safer and more in control. Additionally, issues related to the availability of contraceptive methods within the health services, as well as the mechanisms of access, were mentioned as factors that, in some cases, interfered with the consistent and correct use of these methods. As illustrated in the interviews, such failures were not always due to the women's own use but, particularly in the case of injectable contraceptives, were sometimes linked to institutional factors, such as public health services distributing different supplies depending on availability:

"I got pregnant with my son while taking the pill. I was on birth control, and one day I took it late—I was supposed to take it at a certain time, but I forgot and took it the next day, and I ended up really pregnant." (Irma, 40 years old, T1)

"As always, I used injectable contraception and it never failed me. Now, what happened was that I must have gotten pregnant—I think—because there was a time when public health gave the quarterly shot and then the one-month shot [...] with those changes, I suppose I got pregnant. After the girl was born [...] I always used the injectable, never missed a dose, and at one point my breasts started hurting—I was pregnant." (Fabiana, 35 years old, T1)

With regard to the role of partners and other affective relationships, it was observed that in all cases, women minimized the opinions and positions of those in their intimate circles and asserted the request for ligation as their own autonomous decision. In some cases, partners supported their decision, in others they disagreed, and in most cases, they played no role at all:

"No, never, I always made decisions on my own because I liked to and still like to be independent. I say, if I go somewhere, I don't ask anyone's permission, I don't ask for anyone's opinion, I like to make decisions by myself and that's what happened at that time." (Mercedes, 45 years old, T1)

"At that time, my partner didn't want it, but I did. I had already decided... he didn't agree, he told me no, but he didn't support me either—I mean, he didn't oppose me, I went ahead with what I wanted because I'm in charge; it's my body and my decision." (Daniela, 29 years old, T1)

Lastly, regarding the influence of health professionals, among women in Trajectory 2 (T2), the decision was shaped by medical recommendations in response to pregnancy complications or other health histories, for which tubal ligation was considered a definitive indication. In contrast, for women in Trajectory 1 (T1), the influence of health professionals tended to discourage their decision:

"That's when the doctor told me I would have to get my tubes tied, because I had already had many pregnancies, many cesarean sections. On top of that, I had high blood pressure problems. So, the doctor gave me the option not to have the procedure, but she told me that if I didn't do it now, another pregnancy could be a serious life risk." (Juana, 36 years old, T2)

"Well, I wanted to have the surgery and they told me no because I was 20, it was my first pregnancy, and they said I should think about it, that I was too young, that maybe if I had the surgery I would regret it, that maybe I'd want another child and it would be hard for me." (Natalia, 29 years old, T1)

Access Pathways

This dimension analyzed consultation settings, requested requirements, the response of health professionals to the request, identified obstacles, and/or facilitating circumstances.

Regarding consultation settings, the Lucio Molas Hospital was mentioned most frequently, followed by the Evita Community Hospital and primary care centers to a lesser extent. It is important to note that in all cases, regardless of the site, the request for tubal ligation occurred within the context of prenatal follow-up consultations. The professionals involved were mainly gynecologists and, occasionally, obstetricians and general practitioners. At no point did the request arise during consultations specifically for contraception or other reasons, but exclusively during prenatal care.

Regarding the requirements for access, it was observed that women who made the request during the first part of the study period (up to 2015) were, in some cases, required to fulfill additional conditions beyond signing an informed consent form. These included, depending on the site of consultation, explicit partner support or a psychological evaluation. Thus, prior to that date, a diversity of responses was evident depending on the health care team involved, despite the full legal validity of the frameworks previously mentioned. Among the women, such requirements were often perceived as a routine part of the process at that time, and were generally not questioned, even though in some situations, these conditions, which were not legally mandated, proved decisive in determining access:

"Yes, we went to the psychologist they made you see, because before it was more about going with your partner. Later it became more about women deciding on their own, that we made the decision not to have more children and got our tubes tied. But before, it required the partner's consent." (Carla, 30 years old, T1)

"They were supposed to call me for the psychologist, but I never had the interview... we had agreed that I would have the tubal ligation right there when I gave birth to Fátima, but I was missing the psychologist's evaluation... so I kept waiting and, when I realized, she was born and they hadn't done it." (Paula, 42 years old, T1)

With respect to the signing of consent, it is worth noting that most interviewees expressed limited understanding of what the process entailed. Signing the consent form was often seen as an administrative step, rather than as part of a process of counseling and autonomous decision-making. This is a crucial point, as it highlights limitations in the active transparency of health professionals in facilitating informed choices for women.

"She wrote it down -ligation, she said- when I was rushed in for an emergency C-section. She put the medical record under my pillow and said 'ligation,' so... yes, I think I signed something, a white form, yes." (Flavia, 41 years old, T2)

"No, no, they just skimmed through the thing... they read the papers and that was it." (Irma, 40 years old, T1)

The responses of health professionals to women's requests were heterogeneous and appeared to depend on the site of care and the team involved. In other words, the variety of responses points to a lack of standardization in access protocols, regardless of whether the service was provided at a primary health care center or at a more complex level of care.

Nevertheless, the responses to women's requests allow us to distinguish two groups: those who received an initial denial and thus followed a T1 trajectory, and those who received a positive response, corresponding to a T2 trajectory.

The most frequently cited reasons for denial among T1 women were related to their age and number of children, both of which acted as major barriers to access. Unlike the previously mentioned access requirements, which appear to have evolved over time in the response of health care teams, these obstacles persisted throughout the entire study period:

"When I had my first child, who has a disability, I asked if I could have a tubal ligation and they denied it... they told me I was too young. I asked for it because of my son's condition, in case it happened again." (Marcela, 36 years old, T1)

"I told them I wanted to get my tubes tied and they said 'no, because you're young, later on you might find a new partner and want to have a child...' That's when I felt kind of bad, like they were questioning me for wanting the procedure and they didn't want to let me... I asked the nurse who took my blood pressure how I could get my tubes tied, and she said, 'Ask the doctor, but I don't think they'll do it because you're still too young.'" (Mercedes, 45 years old, T1)

Within the first group of women who began a T1 trajectory, a subgroup of six women can be identified and

categorized as "women on the waiting list." These women reported having been placed on a patient list within the Obstetrics and Gynecology Department at Hospital Molas, awaiting a surgical appointment. In these cases, women mentioned long waiting periods, on average five years, with two women having been on the list for ten years without having undergone the procedure by the time of the interview. The responses provided by health professionals regarding the institutional mechanisms for tracking requests and the channels for follow-up were vague or unclear. The interviewees' accounts reveal the challenges they face in securing access:

"I went to request it and was seen by a social worker, and all they told me was that there's a high demand, that eventually they'd call me... they never did." (Sonia, 45 years old, T1)

"At the first window, there, I asked the guy, I handed him my ID and asked if I had an appointment for tubal ligation. He took the document and told me I was on the waiting list, and that I could leave a phone number in case they needed to call me." (Irma, 40 years old, T1)

As for the second group of women who followed a T2 trajectory, key facilitating factors were the presence of health risks during pregnancy -often combined with multiparity and, in particular, multiple cesarean sections- which led physicians to recommend tubal ligation in order to prevent potential future complications:

"Yes, she told me, we've already signed the papers here, as soon as they do the C-section they'll do the tubal ligation, and that's it... I signed right then, the doctor had me sign, because it was a high-risk pregnancy so they didn't even ask me to see a psychologist or anything." (Juana, 36 years old, T2)

Access to Information

The analysis of access to information focuses on the sources women rely on, as well as the quality and availability of that information. Regarding sources, interviewees reported learning about the method through everyday conversations among women, typically involving reproductive care, pregnancy, and childrearing. When it comes to knowledge about the surgical procedure itself, all of the women mentioned medical consultations as the main space for receiving information. Only one interviewee referred to searching the Internet as a means of informing herself.

However, the responses regarding the quality of information, understood as being clear, complete, and timely, varied among the interviewees. Among T1 women, a lack of understanding about the procedure

and confusion about what actually happens to the body during tubal ligation was evident. In all narratives, the absence of clear explanations about the techniques used resulted in uncertainty, as there is no way for them to verify whether the procedure was actually performed. This uncertainty was reflected in the doubtful adoption of terms such as “they cut me,” “they burned me,” or “they tied me.” For most of these women, the counseling process was insufficient and perceived more as a formal requirement to be fulfilled than as a space for dialogue and information exchange with healthcare professionals.

“What I never really understood –and I never asked either– was whether it was a tubal ligation or tying, that’s what I don’t know. The only thing I can tell you is that it’s been 11 years since my last pregnancy and I haven’t gotten pregnant again.” (Olga, 43 years old, T1)

“No, never. They just told me, ‘We’ll do this and you won’t be able to have more kids...’ I needed a deeper conversation, to know, like, how I would be afterwards. You never really know, because you have doubts, and maybe you don’t know what they’re going to do to you inside while you’re under.” (Mercedes, 45 years old, T1)

It is worth noting that, among T2 women, the information provided by the healthcare team appears to be clearer and is described as satisfactory in addressing their concerns.

“Yes, she explained it well, she told me what the tubal ligation was about. She also explained that once you’re tied, there’s no going back. A lot of moms think they’re tied today and that later they can undo it, but it’s not like that.” (Juana, 36 years old, T2)

“In my case they tied, cut, and burned – straight to it. Mine was done completely.” (Lucía, 38 years old, T2)

Lastly, regarding the availability of information, no differences are observed between the two groups, and the reference is negative in terms of the dissemination of the right and the existence of a law that allows women to request tubal ligation without the conditions imposed on them by health services.

“It would be great if you could walk into a clinic or a hospital and there was a sign that said ‘Tubal ligation is your legal right.’ A lot of moms think about it.” (Sonia, 45 years old, T1)

“There’s a big lack of information. Just like there’s the abortion law, this should also be made more

visible, that you can get your tubes tied and avoid going through a process that can leave you scarred. It’s hard.” (Paula, 42 years old, T1)

Impact of Access / No Access

With regard to impact, the analysis focuses on physical, social, and emotional consequences, as well as the emergence of situations related to access or lack thereof.

Among both T1 women—who were ultimately able to undergo tubal ligation—and T2 women, expressions of relief and calm reveal a sense of satisfaction for having exercised their right. None of the interviewees expressed regret about their decision, one of the arguments often cited by healthcare professionals to deny the procedure. The possibility of reconfiguring a personal life project beyond motherhood is experienced as a positive development at physical, social, and emotional levels:

“Finally! I could breathe and say ahh, now yes! I’d been asking for it, I didn’t want to have more kids. I was very sure I didn’t want to be a mom again.” (Marcela, 36 years old, T1)

“To reconnect... as a woman I need to get to know myself again, my self-esteem... I was born a woman, but can’t I find fulfillment in something else?” (Patricia, 32 years old, T1)

“Yes, it changed. I could start working, I wasn’t pregnant anymore, and a lot of things changed because I even used to work while pregnant.” (Mercedes, 45 years old, T1)

By contrast, the negative implications for physical and mental health resulting from the lack of access are described with sorrow for not having undergone the procedure when it was initially requested. This led these women to face unplanned pregnancies and various consequences related to abortion (including two cases of late-term abortions), unwanted motherhood, and depressive disorders, as shown in the following accounts:

“When I found out, I was already four months along... I kind of fell into a depression, not because I didn’t love the baby, but because of everything I had gone through... It was hard to accept I was going to have another baby, to do it all over again. It was really tough, not because I don’t love my child, but we have to be real.” (Carla, 30 years old, T1)

“I was under psychiatric care. I knew I didn’t want another child because I wasn’t going to make it out of there... and I ended up medicated, and honestly, if you ask me, I don’t even know when I got

pregnant. You see what I mean? So I feel like the decision was made for me. And I love my daughter, but that's not what I wanted at the time. My mindset was totally different, I was actually looking into how not to have more kids, and then I got pregnant.” (Patricia, 32 years old, T1)

Perceptions of the Process

This final section analyzes how women perceived the response of health professionals, the ways in which they experienced moments of empowerment or, conversely, disempowerment in the course of their request, and how they give meaning to these experiences.

Among T1 women, all interviewees expressed feelings of having their decisions overridden and their autonomy violated. Their testimonies reflect the power asymmetries that shape decision-making over women's bodies. These women described their encounters with medical professionals as marked by submission and helplessness, as they did not feel their choices were taken into account:

“At that moment, I didn't feel like they considered what I was going through... or what I wanted... I mean, I wasn't listened to... They treated it like just another request, like from someone else. But for me, it really meant something not to have another child. But I wasn't heard at the time.” (Marcela, 36 years old, T1)

“And honestly, there's not much you can do, because they're the authority, they're the ones in charge, and you can't do anything... unfortunately that's how it is. You can't go above them, they're the ones who say yes or no... and you can't do much.” (Daniela, 29 years old, T1)

A distinct pattern emerged among the “women on the waiting list.” In addition to feelings of vulnerability, they reported a persistent lack of concrete responses from health care teams, which in many cases ultimately discouraged them from continuing to pursue the procedure.

“When I asked for it, honestly, I felt like it was just filed away in some drawer... and I went several times, maybe twice a year, to follow up... like, ‘Hey, I asked for the tubal ligation and...’ ‘They’ll call you, there’s a long waiting list’... I’d go to the hospital, to the window, and they’d send me to the area for pregnant women... there at the front desk a girl would help me... I’d tell her I was on the list for a tubal ligation and she’d say, ‘They’ll call you.’... I felt like I was asking for... I don’t know,

a piece of bread... like you go ask for something and you’re kind of scared... so I went two or three more times and then I stopped going.” (Sonia, 45 years old, T1)

“And me... you feel forgotten as a woman. If I had gotten my tubes tied, I wouldn’t have gone through everything I did with the baby, and I would’ve avoided a lot of anguish, because that really left a mark on me... later, like I said, they said they’d call, and they never did... I lost hope.” (Paula, 42 years old, T1)

In contrast, T2 women reported feeling supported by the healthcare team and expressed satisfaction with the process they experienced:

“By the time I went in for the C-section, everything was ready for the procedure... no problem at all. She told me, ‘We’ll have a chat first, and if you say yes, great.’ She treated me really well, never denied me anything, not a single issue... she was lovely, they did a great job, even though I was super scared, really, they did a great job.” (Lucía, 38 years old, T2)

DISCUSSION

The tensions between women's exercise of autonomy over their bodies and sexuality and the imposition of cultural-moral values by health professionals –who should act as guarantors of rights– open the door to further necessary and relevant debates.

Authors such as Gonçalves Rodrigues et al.⁽¹⁷⁾ address the rejections women in Manaus, Brazil, face when requesting sterilization, introducing the biopolitical dimension of state power that entails invalidating women's consent to make decisions about their bodies. This emerges as a symbolic battleground in the control of women's sexuality and can be understood in terms of violence.

In this context, these dynamics of denying rights, delaying their fulfillment, and the emotional and affective experiences women undergo within institutional settings constitute forms of violence against reproductive freedom. This is reflected in Article 6 of National Law 26485, which defines violence as:

“...any action or omission by personnel of public or private health care institutions [...] that violates women's right to freely and responsibly decide whether or not to have children, the number of pregnancies, or the spacing between births.”⁽¹⁸⁾

It is important to note that collective complaints have been filed in our country,⁽¹⁹⁾ where such actions of paternalism over women's will to undergo tubal ligation have been legally interpreted as institutional violence. This recognizes access to sexual and reproductive health services as a human right that the Argentine state must guarantee based on its national and international commitments.

From an intersectional perspective,⁽²⁰⁾ there is also a need to frame these experiences as discrimination, since the profile of users of state-managed public health services belongs to some of the most vulnerable strata of our society. This creates situations of oppression and privilege in accessing tubal ligation compared to women with private health insurance or the economic means to finance the procedure. Incorporating new analytical variables such as ethnic/racial identity and geographic location –particularly in a culturally diverse province with significant rural territoriality like La Pampa– would be vital for future research on this topic.

CONCLUSIONS

The trajectories women follow align with previous studies showing that women with preexisting health problems or pregnancy-related complications and/or multiparity are encouraged by healthcare professionals to undergo tubal ligation and access the procedure without major difficulties. Their experiences are satisfactory, and they express satisfaction with the care received. In contrast, women who do not meet these criteria face various barriers that constitute violations of their decisions, stemming from healthcare professionals' valuation of women's reproductive roles, where age and number of pregnancies become decisive factors. These "slippages," where professionals respond more to their cultural-moral views than to technical-scientific knowledge, have a significant impact on women's health. The invisibility of these consequences constitutes a barrier that must be overcome to contribute to the planning of public policies that respond to reproductive rights enshrined by law.

Despite differences between the two groups, medical authority plays a decisive role in access to tubal ligation, both when the procedure is recommended and when it is denied or obstructed. Women's submission to these hierarchical relations is influenced, among other factors, by their lack of knowledge about the law and the appropriation of their right to decide, which would enable them to demand more accountability from healthcare teams.

Furthermore, the multiplicity of institutional responses to requests reflects the absence of clear pathways guiding women on how to proceed to access tubal ligation. Among the "women on waiting lists," discouragement due to lack of timely responses leads to

unplanned pregnancies, with significant physical and, above all, emotional repercussions for the women.

In summary, the obstacles women face in accessing tubal ligation reflect a tension between professional autonomy and women's bodily autonomy as a right to make free and informed decisions about their bodies and reproductive functions, resulting in a negative impact on their overall health.

As has been seen, the mere existence of laws is insufficient to regulate healthcare professionals' actions. Local protocol development regarding these laws, along with sensitization and training of involved teams, appears necessary to reduce the variability of responses given by physicians and to support professionals as agents of public policy. The process of obtaining informed consent represents a health opportunity that can strengthen active transparency by healthcare teams and serve as a privileged moment of interaction between professional and service users, where professional autonomy is framed or limited by users' demand for autonomy.

Finally, dissemination of Law 26130 is strategic to facilitate access to information about the right to tubal ligation within health services. Notably, interviewees highlighted the comparatively lower visibility of surgical contraceptive methods compared to legal abortion, which constitutes a contradiction, as timely access to tubal ligation could prevent the later decision to terminate a pregnancy.

In this regard, the availability of reliable and secure information outside prenatal care consultations expands opportunities for women to learn about their rights and demand their fulfillment. A public policy addressing access to tubal ligation as a matter of reproductive justice should recognize that the decision to have or not have children goes beyond individual freedom of choice and is part of a social issue and state responsibility.

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CONFLICT OF INTEREST

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REFERENCES

1. Argentina, Provincia de La Pampa. Ley 1.363 de Creación del Programa Provincial de Procreación Responsable [Internet].

- 27 nov 1991 [cited 10 mar 2025]. Available from: <https://tinyurl.com/4uxy8uvp>.
2. Argentina, Provincia de La Pampa. Ley 2.079 sobre el Ejercicio de las Actividades de la Salud. Boletín Oficial de La Pampa [Internet]. 16 dic 2003 [cited 10 mar 2025]. Available from: <https://tinyurl.com/4hk99n28>.
 3. Moldován M. Garantía de Derechos Sexuales y Reproductivos en La Pampa: Sobre las leyes y la práctica de contracepción quirúrgica. En: VII Jornadas de Sociología de la Universidad Nacional de La Plata "Argentina en el escenario latinoamericano actual: debates desde las ciencias sociales" [Internet]. 2012 [cited 12 mar 2025]. Available from: <https://tinyurl.com/2ts986ts>
 4. Argentina. Ley 26.130 de Régimen para las intervenciones de Contracepción Quirúrgica [Internet]. 29 ago 2006 [cited 10 mar 2025]. Available from: <https://tinyurl.com/3xuzump8>.
 5. Pecheny M, Andía AM, Capriati A, Mario S. Ligadura y vasetomía: obstáculos para su accesibilidad. En: Kornblit AL, Camarotti AC, Wald G, (comps.). Salud, sociedad y derechos: investigaciones y debates interdisciplinarios. Buenos Aires: Teseo. 2012. p. 315–338.
 6. Di Liscia MHB. Legislación, movimientos sociales y ciudadanía de mujeres en La Pampa. En: Di Liscia MHB, Zaikoski Biscay D, Policastro MB, Catalani F. Mujeres Pampeanas: Tensiones entre la ciudadanía formal y el ejercicio de derechos. La Pampa: EdUNLPam; 2015. p. 15–49.
 7. Moschella RG, Charalambopoulos JT, Pawlowicz MP, Nadeo S, Rodríguez PG, Giménez A. Ruta crítica para la realización de ligadura tubaria: Estudio en un hospital público de la ciudad de Buenos Aires. Revista del Hospital Materno Infantil Ramón Sardá. 2011;30(3):100–106.
 8. Consorcio Nacional de Derechos Reproductivos y Sexuales. Monitoreo social y exigibilidad sobre los derechos sexuales y reproductivos: Informe Nacional 2010. Buenos Aires: CoNDeRS; 2010.
 9. Del Río Fortuna C. El acceso a la ligadura de trompas de Falopio en la Ciudad de Buenos Aires: la maternidad responsable y saludable frente al derecho a decidir sobre el propio cuerpo. Cuadernos de Antropología Social. 2007;(25):169–188.
 10. Petracci M, Pecheny M, Mattioli M, Capriati A. El aborto en las trayectorias de mujeres y varones de la ciudad de Buenos Aires. Sexualidad, Salud y Sociedad: Revista Latinoamericana. 2012;(12):164–197. doi: [10.1590/S1984-64872012000600008](https://doi.org/10.1590/S1984-64872012000600008).
 11. Serrano Gallardo P. La perspectiva de género como una apertura conceptual y metodológica en salud pública. Revista Cubana de Salud Pública. 2012;38(5):811–822.
 12. Castro R, López Gómez A, (eds.). Poder médico y ciudadanía: el conflicto social de los profesionales de la salud con los derechos reproductivos en América Latina. Montevideo: Facultad de Psicología; 2009.
 13. Gaeta Quezada R. Reflexiones sobre las bases y procedimientos de la Teoría Fundamentada. Ciencia, Docencia y Tecnología. 2014;25(48):149–172.
 14. Martínez Salgado C. El muestreo en investigación cualitativa: Principios básicos y algunas controversias. Ciência & Saúde Coletiva. 2012;17(3):613–619. doi: [10.1590/S1413-81232012000300006](https://doi.org/10.1590/S1413-81232012000300006).
 15. Minayo MCS. Investigación social: Teoría, método y creatividad. Buenos Aires: Lugar Editorial; 2007.
 16. Guber R. La etnografía: Método, Campo y Reflexividad. Buenos Aires: Siglo XXI Editores; 2011.
 17. Gonçalves Rodrigues C, Peixoto Pinheiro P, Vieira RLS, Neves ALM, Prata MLC, Therense M. "Rechazos iniciales" en el intento de acceso a la ligadura de trompas. RUNA. 2024;45(2):77–86.
 18. Argentina. Ley 26.485 de protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales [Internet]. 5 mar 2009 [cited 10 mar 2025]. Available from: <https://tinyurl.com/2n65styh>.
 19. Cena MJ, Pasquale MF, Villarreal M. Obstaculización de acceso a ligadura tubaria como violencia contra la libertad reproductiva: Las acciones colectivas como herramienta en construcción. Universias. 2022;(38):249–273. doi: [10.20318/universias.2022.6586](https://doi.org/10.20318/universias.2022.6586).
 20. Viveros Vigoya M. La interseccionalidad: una aproximación situada a la dominación. Debate Feminista. 2016;(52):1–17. doi: [10.1016/j.df.2016.09.005](https://doi.org/10.1016/j.df.2016.09.005).

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