

Potent Minds and Sterile Bodies: Desire, Decisions and Reproductive Agency Amongst
Surgically Sterilized, Low-Income Women in Salvador, Brazil

Senior Thesis

Presented to

The Faculty of the School of Arts and Sciences
Brandeis University

Undergraduate Program in Anthropology
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In partial fulfillment of the requirements for the degree of Bachelor of Arts

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May 2013

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Acknowledgments

When I decided that I wanted to do a senior thesis in the spring of my sophomore year, I had no idea just how much time, effort, and energy would go into such a project. I envisioned the final product with pride, but could not comprehend what it would take to get me here.

As it turns out, writing a senior thesis is no small feat, and certainly not one I could have accomplished on my own. Throughout the process, I was blessed to have the help and support of my many mentors, colleagues and friends, both in the United States and in Brazil.

For supporting my idea, even when she doubted its feasibility, and for guiding me from start to finish through the entire process of conceiving, researching and writing a senior thesis, I thank my advisor Elizabeth Ferry. For their support and guidance in finishing and polishing the final product, I am indebted to my readers, Anita Hannig and Faith Smith.

This project would not have been possible without the generous support of the Latin American and Latino Studies Department's Jane's Travel Grant, the funds from which housed me, fed me and got me to and from my research site everyday during my time in Salvador.

In Brazil, I am greatly indebted to Damiana de Miranda, the academic director of the SIT Study Abroad program in Salvador, and Eloisa Bastos at the Secretary of Health in Salvador for helping me to make initial contact with Rosana at the Resident's Union in Cajueiro. I also owe great thanks to Marcella Hausen and Yerko Haupt, who offered their tireless assistance in transcribing and translating hours upon hours of interviews.

Finally, I owe the greatest thanks of all to Rosana and the women of Cajueiro, who so generously and selflessly opened their homes and their lives to my inquisitive, anthropological gaze. Without your stories, your endless banter and your excellent senses of humor, this project would have come to nothing. More than anything, your stories have reminded me that no matter what barriers we face, as women or as humans, we always have the ability to overcome.

Introduction

This project was born in a course on human rights during the spring semester of my sophomore year. Searching for a topic on which to write my final paper, I happened on a scholarly article about reproduction in Brazil with a slightly outdated, but nevertheless shocking statistic: by 1996, more than a quarter of all Brazilian women 30 and under had chosen to become sterilized¹ (O'Dougherty 2008:415). Unable to comprehend that women might be voluntarily and willingly choosing sterilization—something that I saw as mutilation, a denial of women's ability to make reproductive decisions, and a clear violation of human rights—I attributed this statistic to either mass forced sterilization or extremely poor education and a great deal of oversight on the part of the Brazilian government. Incensed by these hypothetical scenarios, I wrote my paper about women who “chose” sterilization out of necessity to protect them from unwanted pregnancies, which I believed to be the inevitable, painful, and expensive result of pervasive gender inequality and sexual abuse.

A year later I found myself in Salvador, Brazil, ready to delve into six months of ethnographic fieldwork on female sterilization. By the time I arrived, I had already done significantly more research on sterilization and was aware that women were indeed choosing this method of birth control for themselves, though I was still quite naive about the circumstances under which this decision is made. It was not until I actually got into the field that I realized how much my North American brand of feminism had shaped my ideas about what it meant to be “empowered” or to have freedom of choice. In my mind, such high rates of sterilization had to be symptomatic of women subjugated under a grossly unequal system because a truly “emancipated” woman would never choose an

invasive², somewhat risky, and irreversible method of birth control if she was properly educated about her body, had access to the full range of contraceptive options, and had a male partner who was willing to shoulder equal responsibility for birth control.

What I found when I entered the field however, was that while gender inequality clearly existed, as it does in one form or another in most parts of the world, women, and especially the women who were getting sterilized, were not the downtrodden, oppressed, and battered unfortunates I had imagined them to be. Nor was sterilization a symptom of this supposed oppression. Rather, the women I met, and particularly the ones who had become sterilized, were smart, shrewd and effective; constantly pinching pennies, scouting out work, twisting the arms of tightfisted ex-husbands and boyfriends, and employing various other methods in order to survive in one of Brazil's poorest cities.

Furthermore, despite what I sometimes saw as painfully overt gender inequality, the feminism I subscribe to, which advocates for emancipation and equality for women under very specific conditions, was a largely unhelpful ideology. Although women valued many of the same feminist ideals including recognition, and fair and equal treatment for women, they did not necessarily identify with a movement that was often popularly painted as being "mutually exclusive" to femininity (Hautzinger 2007:248). Additionally, the conditions I thought were necessary for this kind of feminist "emancipation" including education on the biomedical model of the female body and the reproductive process, and a male partner willing to shoulder equal responsibility for birth control were not only unattainable, but also largely irrelevant in a context where a woman's survival and the survival of her children are very often at stake. Thus, when I tried to talk about *feminismo* as one of the reasons why a woman might want to become

sterilized, I was usually greeted with blank stares before my informants astutely steered the conversation towards more important matters like responsible motherhood, economic necessity, or a freer and more enjoyable sexuality.

My arrival in Salvador essentially meant throwing out all of the fruits of the intellectual labor I had done over the past year, but it also meant gaining a much more complex and nuanced understanding of the processes surrounding the decision to become sterilized and the realization of the surgery, as well as the significance of this seemingly radical method of fertility control. The result is documented here as a discussion and analysis of sterilization as a particular kind of agency: a tool, so to speak, that women use to painstakingly carve out better lives for themselves and their children.

The Backdrop: Salvador da Baia

The fieldwork for this project was conducted in the northeastern Brazilian city of São Salvador da Baia de Todos os Santos, most commonly known as Salvador. Nestled on a triangular peninsula, which separates the vast Baia de Todos os Santos (Bay of All Saints) from the Atlantic Ocean, Salvador served as the capital of the Portuguese empire for over two hundred years, from 1549 until 1763 (Hautzinger 2007:11). Today, in addition to serving as the capital city of the northeastern state of Bahia, Salvador is also held by many as the Afro-Brazilian capital of Brazil because roughly 80 percent of the city's population is black or brown and of African descent, and because the city is rich with Afro-Brazilian culture and religion (McCallum 2007:61).

Although the sloping cobblestoned streets, ceramic rooftops and exquisite churches of Pelourinho, the historic colonial center, are some of the most iconic images of Salvador, the city is also home to a range of other districts.³ Stretching along the

Atlantic side of the peninsula one can find many of Salvador's middle- and upper- class neighborhoods including the artsy, bohemian *bairro* Rio Vermelho, and what my guidebook described as the "soulless" Pituba, where many of Salvador's white families "hide away" in their condos.⁴

Along the bay side of the peninsula, are a few well-to-do *bairros* at the tip, including Barra and Vitória, two of the wealthiest neighborhoods in the city. Further up along the peninsula towards the outer limits of the city however, one will begin to encounter poorer, more densely populated and demographically blacker *bairros* such as Liberdade, Plataforma and the other sprawling slums that make up Salvador's *subúrbio*.

Although Salvador is one of the poorest cities in Brazil overall, it still accounts for the wealthiest urban area in the whole northeast region consisting of nine states. As the third most populous city in the country and a growing tourist destination, Salvador offers a plethora of economic opportunities that the smaller, rural and mostly agricultural towns and cities in the interior of Bahia and other northeastern states do not. As a result, Salvador has seen a tremendous influx of migration from the rural areas of the northeast.

Between 1960 and 1970, out-migration from the rural areas of the northeast accounted for 32.9 percent of the total net rural to urban migration in that decade, and the magnitude of that migration continued to grow in the ensuing decades. These numbers are consistent with more popular views of the population movement of the northeast in Brazilian literature and folklore, which tell of the "plight of subsistence farmers in this drought-ridden area, and their dramatic treks to urban centers in search of a livelihood" (Carvalho & Wood 1988:218-20).

This dramatic influx of migrants from rural areas has created a difficult situation of “labor surplus,” in which there are far more urban job seekers than there are available jobs (Ibid.:201). The influx of rural migrants to Salvador has also contributed to the geographic expansion and demographic distribution of the city. Given that the rural migrants are extremely poor when they arrive in Salvador, and that they often cannot find work as a result of this labor surplus, they cannot afford to live in the more developed, central areas of the city. Thus, they build their ramshackle shacks wherever there is available land, usually on the outskirts of the city. Overtime, these small shantytowns known as *favelas* grow into whole *bairros* and eventually become incorporated as part of the larger city. However, because they usually began as *invasões* of squatters on land that they did not own, these *bairros* which make up the Salvador’s expansive *subúrbio*, remain disproportionately poor, densely populated, and without access to basic government services such as proper sewage disposal, schools, roads, and health posts.

Unlike cities in the United States, where the poorest, most under-resourced, and usually most dangerous areas are to be found in the “inner city,” comparable areas of Salvador exist on the periphery, both symbolically and literally. Far away from government buildings, hospitals, universities and bustling financial districts, many of the *soteropolitanos* I met referred, in their usual hyperbolic style, to the *bairros* that made up Salvador’s periphery as being at the *fim do mundo* (the ends of the earth).

The Site: Cajueiro

The *bairro* where I conducted my fieldwork, which I will call Cajueiro,⁵ is one of several that make up Salvador’s *subúrbio*. My research was based at the Resident’s Union of the neighborhood, where many of the locals came regularly for assistance with

welfare payments, government programs such as “Minha Casa, Minha Vida” (My House, My Life), enrolling their children in public school, and voting. The Union also provided a basic vocational class for women who wanted to learn to be manicurists, and several language courses including English, Spanish, and Italian. On several occasions, the Union also ran a number of successful campaigns to get the government to fill in potholes, pave streets, and install better sewage systems.

The Union office was located on a side street that ran parallel to the main *avenida* in the neighborhood. The *avenida* was lined with shops, restaurants and supermarkets and was always congested with pedestrian and automobile traffic. The residential areas of the neighborhood were located off the *avenida* on a complex network of twisting and turning side streets. Although many of the residents of Cajueiro still lived in the shacks that are a defining characteristic of a *favela*, there were also a number of more permanently constructed homes that were beginning to spring up in the area, particularly along the side streets directly off the *avenida*.

Since Cajueiro is an extremely dangerous area of Salvador, particularly at night, and I was alone in Salvador for a limited amount of time as a single, white, North American woman, it was neither practical nor possible for me to live in Cajueiro and integrate myself into the daily routine of my informants as much as I would have liked. I did however, travel to Cajueiro by bus three to four days a week, where my presence at the union office quickly became a regular part of their operations.

I would sit in the reception area with my notebook and tape-recorder and chat with everyone who dropped by. Rosana, the secretary of the Union, would identify the women who had been sterilized or who were interested in becoming sterilized and help

me to introduce my project and invite them to participate. In this way, I conducted a number of interviews on site at the Union office.

All of my informants were either active members of the Union, some of whom volunteered regularly at the office, or local neighborhood women whom the Union served. All were low-income, and most survived on the minimum wage salary of R\$622 (approximately \$307.51) per month, although some could count on an additional monthly salary from a stable partner or from Brazil's social welfare program Bolsa Família. A very small number of informants survived on less than minimum wage, or had no income at all and relied entirely on Bolsa Família to survive.

Most of my informants also had very low levels of formal education and had only completed elementary school at most and many were illiterate. With the exception of Carla and Maria, whom readers will meet in Chapter two, none of them had completed high school, although several of them were attending night classes to complete high school, with the hopes of one day being able to attend college.

Given the low-income status of my informants, the majority of them relied upon Brazil's public health system, the Unified Health System (SUS) and the public school system for healthcare and education services. Both systems are extremely bureaucratic, and are considered by middle- and upper-class Brazilians who can afford private schools an health insurance to be a "joke," because the public systems provide what they consider to be vastly inferior services. During my time in Salvador, public school teachers began a three-month long strike halting all public education, and feeding into the scorn with which the public systems were viewed.

All of the interviews I conducted were semi-structured and in-depth. I always went in with a pre-determined list of demographic questions and a few more general open-ended ones, but it was rare that I stuck strictly to my interview guide, as I let the women steer the tone and direction of our conversations.

As time went on and those that frequented the union became more comfortable with me, some of the women I had previously interviewed began to invite me to their homes to interview their friends and neighbors who had also been sterilized. In this way, I also met many of the children that so dominated these women's narratives, as well as their sisters, aunts and mothers. Noticeably absent from these intimate domestic settings were any male figures, and though I desperately wanted a male perspective on sterilization, I never did get the opportunity to talk to a man on the subject in any significant way.

The women however, were surprisingly receptive to my interest in such a personal matter as their decisions to become sterilized. Even before my presence in Cajueiro was comfortable and familiar, I found that the women Rosana introduced me to were not shy about sharing the details of their lives with me, and in some cases they talked so freely and openly about their experiences that I had to gently cut them off and steer them back on track lest they spend all day telling me their entire life stories. When I asked Rosana about this receptiveness, she did not share any of my surprise.

“Of course they would be open to talking to you,” she told me, “this is the first time that anyone, let alone a white woman from the United States, has ever been interested in their lives.”

Sterilization and Agency

In order to understand the significance of sterilization in the lives of the women who choose it, it is necessary to think of this surgery and its repercussions as extending beyond reproduction and fertility control.

In her ethnography *Submissão e Desejo* (Submission and Desire), Brazilian anthropologist Suzane Serruya (1996) explores sterilization as a symbol both of women's desire to "get ahead in life," as well as their ultimate "alienation" from their own bodies. For her, the surgery is an act of "bodily violence," the result of which produces "not just a body that is simply dominated, but also one that is subservient and docile" (138-140, my translation).

In Serruya's interpretation of sterilization, the significance of the surgery lies not in its power as a permanent method of fertility control, but in its ability to enable a woman to do better for herself in life, while simultaneously, if not contradictorily, removing her power and control over her own body. Serruya argues that given women desire sterilization because they associate it with betterment and privilege, however misguided these associations may be, they "in a perverse manner," also desire their own domination by biomedicine (Ibid.:172, my translation).

On the opposite end of the spectrum from Serruya, Simone Grilo Diniz et al. (1998) argue that choosing any type of fertility control, including but not limited to sterilization, represents the "heroic efforts" on the part of their informants to gain more control over their bodies and their sexuality (63). According to Diniz, "reproductive activity is woven into the larger fabric" of the power relations found in everyday life, and represents women's desires to "transform their own pain and hardships into a better life for themselves and their children" (Ibid.:31-32).

Like Serruya, Diniz recognizes that fertility control in general has a greater significance for women than just the control of reproduction and birth. It also allows for women to improve their lives by using fertility control as an important strategy for navigating the various relations of power to which these women find themselves subjected. Unlike Serruya however, Diniz places the control over fertility decisions squarely in the hands of the women, and she posits that women are acting with agency and purpose in order to gain that control.

Gina Hunter de Bessa (2006) and Anne Line Dalsgaard (2004) have produced similar arguments to Diniz on the significance of sterilization, particularly in the lives of low-income women. They both acknowledge, however, that the agency that women demonstrate in their reproductive choices is necessarily constrained by their contexts of poverty and marginalization. For de Bessa, the significance of sterilization for low-income women lies particularly in their desire not only to be better mothers, but also to be modern women. They consider having many children to be a mark of “backwardness,” and thus sterilization is an important route to a better life through the perceived social mobility that modernity can offer. Her one caveat to the agency women display in their choice to become sterilized however, is that “women’s attempts to be good mothers and modern women are often fraught with conflict, especially in relation to their husbands, who, they say, have not ‘kept up’ with the times” (2006:227).

Dalsgaard offers a similar argument with a more nuanced caveat. For her, the significance of sterilization lies in the idea of recognition. Low-income women feel inferior, argues Dalsgaard, when they encounter Brazilians who are better off than themselves, and this inferiority denies them the recognition they seek as good,

responsible mothers and citizens. Sterilization allows for a woman's recognition as a responsible mother and "relieves immediate pressures" in difficult lives full of multiple concerns. Ultimately, however, the surgery itself "does not fundamentally alter problematic relationships and leaves her with a longing for more than a surgical intervention in itself can bring" (2004:26-27).

While Serruya argues that women lose dominion over their bodies when they "submit" to medical intervention without understanding how their bodies work or how sterilization works upon them, I ultimately reject her claim because her argument privileges a biomedical understanding of the body, and because it is not at all consistent with the stories and narratives of my informants. Indeed, women in Cajueiro knew very little about the scientific mechanics of reproduction and sterilization, but they certainly understood pregnancy and the ways it worked upon the body as a lived experience, and one that sterilization was guaranteed to prevent. Furthermore, it would not be accurate to say that they misunderstood the effects of sterilization and thus perversely wished their own domination. On the contrary, my informants associated sterilization with betterment and privilege because their lives did improve in very real ways once they had obtained the surgery, and they were very explicit in their desire for sterilization so that they could have *more* control over their bodies, given that pregnancy so often happens when a woman was not planning for it, and taking precautions against it.

On the other hand, while I tend far more towards de Bessa, Diniz and Dalsgaard's estimations that sterilization represents agency and a method of taking greater control in a woman's life, I do not completely agree with their arguments either. This has largely to do with the fact that their understandings of the concept of agency are not fully fleshed

out. For Diniz, the agency implicit in fertility control is bound up with her notion of women's "heroic efforts" to gain more control in their lives, especially in the face of oppressive power structures, and thus is synonymous with action and resistance.

De Bessa and Dalsgaard both offer important caveats on the limits of the agency that women are able to achieve through sterilization because an individual woman's surgery does not have the ability to transform relations of power, but their arguments both claim that sterilization is a means for women to attempt to take more control in their lives and achieve social mobility, modernity and responsible motherhood. For them, sterilization is agentic inasmuch as it is an action and a choice with the goal of betterment and change. They consider that the agency inhering in sterilization is not always effective because it is constrained by oppressive power structures, but their arguments do not go far enough because they do not address the ways in which that agency results from and also interacts with such power structures.

Although agency, "the human capacity to act," has frequently come to be understood as synonymous with resistance, Laura Ahearn reminds us in her important theoretical framework on agency *both* that "actions are always... socially, culturally and linguistically constrained," *and* that "agentic acts may also involve complicity with, accommodation to, or reinforcement of the status quo" (2000:12-13).

In her article "Feminist Theory, Embodiment and the Docile Agent," Saba Mahmood offers a contextualized example of Ahearn's "socially, culturally and linguistically constrained" agency that is not at all synonymous with resistance. She analyzes the agency inhering in the actions of Egyptian women engaged in a mosque movement. For the first time in Egyptian history, a large number of women are publicly

mobilizing in mosques to engage in teaching and learning Islamic doctrine, an area that is traditionally under the purview of men. The idea that a mosque movement might be an agentive one for women is at once apparent—given that they are breaking into a formerly exclusively male realm—and counter-intuitive—given that Islamic doctrine holds “subordination to a transcendent will (and thus, in many instances, to male authority) as its coveted goal” (2001:203-204). In light of this apparent tension between agentive actions and a submission to or maintenance of the status quo, Mahmood suggests a different way of thinking about agency “not as a synonym for resistance to relations of domination, but as a capacity for action that historically specific relations of domination enable and create” (Ibid.:203).

In looking at the significance of sterilization in the lives of the women of Cajueiro, one can see the importance it has in “freeing” women from a state of social, economic and sexual stasis in which their fertility so often holds them. Being fertile in the context of poverty and marginalization in Brazil means that women are far more vulnerable to oppressive power structures than are their male counterparts or younger women who have not yet reached childbearing age. As long as the fertility and the possibility of pregnancy exists women must be wary, cautious and guarded in their sexuality lest they suffer the irreversible consequences (abortion is illegal in Brazil). If they do suffer the consequence of pregnancy, especially if it is a third, fourth, or fifth pregnancy, then they must face the shame of their “backwardness;” struggle to scrape together enough to not only support their children, but also give them “good” lives; and fight against the physical and emotional tolls of constant childbearing. As many women said to me: “if I hadn’t [become sterilized], I would still be birthing until today.”

In Chapter one, I discuss the desire of women to be able to “play” or “fool around” at will (*brincar a vontade*). While this phrase was used specifically to talk about a desire for sexual freedom, it also represents more generally the agency that inheres in the choice to become sterilized. To *brincar a vontade* means, in many ways, to achieve more mobility within the relatively stagnant position that fertility represents and creates. Sterilization thus represents an incredible opportunity to attain the kind of mobility that women are so often seeking in their lives.

On the other hand, however, like Mahmood’s contradictory agency of women participating in a mosque movement, the agentic choice for sterilization presents a significant tension in that it while it represents an opportunity for mobility, it also represents a responsibility to a larger hegemonic culture. As I will discuss in Chapter two, popular social discourses in Brazil paint female fertility, and particularly poor, black female fertility as a social ill; a dangerous and threatening force which needs to be controlled. Thus, when women chose to control their fertility through sterilization, they are maintaining a particular hegemonic discourse that seeks to demonize their fertility. Though this seems counterintuitive, Jackson Lears explains: “a given symbolic universe, if it becomes hegemonic, can serve the interests of some groups better than others. Subordinate groups may participate in maintaining a symbolic universe, even if it serves to legitimate their domination. In other words, they can share a kind of half-conscious complicity in their own victimization” (1985:573). In this case, women participate in the “symbolic universe” of female sterilization because it has obvious benefits in their individual lives, yet in their participation they are also fulfilling a responsibility to those

who believe their fertility is dangerous, and thus maintaining the same “symbolic universe” that dominates them.

Thus, even as women seek to better their lives and the lives of their children through sterilization, they are also “backing... into wider and different sets of authority structures,” which dictate that the fertility of the poor is a dangerous social ill, or that women need to be ashamed of a visible, physical mark of their sexuality, or that fertile women are necessarily unreliable and unemployable because of the demands of motherhood (Abu-Lughod 1990:52).

Given these conflicting roles that sterilization plays in the lives of Brazilian women, I argue that the oppressive power structures against which women attempt to realize better lives for themselves and their children, and the agency with which sterilization endows them to achieve better lives are mutually constitutive. As Mahmood argues, in the Brazilian case, the “historically specific relations of domination” that women in Cajueiro are subject to, namely their position as poor, urban, black women in a racist, patriarchal and economically unequal society “enable and create” their ability to exercise agency through the use of sterilization. At the same time, the agency that they exercise when they choose sterilization, while undeniably improving the lives of the individual women who choose it, also continues to reinforce the status quo of relations of domination.

Although I believe that the agency women exert in their decision to become sterilized is inextricably bound up with the relations of domination and power to which they are subjected, I want to stress that I do not believe women are operating under a “false consciousness” when they choose sterilization. The idea that when women choose

sterilization, they might be supporting a “symbolic universe” that “legitimizes their domination” is an uncomfortable one as it seems to deny any value that their choices might have, especially as a choice to better their lives. Lears clarifies, however, that the “essence” of the concept of hegemony is not “manipulation but legitimation. The ideas, values, and experiences of dominant groups are validated in public discourse; those of subordinate groups are not, though they may continue to thrive beyond the boundaries of received opinion” (1985:574). Thus, even as women as a “subordinate group” legitimate the hegemonic discourse of dominant society, their personal experiences of empowerment and mobility that result from sterilization continue to be reified in their own communities.

In what follows I lay out the various ways in which women exercise agency and navigate the problematic relations of power that they face in their decisions to become sterilized. Using Scheper-Hughes’ and Lock’s (1987) “three bodies,” as a rough guide for my work, I explore how sterilization affects a woman’s individual body, the social body of Brazil in general and Cajueiro in particular, and the “economic” body, my own, more relevant interpretation of the body politic.

Chapter one presents the ways in which sterilization affords individual women greater mobility in their sexuality and in social spaces that are traditionally constructed as masculine. While female fertility is something that is considered dangerous and must be controlled, a woman’s sexuality must be controlled to the extent that it is linked to her fertility. Sterilization delinks fertility and sexuality and eliminates the possibility of visibly marking the consequences of a woman’s sexuality on her body in the form of

pregnancy. Thus, it gives women greater sexual self-determination, and the possibility of moving more freely in male spheres.

In Chapter two, I discuss the implications of sterilization for the well-being of Brazil's social body. Given that the unregulated fertility of the poor is constructed as a social illness which threatens Brazil's stability and development, and that there is no over-arching political entity to regulate, administer or promote female sterilization, women are taking the political agency to control their fertility and protect Brazil's well-being upon themselves, which affords them a greater social and political mobility. On the other hand, given that the construction of unregulated fertility as a social illness is a discourse shared by women and by powerful figures such as doctors and politicians alike, this political agency is not entirely constructed by women themselves, but instead borne of the women's adoption and integration of hegemonic values into their own personal discourses.

In Chapter three, I analyze the various ways that women use sterilization as a "survival strategy" in order to sustain themselves and achieve greater economic mobility. Despite the fact that women enjoy a kind of symbolic spiritual superiority in Bahia, this status does not serve a practical purpose for survival if women do not also have the social, political and material capital to support them. Thus, sterilization is an important tool for women to combat the ill effects of poverty and political marginalization in their lives, including an inability to define and own their roles as "good" mothers; the loss of beauty and vitality; and the loss of self-determination.

To conclude, I bring readers back to Salvador four months after the completion of my fieldwork. Revisiting the same site after having read a wider range of work on

agency, women's rights, and reproductive health, I make a case for continuing research and analysis on questions of women's reproductive health and decision-making, particularly when such decision-making has such wide implications for all aspects of a woman's life.

Chapter One – “Brincando a Vontade”: Sterilization, Sexuality, and Gender

In his ethnography *Carnivals, Rogues and Heroes*, Brazilian anthropologist Roberto DaMatta astutely observes that Brazilian society is so full of dichotomies as to be “at odds with itself” (1991:1-2). During my time in Brazil, I found this to be true in the multitude of dichotomous social categories that I observed or heard about, which were frequently at odds with each other—rich and poor, white and black, politicians and constituents, doctors and patients, and most poignantly, men and women.

The division between men and women was most striking to me because I am not at all accustomed to gender segregation, neither in labor nor in leisure. So from the time I first arrived in Brazil in late February 2012, a clear and uncontested segregation of gender roles and spaces was one of the first things I noticed about my new social landscape.

The nature of this gender segregation became clear to me only several months later however, as I began to get situated with my research. While searching for a research site, I had neglected to find a place to live. In a frantic last-minute search, I came across a room for rent in the home of some German expatriates who lived in a small *favela* on a slope underneath Salvador’s wealthiest neighborhood Vitória. The situation was far from ideal, but with no other options, I took the room.

Since I was temporarily stuck in the *favela*, I decided to try and make the most of it by beginning to talk to some of the neighborhood women about sterilization. This proved difficult however, because I never once encountered a woman outside of the house long enough to make an introduction. They were always rushing out to run errands or to work, or rushing back to cook lunch or tend to their children.

The men, on the other hand, stayed out socializing in their doorways or at the local bar from dawn until dusk, and often later. Unlike their girlfriends, wives and daughters, they were intrigued by me, the new *gringa* in the neighborhood, and were particularly talkative and friendly whenever I walked by. I at first jumped at the opportunity to talk to them, thinking it would add depth to my work to have some men's perspectives.

What I quickly learned however was that their interest in me did not extend beyond my "exotic" light hair and visibly unmarried status: their friendliness soon dissolved into lewd comments and sexual propositions. Aside from being incredibly uncomfortable with this type of explicit sexual joking—which, I acknowledge, would not be the reaction of most Brazilian women, who almost never took such come-ons seriously—I was worried about the effect that such advances from men I knew to be married would have on my reputation in the *favela*. I was already known because of my status as a foreigner, and I did not want to add to my infamy because I was propagating inappropriate relationships with the men in the neighborhood. I decided perhaps there was some rhyme and reason to the uncontested gender segregation that had previously baffled me. For the rest of my time living in the *favela*, I avoided the street as much as possible, only leaving the house for groceries, to go to my research site, or to meet friends outside of the neighborhood.

Casa and Rua: The Gendered Landscape

Although this experience with the men in the *favela* is one that stands out in my mind because of the discomfort it caused, until I began reading more about Brazil's social dichotomies, it did not strike me as one of much importance to my fieldwork.

Of the dichotomous social categories DaMatta discusses in his ethnography, the ones that have perhaps the most bearing on the role that sterilization plays in the lives of individual women are the gendered categories of space in Brazilian life—the categories of *casa* and *rua*, house and street.

DaMatta explains that “the opposition between street and house is basic... The category *street* basically points to the world with its unpredictable events, accidents, and passions; the *house* refers to a controlled universe where everything is in its proper place” (1991:64). Additionally, DaMatta defines the street as a place of “movement,”¹ and one where work and financial transactions occur, versus the house, which is a place of “calm” and “rest” (Ibid.:64-67). Thus, despite its potential dangers, the street is an open world with innumerable opportunities for mobility, including social and class mobility as well as physical movement from one place to another. The house, on the other hand, represents the safety and calm of an enclosed space, one that is bounded and comparatively static because it lacks the same opportunities for social and economic mobility.

The gendering of these spaces is as deeply embedded in the Brazilian social landscape as the categories of *casa* and *rua* themselves, and dates back to the Portuguese empire and the early years of Brazil’s independence. In the mid to late 1800s, there was a strong social “conviction that street and house were vastly different social worlds,” with different expectations of behavior for men and women. While “Brazilian men might enjoy ‘the easy fellowship of the street and plaza... where they discussed politics and transacted business,’” women “who went out onto the street... went accompanied by

maids who by their presence brought the protecting mantle of the household to the world outside” (Graham 1988:17).

As my experience in the *favela* suggests, this gendered *casa* and *rua* dichotomy, whereby men enjoy an easier and freer mobility on the street and women are considered to be vulnerable while on the street, is still very relevant to today’s social landscape.

My experience in the *favela* also suggests that the gendered distinction between house and street has as much to do with constructions of male and female sexualities as it does with mobility and stasis. Indeed, male and female sexualities are defined by these same characteristics that define the spaces of *casa* and *rua*. As Donna Goldstein explains in her ethnography *Laughter out of Place*, male sexuality is seen as “active,” and is connected to the word *comer*, which means “to eat,” but also, “to actively consume another person sexually.” Female sexuality, on the other hand, is marked as “passive,” and women are “generally the metaphorical receivers,” their sexuality being connected with the word *dar*, meaning “to give” (2003:263).

It is interesting that Goldstein describes women as being passive receivers in sexual relationships, when the word *dar* means quite the opposite. Although “giving” can be seen an active action, I think of the use of *dar* to describe female sexuality in terms of a significant sexual double standard that exists between men and women. While women are expected to *dar* to their partners for the man’s sexual enjoyment and fulfillment, there is significantly less pressure on men to sexually satisfy their female partners. Women are “active” then in the sense that they take on an active role in giving sexual pleasure to their partners, but they are passive with regard to their own sexuality. The female orgasm is less valued as a marker of successful sexual intercourse and is referred to far less

frequently in open sexual banter. Even the colloquial term “to orgasm,” or “to cum,” *gozar*, implies orgasm through ejaculation. Thus, with regard to explorations of their own sexuality and sexual pleasure, women are passive and have far less room to navigate and explore.

In addition to being endowed with the mobile/static qualities of street/house, male and female sexuality are also marked by these spaces. This is in part why calling a woman a prostitute (*mulher da rua*, literally woman of the street) is such a powerfully offensive insult: “such women are ‘dangerous’ because they are outside of the home and because they do not act like other women. By being perceived as *active* sexually, they are causing a category disturbance” (Ibid). Thus, an appropriate, passive female sexuality is linked to the *casa* and imbued with the same quality of relative stasis.

Male sexuality and masculinity, on the other hand, are constructed around the space of the *rua*. Not only is male sexuality imbued with the qualities of the *rua*, but men also use this space to exercise their active sexuality outside of the home. It is for this reason that when men have extramarital—and thus extra-domestic—affairs, their actions are referred to as occurring “in the street,” and the other women (*outras*) with whom these affairs occur are also sometimes called *mulhers da rua*, even when they are not actually prostitutes. (Hautzinger 2007:100).

If femininity and female sexuality are constructed as relatively static categories, then sterilization presents a considerable opportunity for women to achieve more mobility with regard to their sexualities. Like the Northern Indian women that appear in Sarah Lamb’s ethnography, whose bodies are considered to be more open and porous, and who are consequently more vulnerable in spaces outside of the home, an important

reason that Brazilian women are more vulnerable in spaces outside the home is because “things ‘happen’ to women ...—menstruation, childbirth, ... and so on. As passive receivers of action, women have a greater vulnerability to outside agents” (2000:186).

When women eliminate their fertility through sterilization, they also eliminate the possibility of pregnancy: a direct result of their fertility and a thing that “happens” to them. Once pregnancy is no longer possible, the definitive link that exists between a woman’s sexuality and her fertility is eliminated, and she becomes freer to explore her sexuality in a more mobile, active manner, without fear that her sexuality will be betrayed by her fertility. Sterilization then represents an opportunity for women to move more freely both within their own sexualities and within the outside space of the *rua*. By definitively ending their reproductive ability, women are eliminating the thing that makes them so vulnerable to the world of the *rua*, and thus they are freed to new, formerly unavailable possibilities of mobility through sexuality.

Sexual Longing: The Desire for a Free Sexuality in a Sex-Positive Society

In the minds of many North Americans, Brazil is a sensual tropical paradise. Just the name of the country evokes images of white sand beaches seething with a plethora of beautiful men and women flaunting their finely toned and tanned bodies. According to anthropologist Richard Parker, whose ethnography *Bodies, Pleasures and Passions* discusses sexual culture in Brazil, this sexual image of Brazil has a great deal of truth to it: “While sexual life in North America or Europe has been treated as an essentially individual phenomenon, in Brazil it has also emerged as a central issue at a social or cultural level, and has been taken, for better or worse, as a kind of key to the peculiar nature of Brazilian reality” (1991:28). I agree with Parker that sexual culture is quite a

central issue at the social level in Brazil; sexual joking and banter are a natural part of everyday social interactions, and those who are not open to such interactions are considered “cold” (*frio*). On the other hand however, I, like Donna Goldstein, am cautious in attributing sexuality as “central to *all* of Brazil,” especially when it comes to women (2003:228).

Women are indeed involved in discourses about sexual culture, and about the free and open nature of Brazil’s “sex-positiveness,” yet in practice, women are far more restricted in their sexuality. While men frequently and openly discuss or brag about their sexual excesses, this is not a topic that is considered appropriate for or available to women (Ibid.:229-230).

I found a similar trend to be true amongst many of the women I spoke with who had not yet been sterilized. While they frequently invoked discourses of “sex-positiveness,” they also usually referred to ideas of a freer, more active sexuality with longing, as though it were something they wanted, but could not achieve.

On my return to Brazil four months after the conclusion of my fieldwork, a friend of mine, Yerko, took me to visit his best friend Roberto and Roberto’s wife, Juliana. Yerko had been named godfather of their son, Heitor, who was turning one that week. Heitor had been an unplanned pregnancy, and Roberto decided that he should assume his fatherly responsibilities and moved in with Juliana so they could raise their son together. As it turned out, Roberto and Juliana lived in Cajueiro, and also frequented the Resident’s Union. When I mentioned that I had conducted research on female sterilization there, Juliana let out a wistful sigh. “If I could get a ligation, I would,” she said. “Imagine, to be

able to fool around at will (*brincar a vontade*). But I only have one son, and I'm certainly not going to have another one, so it's not an option for me."²

I was very surprised to hear Juliana expressing a desire for sterilization. Although she and Roberto were not financially stable, they had the promise of a bright future in front of them, as soon as Roberto finished his degree. Juliana was also college educated and appeared to have a stable and loving relationship with Roberto, who had willingly shouldered the responsibility of helping Juliana to raise Heitor. Thus, Juliana did not appear to lack any of the conditions that women usually attributed to their desire for or motivation to become sterilized. Her desire for sterilization seemed to stem entirely from her desire for a free sexuality, without the worry of a second unplanned pregnancy. In fact, given her resolve not to have a second child, it seemed that her fertility was the only barrier to her enjoying the kind of free sexuality she wanted, and sterilization would have been the perfect solution for her.

I heard a similar desire from Carolina, a woman I met many times at the association, but whom I never got the opportunity to interview. She was a young woman in her early thirties with one child. Like Juliana, she wanted to become sterilized but could not because of the 1997 law stipulating that a woman must have at least two children to undergo the procedure. Unlike Juliana, Carolina was in a far more precarious position. She was a single mother with no regular income. She had come to the association to sign up for “Minha Casa Minha Vida” (My House My Life)—a program of the federal government which constructs houses and then helps subsidize families with a monthly income of under R\$5,000 (about \$2,500) to buy them—but the process of

actually getting a house was a long and arduous one, and it would be a long time before she saw any real improvement in her quality of life.

I learned of Carolina's desire for more sexual mobility when she came to a workshop I gave for adolescent girls about the anatomy of a woman's body and the menstrual cycle. At the beginning of the workshop, everyone went around and introduced herself. When we got to Carolina she said: "I know I'm not a girl, but I came because I never learned this in school and I want to know. Maybe if I know what's in this body and how it works, I won't need sterilization to be able to enjoy..." At this point she trailed off as the rest of the girls began to titter amongst themselves. Then one of them proclaimed loudly "you mean enjoy sex! (*aproveitar transar*)" before they all dissolved into uncontrollable giggles. Carolina looked mortified, but still she nodded at me—she wanted to be sure that I understood her intentions.

This incident was striking to me for several reasons. Firstly, it hammered home the idea that the fear of unwanted pregnancy is one of the biggest barriers to enjoying the kind of carefree sexuality women desire. Carolina was clearly embarrassed by her presence at a workshop for adolescent girls, but she felt that the knowledge to be gained by attending was more valuable than social etiquette. That she would put herself in a position of potential social ridicule—not just from the girls, but from other women in the neighborhood who would inevitably hear about Carolina's attendance later—in order to open new opportunities of sexuality shows a great deal of determination.

Second, the fact that the girls present all knew that Carolina wanted to avoid pregnancy for the sake of her sex life speaks volumes about the challenge that pregnancy presents for Brazilian women. Though most of the girls were not older than 15 and knew

very little about their bodies or about any of the other risks associated with sexual activity, it seemed that they all knew and took for granted that they should not take too much license with their budding sexualities lest they end up pregnant.

Jennifer's Story

Jennifer was one of the first women I met and interviewed, shortly after I arrived in Cajueiro. Though many of the women I talked to spoke about their desire for sexuality, Jennifer was one of the only ones who spoke openly about the sexuality mobility she had actually attained through sterilization. She was 52 when I interviewed her, and had been sterilized at the age of 40. She lived alone in a relatively comfortable house with her 11-year-old daughter. What made her case unusual was that she also had an adult son who supported her by supplementing her income as a temporary domestic worker. She was by no means well-off, but she also lived a life of relative financial ease, especially in comparison with many of the other women I spoke to. Despite her unusual financial situation however, Jennifer's achieved sexual mobility represented what I understood to be the archetype of the free and unhindered sexuality for which so many women had expressed a desire.

Unlike other women, issues of sexuality permeated almost my entire conversation with Jennifer. I began by asking her the usual demographic questions—"how old are you?", "how many children do you have?", and so forth. When I asked her what her marital status was, she told me she was single. Knowing that being single only meant she was not legally married, I asked her if she had anyone in her life. She told me: "Not now. I'm dying to fool around (*doida pra futucar*), but I don't have anyone, no."

Later, when I asked her if she was satisfied with the outcome of her sterilization, her response was overwhelmingly positive, and she attributed this satisfaction to her newfound sexual mobility:

[I am] very [satisfied]. Because now, *minha filha*, I can fool around at will (*brincar a vontade*), without headache. Knowing that I will not have a child, without having any problems or getting any diseases. And today I feel more like a woman than before. Because I used to think that when I had this surgery, I wouldn't feel like a woman anymore, I wouldn't feel anything. My worry was that I wouldn't feel pleasure anymore... But today I feel more than before, I actually have dreams, you know?

Jennifer's enjoyment of her sexuality was particularly striking to me because she associated her enjoyment of sex "without headache" so strongly with her sense of womanhood. This stands in stark contrast with the ideal constructions of femininity and female sexuality, which dictate that women are static and passive receivers. Instead, she attained so much enjoyment from her sexuality mobility that she began to have erotic dreams as well. This type of sexual fantasizing is also quite out of line with the ideal, passive female sexuality, which receives or performs sexual actions for the benefit of a male partner, rather than performs or dictates them for her own benefit. Though dreams are not necessarily "active" or consumptive of another person in the same way one might describe male sexuality, they are still indicative of Jennifer's own sexual desires, which she is acting upon in her subconscious. Though she feared that sterilization would cause her to lose her womanhood, Jennifer ultimately ends up claiming her identity as a woman all the more firmly once she is able to discover her own sexuality. Thus, her newfound sexual mobility becomes definitively linked with her identity as a woman.

In addition to acting upon her desires rather than retaining a passive sexual role upon which the desires of others are acted, Jennifer also exemplifies the opportunity for

sexual mobility that sterilization presents in her desire to experience her sexuality with a man of her own choice:

[Things] actually get better because just by not needing to worry, just by knowing that you won't have another child, you can go to bed with someone you like, and you will feel pleasure. It's just this you'll feel, wellness and pleasure, you won't have any worries at all, understand? ... I'm not going to have another boyfriend, and I'm not going to have another husband. Today, I am the one that chooses the man, so that I can have *my* pleasure. [Emphasis added].

The idea that a woman might choose to never again enter into a binding relationship with a man is one that runs completely counter to constructions of femininity as static, and represents the extreme end of the opportunities that sterilization presents for sexual mobility. Without a husband or a boyfriend, Jennifer need not be tied to the home, completing domestic tasks and looking after the needs of a man. She also need not be tied to anyone sexually, for without a definitive partner there is no one she could possibly betray. Without the ability to bear children as a result of her sterilization, she need no longer worry about the possibility that her fertility might betray her sexuality, nor about having to live with, feed and support the consequences of that fertility. Additionally, she has no male figure in her life to tell her what to do, and she now has the license to ensure that she is never again attached to a male figure. Thus, her sterilization releases her from the stasis of her fertility, and she can do as she pleases.

“Standardized Femininity as a Hegemonic Gender Ideology”: The Male Backlash

Given that sterilization allows women to have a much greater sexual license; allows them to move freely in the *rua*, an exclusively male domain; and gives women access to a resource which revokes, to an extent, some male power over women, it is not surprising that there might be a male backlash against the opportunities that sterilization affords women.

During my time in the field, I was unfortunately not able to get any male perspectives on the matter, but I did hear a number of women speak about the reactions of the men in their lives to their decision to become sterilized.

Jennifer was perhaps the most vocal about the reactions of men to her status as a sterilized woman. She told me that when men found out she was sterilized, they looked at her as though she were a “seven-headed beast,” and they thought that she had “stopped being a woman because of this.” She also told me that men wouldn’t sleep with her because they thought she was “cold,” and that later she learned it was better not to say anything because “they didn’t even notice if they didn’t know.”

The use of the word “cold” to describe a sterilized woman is a particularly significant insult because it implies a woman who is unsexed. A “cold” woman, like a cold environment, is considered to be hostile and unwelcoming, qualities that are anathema to a healthy sexuality, which should be “hot” and “passionate.” The connotations of describing Jennifer as “cold” after she became sterilized are similar to those of describing as “cold” someone who refuses, or is closed off to engaging in the commonplace sexual banter I discussed at the beginning of the chapter. Such people, like sterilized women, are thought of as devoid of sexuality and incapable of engaging in pleasurable sexual relations.

This refrain of men who thought a woman would become “cold” after she underwent a sterilization procedure was common amongst the women I spoke with, even though all of them protested that being sterile made no difference at all in their sex drives and that they still felt like the same women they had been before.

In her ethnography, Sarah Hautzinger discusses her “theory of standardized femininity as a hegemonic gender ideology” to explain why female police officers in Brazil, who run the women-only police stations that deal with issues of domestic violence and sexual assault, are so often constructed as not being real women, or not being appropriate women. This ideology, Hautzinger posits, is “used—though rarely consciously—as a way of isolating and disabling feminism. When persons threatened by the purported goals of feminism desire to create negative images of feminists, one of the most common tactics employed to do so is to construe femininity and feminism as mutually exclusive, antagonistic ways of being” (2007:248). I would argue that this use of standardized femininity to attempt to stall or reverse progress for women does not just apply to actions and movements that identify as feminism, but also to any action or movement, like sterilization, which attempts to better the position of women, sometimes in the face of subjugating power structures.

Although Jennifer and other women like her might not necessarily identify as feminist or identify their choice to become sterilized as motivated by feminism, these women are inarguably choosing sterilization to better their lot in life. Whether they intend to or not, their choice also changes the boundaries of what counts as acceptable femininity in the process. Thus, male discourses about women who go “cold” after sterilization and are no longer good for sex, or by extension, male attention, are an attempt to appropriate the ideology of standardized femininity towards regaining some of their lost power.

Importantly however, Jennifer, like other sterilized women makes a strong claim to her womanhood, despite the fact that she is no longer fertile and can now move

relatively comfortably in both the female domain of the *casa* and the male domain of the *rua*. Furthermore, despite the negative feedback she received from many of the men in her life, she continued to act as she wished, and thus was able to redefine the boundaries of her femininity and her sexuality.

Although women, and particularly poor, black, urban women face innumerable difficulties and power-struggles in their daily existence, the implications that sterilization has for female sexuality present an important opportunity for women to claim more sexual mobility. By removing their fertility and thus much of their vulnerability as passive receptors of action in the domain of the *rua*, women are able to make more choices about where, when, how and with whom they enjoy sex. Thus, sterilization creates an opportunity for women to enjoy more mobility not only in their sexuality, but also in their relationships to men in general.

As women use sterilization to reinterpret the boundaries of culturally appropriate female sexuality, they are engaging in a discourse about gender roles, sexuality and fertility, which has political implications not just for their individual lives and sexualities, but for the social body of Brazil as whole as well.

Chapter Two – Social Control of Women, by Women and for Women

Throughout my fieldwork, I often found the process of interviewing women about their experiences with sterilization to be a rather tedious one. This was not because the individual stories were not interesting: each woman brought her own unique perspective on the matter to light. Yet, I did find that most of these narratives had many similar and often repetitive refrains. When I asked women why they had chosen to become sterilized, the simple chorus, before I gently prompted them to elaborate, was almost always: “because I didn’t have the conditions to have more children.”

Given the fact that the decision to become sterilized is a deeply personal one with major implications for one’s individual body and the future of one’s family, I was struck by how much the experience of sterilization extended beyond the individual and the family into the community and society at large. I first became aware of this social consciousness of sterilization when I realized that most of the women I interviewed, even those who did know each other at all, shared almost identical word-for-word reasoning for why they had chosen to become sterilized. Later, as I began transcribing and reading through their narratives, it also became clear to me that whether they expressed it directly or not, their decision usually had wider implications for their neighbors, the community, and very often, for the whole country as well.

In this chapter, I will discuss the ways in which the needs, desires and anxieties of the social body—that is the wider community of Cajueiro, and of Brazil as a whole—are mapped onto the bodies of individual women as they think about and negotiate the decision to become sterilized.

In their article “The Mindful Body,” Nancy Scheper-Hughes and Margaret Lock (1987) discuss three analytical categories in medical anthropology, which they present in the form of three bodies—the individual body, the social body and the body politic. According to their definitions, the individual body is the category through which we may understand the “lived experience of the body-self,” and the social body represents the way we use the body as a symbol “to think about nature, society and culture” (7).

To understand how the needs and anxieties of the social body can become conflated with the individual body’s experience of sterilization, I turn to Foucault’s notion of a “social, centralized consciousness of disease” (1973:40). According to Foucault, when an individual, “private patient” is medically treated, that individual experience is “bound up with the very structure of society” as it involves, “because of the special attention it pays to the individual, a generalized vigilance that by extension applies to the group as a whole” (Ibid.:19). Given that each individual constitutes a part of a larger whole—the society in which he or she lives—diseases and ills that are experienced by the individual body are also then experienced by the social body, whether through the literal spread of contagious disease, or through the anxiety that society experiences about the literal or perceived threat that the individual’s disease poses.

Although a medical experience like sterilization could arguably be taken simply as a “lived experience of the body self,” felt and reified only in the body of an individual, the ills and anxieties the procedure addresses and solutions it presents are keenly felt by the social body as well. When one woman becomes sterilized and thus limits the number of children she will have, her newly limited and controlled fertility represents a symbol of “modernity” and development, goals that all of Brazil is concerned with achieving. It

would be misleading then to present sterilization only as it is experienced by the individual. Thus, I seek to understand its significance as an experience that, like the cancer epidemic that Julie Livingston explores in her ethnography, “happens *between* people [emphasis in original]” (2012:6).

This conflation of individual and social ills can therefore be understood as “symbolic equations between the healthy body and the healthy society, as well as the diseased body and the malfunctioning society” (Lock & Scheper-Hughes 1987:20). Thus, as individual diseases and ills are taken on and experienced as the diseases of society, and particularly when those diseases pose a threat to the social order, individual bodies are frequently regulated and controlled in order to ensure the well being of society (Lock & Scheper-Hughes 1987:24).

The kind of social control that results from this mapping of social anxieties onto individual bodies is most often implemented by the state. In her book *Prostitution and Victorian Society*, Judith Walkowitz (1980) demonstrates how the British state of the 1860s attempted to contain society’s anxieties about prostitution and the spread of venereal disease through the passage of the Contagious Diseases Acts. These acts mandated the fortnightly examination of common prostitutes for venereal disease, and if found to be infected, their internment in a venereal disease ward until it was determined that they no longer posed a threat of contagion (1980:1-2).

At the time that these acts were passed, British society was obsessed with sin, which it believed to be the cause of disease in addition to “bodily imbalance and excess” (Ibid.:56). Although venereal disease was spread as much by the men who purchased sex as it was by prostitutes themselves, prostitutes practiced a “mode of life,” which involved

a great deal of moral corruption and an excess of the bodily fluids involved in sexual activity. Furthermore, as working-class women living alone without the protection of fathers or husbands, they were some of the most vulnerable members of society, and perhaps an easier population to target with regulation. Thus, common prostitutes naturally became symbol a of social anxiety: “prostitutes had become the social lepers of the eighteenth century, as syphilis replaced leprosy as the symbol of one kind of dreaded social contagion” (Ibid.:59). According to Walkowitz, the Contagious Diseases Acts were therefore an oppressive way for the Victorian state to “arrest disease at its source” and protect society by controlling and regulating those bodies that were thought to be the source of one of society’s greatest ills (Ibid.:76).

Like with prostitution in Victorian Britain, in Brazil there is a strong connection in popular consciousness between the unregulated female fertility of the poor, and Brazil’s greatest social ills: poverty, violence and a lack of “modernity.” This idea is pervasive across the social strata and I often found it being espoused by Brazilian social scientists and health professionals.

In her work on sterilization, Serruya begins by explaining that the unequal economic state of Brazil and other countries of the Third World “is attributed to disorderly demographic growth, thus establishing an uncontestable relationship between development and population” (1996:7, my translation). In addition, I also encountered a number of doctors, nurses and Community Health Agents (ACSs) who shared the views that Brazil’s poor economic conditions relative to the United States were due, in large part, to the uncontrolled fertility of the low-income women they served, and that women who were able to successfully control their fertility would have an easier time escaping

from poverty and doing better for themselves than those who were not. These public health professionals all worked in public clinics that generally served the poorest members of the population through the SUS. Having seen the extreme destitution in which women with many children often lived, especially in comparison to those women who had limited their fertility to only two or three children, these public health professionals were generally of the mind that birth control was absolutely necessary to help women avoid extreme poverty, and that of the available methods, sterilization was the best way to go.

One nurse I spoke with at a SUS-sponsored health post that served a small *favela* in a city in the interior clucked her tongue when I asked her what she thought about the fact that so many women rely on sterilization for birth control.

“Poor things (*coitadas*),” she said, referring to the women in the district that she served. “They just keep having children, they don’t know any better. They don’t know that every child they have, they are hurting themselves and they are hurting Brazil. All these children in the street, so much violence. They aren’t responsible enough to use the pill, but they have to do something. So sterilization is completely necessary.”

This kind of paternalistic attitude that most of the healthcare professionals I encountered had suggested to me that although the Brazilian state does not support or condone sterilization, some of the discourse that drives women to obtain it does feed into a hegemonic “symbolic universe.” The idea that it is the birthrates of low-income women that are “hurting” Brazil and causing high rates of violence in the country, particularly as a result of children living on the street, certainly serves the interests of the government and the elite classes far better than it does the interests of the women themselves. While

the fertility of low-income women is demonized and they take on the responsibility for controlling it, the government is able to evade the responsibility of implementing comprehensive family planning and sexual education programs, or working to improve the quality of family planning services that are provided through the SUS.

On the other hand however, the idea that the excessive fertility of low-income women is responsible for Brazil's social ills is common amongst more popular discourses, including those of the women themselves. As de Bessa found during her fieldwork on female sterilization in Belo Horizonte, the association between excessive fertility and poverty, violence and "backwardness" are constantly displayed in the media, on popular *novelas* and in the news (2006:237). According to her analysis, "the prevalence of an 'economic rationality' demonstrates the extent to which reproductive discourses and practices have become a central site for measuring social 'progress' as a marker of self and other—in this case, rural versus urban, working class versus middle class, ignorant versus 'cultured'" (Ibid.:237-8). Furthermore, in addition to having often identical word-for-word reasoning on why they wanted to become sterilized, the majority of my informants also shared the view that more children was bad for the economic conditions of the country as a whole, and that the more children a woman had, the less likely she would be able to properly care for all of them, and the more likely that some of them would slip through the cracks and turn to violence and drug-trafficking on "the street."

Given the extent to which the Brazilian social consciousness measures its own progress toward "modernity" and away from poverty and violence based upon the fertility of individual, low-income women, it is clear that in thinking about and

negotiating the decision to end their reproductive ability through sterilization, Brazilian women are also incorporating the ills and anxieties of society at large, as well as some of the hegemonic values about low-income, female fertility into their decision-making processes.

The connections that are drawn in Brazilian society between uncontrolled fertility and social and economic “backwardness,” poverty, and violence are an indication that like venereal disease examination and internment in Victorian Britain, sterilization is used as a method to control and regulate society via the control and regulation of female bodies. Unlike Victorian Britain however, Brazil has never had an official policy condoning or encouraging the use of the procedure, let alone mandating it (Ford & Vieira 2004:1202). Thus, in the Brazilian case, while the Brazilian government and other institutions of power benefit from this social control, they cannot be definitively identified as its agents. Nor can the widespread use of sterilization be understood to be necessarily restrictive. In light of popular narratives amongst poor, urban women, which attribute poverty to unregulated fertility and claim responsibility for the “situation” of Brazil, and without an overarching political entity regulating and administering female sterilization, I locate the primary agents of this social control in the women themselves, even as they are acting in the interests of structures of power, and, in some ways, against their own. As some of Brazil’s poorest and most marginalized citizens, these women are very concerned with the economic state of their country. They have thus taken on and rallied around the narrative of their unregulated fertility as a social ill as one of the only areas where they can take effective political action for positive change.

Popular Narratives of Unregulated Fertility and Responsibility

When you type ‘street children’ into a Google search form, the first suggested query in the list of drop-downs is ‘street children in Brazil.’ If you accept that query and click the search button, your results will be a range of newspaper articles, travel guides, academic journals and blog posts discussing the state of the apparently thousands of children who live on the street in Brazil.

Throughout the 1990s, Brazil received a great deal of international press coverage for its treatment of street children, and particularly for the gruesome massacre of seven children who were sleeping in front of the Candelária Church in Rio de Janeiro in 1993. Headlines included “Gunmen in Police Uniforms Kill 7 Street Children in Brazil”¹; “Dead End Kids”²; and “Violent Death Claims Survivors of Brazil’s Child Massacres.”³ This kind of international attention was deeply uncomfortable for many Brazilians, who tend to be fiercely patriotic and are very concerned about the portrayal of their country in the international press. Yet, their discomfort with this press rivals only the discomfort they feel with the street children themselves (Goldstein 2006:147).

In March 2011, headlines in Brazil reported the results of a study by the federal government, which found that there are 23,973 children and adolescents living on the street in 75 cities with more than 300,000 inhabitants.⁴ This number has gone down a great deal since the 1990s, when it was reported that there were some 200,000 street children. However, ambivalent opinions about this vulnerable population have not changed much. While children on the street are pitied as “innocent victims,” they are also feared and perceived as a threat to society “as part of a growing population of irredeemable criminals” (Goldstein 2003:147).

This idea that street children are a threat to society is shared and frequently invoked by low-income women who feel that it is their responsibility not only to keep their children off the street, but also to educate them to be productive members of society. As Dalsgaard describes in her ethnography, this attitude that “children should no longer just survive, but become proper citizens,” is an example of how women have “incorporated the idea of responsible behaviour” into their fertility practices (2004:135).

A key part of this responsibility is planning the number of children one has and taking care not to have too many. There was little variability as to what the women considered to be the ideal number of children, and refrains such as “one [child] is good, two is already too much,” which I heard from Vitória, a 41-year-old mother of three who was unemployed at the time of the interview, were quite common. Another woman, Fatima, a 57-year-old mother of seven who made her living from recycling discarded cans and other scrap metals told me: “I should not have had all these children, I should not have had seven children. If I thought [then] the way I think now, it would not have been all this. I should have had one or two or none.”

Women who have more children than this stated ideal of one or two often chastised themselves for having had too many children, or felt ashamed of their fertility. This kind of shame was exacerbated in the presence of other women who had adhered to the ideal number of children. During an interview with Carla and Maria, two women in their early 50s who were active community organizers in the association, Carla, who had only had two children, expressed her opinion that “all women should only have at the maximum, three children.” She turned to Maria to confirm her view, who nodded in agreement. Later, when I asked how many children each of them had, Maria admitted

somewhat reluctantly that she had six children, but hastily qualified this embarrassing fact by stating that it was because she “wanted to.” Later still however, as she explained the circumstances under which she was able to obtain sterilization, she told me that her primary care physician had written a report for the hospital in support of her decision to become sterilized because she did not have the conditions to raise the six children she already had, let alone have any more. “I passed the limit. I did too much, didn’t I?” she asked, as she averted her eyes and fidgeted with embarrassed discomfort.

It is important to note here that although the shame some women feel when they have too many children is a key indicator of the ways in which they have incorporated discourses of responsible fertility and motherhood, it also shows the ways in which they are subjected to hegemonic ideals about the fertility of the poor. Unlike the pride women take in having fewer children, shame indicates remorse, regret, and wrongdoing, which are generally not feelings associated with childbearing, especially in Brazil’s family-oriented society. In Maria’s case, and in the case of many other women, these feelings seemed to come out particularly in the face of social pressures from other more responsible women, such as Carla, who represent the interests and desires of society and the Brazilian government.

Although only having one or two children is a key indicator of responsible behavior, limiting one’s fertility is not enough to be considered a responsible citizen or a responsible mother. A woman must also ensure that she can “give the best” to her children so that they will also grow up to be responsible and productive citizens. This includes giving a good education, providing healthy food and nutrition, and ensuring that children have access to quality health care. Although education and health care are both

free through the public systems in Brazil, it is generally understood that the services received through the public systems are greatly inferior to those one can attain if one is able to pay for a private school and a private health care plan, and do not necessarily constitute “quality.”

Given the significant financial burden it takes to raise children, it is all the more important for women to limit the number of children they have so they can ensure the best rather than further spreading their already thin financial resources. Fatima, who had particular difficulty raising her seven children with informal employment and an irregular salary told me of the difficulties she encountered, especially trying to feed them: “When I went to buy for one, I couldn’t buy for the others. Because when you have a lot of children it’s like that. When one starts to get a little bigger, one right after the other, you have to take the milk from the oldest to give to the one that was just born.”

This kind of deprivation and financial instability is a situation that women do their best to avoid. Vitória, who also experienced difficulties educating her children, even with only three, stressed to me the importance of having a “stable financial life”:

If you were to analyze, today, the generation of today is more difficult for you to educate. For you to put on the right path.... If you don’t have a stable life, a stable financial life for you to educate your child... to dress [him], if you don’t have [enough] to give for two, for three it will be more complicated. Understand? Because... today’s generation is more agitated, they think their way is easier and it isn’t. So for parents today I think it’s harder because it’s easier for youth today to go... to the wrong field.... I try, if possible, to ask direction from G-d everyday for my children to be good people. Because today, *minha filha*, their minds are very inclined towards... perversity.

Nathalia, a 36-year-old mother of two who was seeking sterilization at the time of her interview, further elaborated on the importance of sufficient “financial conditions,” particularly because she was unemployed and depended on welfare and the income of her partner: “I already have two children... and I don’t have any mind to have another

child... because I don't have the financial conditions. They depend on [you for]... everything... I already pay for health insurance... but it's a burden.... So for me, I don't want more children, no. I don't have this mind to put children in the world to suffer, no.”

Although women do their best to ensure stable conditions and a quality upbringing for their children, fears of what will happen if they are not successful, not only to their children, but to society at large as well are never far from the fore.

During a focus group interview with four women who were all seeking sterilization, and who volunteered as street sweepers to help keep the neighborhood clean, I asked what the motivation was behind their desire for tubal ligation. Three of the four answered enthusiastically, but Wilma, who had been more reserved for the whole interview, stayed quiet. Curious to hear what she had to say, I asked her directly. Her response was exasperated, but not unexpected: “How many more children do we need in this chaotic world we live in? And that's without counting the children that are abandoned, undesired pregnancy, they're abandoned. We see all of this as a motive for doing a ligation.”

This focus group was one of the first interviews I conducted and at the time, it was unclear to me what Wilma meant when she referred to the “chaotic world” we live in. I did not ask because I was too uncomfortable to admit my ignorance as the rest of the women nodded in support and agreement.

The meaning became illuminated to me soon after however, during my interview with Carla and Maria. Both women spoke seriously about the mess Brazilian society is in as a result of the excessive fertility of the poor. The number of teenage girls who get pregnant before they can reasonably raise children properly particularly perturbed Maria:

There are people who are poor... who don't have an education, or anything, most have this thought. To not have more children. But there are others, who are the majority... you arrive in any maternity [ward] and what you see is youth having children, youth of 11 years old, 12, 13, 14, 15... Every maternity that you go to is like that, it looks like an *escola de samba*, all these little girls full of addiction, no work, doing things that they shouldn't be doing, it's a misery and every day that goes by it gets worse.

This disturbing image was only made worse when coupled with Carla's concerns about drug trafficking: "Today, you see everyday on the radio, the youth are dying, it's not adults anymore, it's youth. Why are they dying? At the hands of [drug] trafficking, owing the dealer, killing, stealing, assaulting, and all of them minors. It's because the mothers... just don't have the conditions."

It is important to note here that although Carla and Maria position themselves in their discourses as being somewhat removed from the poor women they are speaking of, they too were members of the community in Cjauairo and were also low-income. They differed from other women I spoke to in that they had gone to college. Both women, however, were school teachers in the public school system, and had very low salaries, not to mention they had not been working for an entire month when I interviewed them, because of the teacher's strike. Although they seem aloof when referring to "poor" women, the fact remains that they are still included in that group. I believe they tended to position themselves as higher than other low-income women because they had achieved such high levels of education, which was extremely uncommon in the community.

While it was clear to me that these women all love and cherish their children immensely, it was also clear that they are extremely concerned about raising their children well and preventing them from participating in various societal ills. With limited government resources to help raise children and with almost no government oversight on questions of family planning, these women have taken up the hegemonic discourses of

responsibility as their own, for they know that no one else will take responsibility for their children and for society if they do not do it themselves.

A Lack of Political and Medical Regulation

Although sterilization has been connected with the social ills of poverty, violence and backwardness, unlike in Victorian Britain, there is no government program that mandates or encourages sterilization in any way. Indeed, before 1997, the procedure was illegal, and the actions the government has taken since 1997 with regard to sterilization and family planning have legalized the procedure, but also regulated it and made it far more difficult to achieve (Caetano & Potter 2004:80).

In the 1980s, researchers and social activists became concerned with “the increasing number of low-income women seeking and obtaining” sterilization. Concerns mainly centered on what many considered to be the eugenic use of sterilization to end the reproductive ability of poor women and women of color. In response to these concerns, the National Congress launched an investigation in 1992 “to examine the spread of female sterilization in Brazil” (Ibid.:95).

In 1993, the final report of this investigation was released, which found that “pervasive poverty and the lack of reproductive health services contributed to women’s dependence on sterilization as a birth planning method” (Ibid.:96). In response to these findings, the National Congress drafted and passed in 1997 a law to legalize sterilization and regulate its use. The law stipulated that any man or woman over the age of 25 and with at least two living children has the right to sterilization, but that those seeking the procedure must undergo a waiting period of 60 days, during which time they are to be

counseled on other available contraceptives and on the results and possible side effects of sterilization (Ibid.:96).

Although these restrictions on who is able to obtain sterilization made the procedure far more difficult to achieve than it had been before, no significant family planning program was put into action, and access to other forms of contraceptives remained precarious at best. While the full range of contraceptive options exist in Brazil, low-income women who rely on the SUS to obtain them usually have only sporadic access to oral or injectable hormonal contraceptives, as local health posts frequently do not have enough to meet the needs of all the women they serve. Condoms, while available for free at any health post, also represent the most difficult contraceptive method to negotiate the use of, particularly with male partners who firmly believe that the use of a condom is detrimental to sexual pleasure. Thus, the results of the most recent national survey on women's health and family planning show that sterilization is still the most used form of birth control, with 29 percent of women in stable union having undergone the procedure (BEMFAM/DHS 2006).

To understand why there is no significant family planning program to help women gain access to sterilization and other forms of contraceptives, it is useful to look at the trajectory of Brazil's AIDS program. Brazil has often been referred to as an "Activist State" for the advent of their AIDS program. Violating international patent law and the Trade Related Aspects of Intellectual Property Agreement (TRIPS), Brazil began locally manufacturing antiretroviral (ARV) medicines in the 1990s, which they were then able to provide free of charge, as a right to all HIV positive citizens beginning in 1997. As a result of these freely distributed, locally manufactured ARVs, and a mass education

campaign, “Brazil was able to reduce rates of AIDS death and rates of new HIV infection by 50 percent in three years” (Davis & Fort 2004:153).

Given this widely successful program, it is difficult to understand why the government was unable able to implement a successful family planning program. However, the implementation of the AIDS program was largely a result of political pressure and social mobilization from those middle- and upper-class HIV patients who had access to activist spaces, a constituency which the family planning program lacks. Furthermore, even with the widespread success of the AIDS program and guaranteeing access to ARVs for all AIDS patients, Brazil still had a lot of trouble reaching those in the poorest regions, who were then left with inadequate care (Biehl 2007:69).

Since those who are HIV positive and poor have such little visibility in AIDS activism, “contrary to other epidemics and endemic diseases, AIDS did not... configure itself as a ‘disease of the poor’ in Brazil, and this... ‘might explain the privileged space that AIDS occupies in public health and in the state’s social policy at large’” (Ibid.:107). Diseases of the poor, on the other hand, are often not responded to because they are as invisible in activist spaces as the people who carry them.

Thus, efforts to implement a family planning program in Brazil have not been successful because unregulated fertility is seen by women, the health system, and the government as a “disease” of the poor. Although there are no statistics that breakdown the use of different contraceptive methods by socioeconomic class, it is generally accepted and understood by most Brazilians that middle- and upper-class women who live in more developed areas of the country have easier access to sterilization and other contraceptive methods because they can afford to pay for them. Poorer women in less

developed regions of Brazil, and particularly in the northeast are sterilized at lower rates, but the majority of those who do achieve the surgery are able to do so free of charge whether through the SUS or by arranging for a politician to pay for the surgery in exchange for votes (Caetano & Potter 2004:87). Although there is very little they can do about it on a political scale, the fact that the “disease” of unregulated fertility most affects poor women is not lost on those women. As Carla said to me: “the population keeps growing, but just the poor, you know? You see, the rich have two, three children and the poor have five, six.”

Without a wealthier constituency of women who have access to activist spaces from which they can pressure the government to implement a comprehensive family planning program, the poor women who most need access to such a program are left alone to navigate the system as best they can. While discussing the difficulties of accessing a sterilization procedure free of charge through the SUS, Carla explained to me: “through the SUS a person has to have... a doctor that is interested in the case. If someone gets lucky or has someone known in this medical field, who can make a referral, because if you don’t have [that], you will return to have one [child], then come back to have another, then another.”

Despite these difficulties however, achieving sterilization is not impossible and women are still able to successfully navigate a medical and political system that is largely stacked against them in order to gain access to the surgery.

Women as Agents of Social Control

Given the many barriers women face to achieving sterilization and their position as some of the most marginalized members of society, women themselves become the

agents of social control as they seek to remedy Brazil's social ills by sterilizing their bodies in order to regulate their fertility.

As mostly black, poor, and urban, the women I worked with in Cajueiro occupy a position of marginalization that was structured during colonial times and in the early years of Brazil's independence. Although Brazil gained independence from Portugal in 1822, many of the structures of power that the Portuguese put in place continued after independence and into the present day. In the late 1800s and early 1900s, poor, urban women were particularly vulnerable to these power structures. The majority of these women came into contact with oppressive power structures through domestic servitude, as in 1906, when "nearly half of all working age women declared themselves employed.... [and] most women who worked, worked as domestics. During the 1870s, between 61 and 65 percent of free working women were counted as servants, and, together with between 87 and 90 percent of slave women, servants comprised 71 percent of all working women" (Graham 1988:5). Within the confines of domestic servitude, these women were at the mercy of their masters, whose "power exercised... within the domain of family and household... was private and personal. No public institutions could be appealed to by dependents that might, on their behalf, counter the weight of private power or temper the personal actions of masters" (Ibid.:1). The only way in which women could exercise power and independence was if they were able to build a private life away from the homes of their masters where they could retreat, even if it was only for one night a week (Ibid.:60).

Today, employers of domestic workers do not have the same kind of unlimited power over the women who work in their households, nor are the women who work as

domestics considered dependents. Yet, the power vacuum left by this colonial structure has been filled by other paternalistic figures including doctors and politicians, and women still experience much of the same kind of subordination in their daily lives.

Most doctors (though not *all*), even the obstetrician/gynecologists who handle sterilization procedures, are male and they often are arbitrary in their dealings with women seeking sterilization. Many doctors follow more stringent criteria for sterilization than the 1997 law stipulates, requiring that women be 30 years of age, have three children and a stable marriage, which the 1997 law does not require (Caetano & Potter 2004:98). Eugênia, one of the volunteer street cleaners with whom I conducted a focus group told me that even though she is over the required age of 25 and has two children, her doctor refused to perform the surgery because she was “very young.” The doctor told her: “if you tie [your tubes], later you will regret it because with [your boyfriend] you haven’t had a child, one day he could want to have a child with you.” Eugênia has no desire to have more children with any partner because she knows there is a great possibility that once she is pregnant he might leave her. She still wants to become sterilized, but she does not believe that any doctor will perform the surgery after her first experience.

Politicians also contribute to the structural subjugation of poor, urban women. Imitating patterns of clientelistic relationships that developed during colonial times between *fazendeiros* and the poor, rural tenant farmers, politicians began to “gather dispersed followings and to enjoy prestige by offering services to the... peripheral urban poor without obtaining significant immediate returns, thus creating ties of indebtedness that were turned into political support when these powerholders ran for office” (Eisenstadt & Roniger 1984:107). Incidentally, one of the “services” these politicians

frequently offer is arranging and paying for the sterilization procedure in exchange for votes and political support from the woman, her family and friends. One woman I spoke to who was seeking sterilization told me that she was unlikely to obtain the surgery even though she met the requirements of the 1997 law. Since it was an election year however, she hoped that she might be able to find a politician to sponsor her. Another woman, Lane, a 43-year-old mother of seven was able to attain her surgery because she sought out a politician who was also a physician and who performed the surgery free of charge.

These structural relationships of subjugation that women experience with doctors, politicians and society at large limit their capacity for political action to make significant change. The government does not help them limit their fertility through an organized family planning program, and as poor and marginalized citizens, they are unable to mobilize for change.

Although the patronage stories I tell here are about the ways women do get access to the sterilization procedure, these relationships still serve to prevent women from mobilizing to make change for *all* women, even as they allow the individual to make change for herself. It is clear from the women's adoption of narratives of responsibility for Brazil's social ills however, that they are deeply concerned about the well being of their society. Thus, as they fight to achieve sterilization, the women are taking matters into their own hands as agents of social control.

Paula, a 39-year-old mother of two who was unemployed at the time of her interview made a particularly forceful statement to me about the responsibility that women have to control their fertility, particularly via sterilization, if possible:

For the situation of the country, if all women did this, if they wouldn't put so many kids in the world without the financial conditions to maintain them... And what are those kids doing now, they're what? Stealing, getting into drugs, so

much violence. So, if everyone thought like this, have two children, or three at the maximum ... I'm talking in the context of the financial situation of the country. Ligation is a way to take control. Because if you put children in the world randomly, the world will be the one to pick up the tab. That life there, drugs, stealing.

Though Paula shares her strong convictions with many of the women I spoke to, she was particularly lucky in that she was able to afford to pay for her own surgery at a private clinic that specializes in birth control and family planning. Most other women were not able to afford such services, and had to find other ways to negotiate the SUS system in order to obtain the surgery.

Giovanna, a 43-year-old mother of three who was supporting herself and her children with informal odd jobs in security and waitressing at the time of her interview told me about her struggle with her then husband to obtain the surgery. Another stipulation of the 1997 law is that a woman in stable union must have the signature of her partner giving his permission in order for the surgery to be performed:

[My husband] didn't want me to do it, it was that whole confusion. So, we went to the doctor, me and my sister. The doctor said that he had to sign, he had to give his signature to be able to do the surgery. So, I talked to him and he said that he wouldn't give. That he wouldn't sign... The following day I went to this [new] doctor with my sister. So, I started with her. I said like this: 'Doctor, I am separated... This is the third child I have.' I outright lied to her. I said that he disappeared when I got pregnant with the girl and I hadn't seen him since. So, she asked if I had someone responsible to sign for me, and I said 'I do.' So, my sister went and signed the document and [the doctor] did [the surgery].

This kind of struggle is common and is an important indication of the force and energy women put into their search for the surgery. In this case, Giovanna subverted three levels of power—Brazilian law, medical knowledge and the desires of her husband—in order to make change and create opportunities for mobility in her life, even as she maintained the hegemonic value that her fertility is a social ill.

Although sterilization in itself is a small, personal act with apparent implications for only one woman, to define it as such would be to ignore the importance of the narratives of the women in Brazil who seek it. Through the realization of this surgery, women are attempting not only to improve their own lot in life, but also to improve the state of their society through the remedying of a social ill that they firmly believe is their responsibility. For them, the realization of the sterilization procedure is an opportunity for more social and political mobility. In the absence of government assistance, and without the financial and educational resources to pressure the government to act on their behalf, women are actively mapping Brazil's social ills onto their own bodies and then taking the necessary action to remedy them.

Although the women contribute to maintaining and bettering Brazilian society as a whole through their adoption of the hegemonic social discourse of responsible fertility, their use of sterilization also represents a tool for their own economic survival and that of their children. In the next chapter, I turn to an analysis of the ways in which women use this tool to survive, and its significance to their economic well-being.

Chapter Three: Sterilization in the City of Women

During my six months in Salvador, I both witnessed and personally experienced a great deal of overt sexism that was usually classified by Brazilians as *machismo*. *Machismo* is a term that is used across Latin America to describe a whole range of behaviors, attitudes and ideologies, but “it is most succinctly described as the cult of virility. The chief characteristics of this cult are exaggerated aggressiveness and intransigence in male-to-male interpersonal relationships and arrogance and sexual aggression in male-to-female relationships” (Stevens 1973:90).

Although *machismo* is a term that is used to encompass a whole range of behaviors that discriminate or perpetrate violence against women in Latin America, it also can be used to generalize a block of very different and distinct societies, and to paint them as “backward” by western women who do not appreciate being catcalled on the street. By using this term, I do not mean to generalize, nor to portray Brazil as backwards. Rather, I use *machismo* in the same sense that many Brazilians use it, to describe behaviors that include serious and deeply entrenched physical and emotional violence against women and that lock women into domesticity and manipulate and coerce them into being dependent on men. When I refer to *machismo*, I am not referring to trivial behaviors such as catcalling, but rather to the kind of entrenched attitudes and ideologies, which cause physical and emotional violence against women.

Despite the pervasive presence of this ideology and its effects in everyday life in Salvador, I was repeatedly struck by the fact that the women I encountered never spoke of themselves as being subjected to or victimized by *machismo*, even when it seemed clear to me that their husbands or boyfriends confined them to the home, or placed the

disproportionate bulk of domestic and child-rearing responsibilities on their shoulders. They spoke of it instead as though it were an irritating fact of life, like a fly buzzing around one's face in the heat, rather than an ideology, which, as I felt, contributed to the routine subjugation of women. Men who were described as *machista* by women were, in the same breath, usually also described as *idiotas*¹ (idiots, fools), and were casually written off as being of no consequence whatsoever.

As a North American feminist, it took me a long time to understand how and why women who live in a society steeped in this ideology could treat it so lightly. As I began reading more about women in Latin America in general and Bahia in particular however, it became clearer to me that though women do suffer in very real ways as a result of this ideology, the existence of *machismo* does not necessarily have implications for the behavior and attitudes of women. Simply because an ideology that is oppressive to women exists does not mean that women will be oppressed, and indeed Latina women are neither submissive nor suppressed, though they may not act in the same "liberated" way that the North American feminist might hope.

Unlike North American women, Latinas enjoy a kind of spiritual privilege, which allows them to easily write off the arrogance and aggressiveness of men as inconsequential, even when it pervades most aspects of everyday life. According to Evelyn Stevens, this spiritual privilege manifests itself across Latin America as a kind of counter-ideology to *machismo* known as *Marianismo*, which she describes as "the other face of *machismo*." Stevens explains that this ideology is "the cult of feminine spiritual superiority, which teaches that women are semi-divine, morally superior to and spiritually stronger than men" (1973:91). Stevens also posits that although many Latinas

are often “submissive to the demands of the men,” their submission is a way only to “humor” men “for after all, everyone knows that they are *como niños* (like little boys) whose intemperance, foolishness, and obstinacy must be forgiven because ‘they can’t help the way they are’” (Ibid.:95).

It is important to remember that *Marianismo* can have the same generalizing effect as *machismo*, but as an ideology it helps shed some light on the position of women in Bahia, particularly in light of Ruth Landes’ work on feminine spiritual superiority in the Afro-Brazilian religion of Candomblé that is specific to the region. Candomblé is a syncretic religion unique to Brazil, which combines many aspects of Catholicism with the beliefs, practices, and deities of various African religions. It was created by African slaves brought to Brazil during the Portuguese empire and today continues to be practiced primarily by black, Afro-Brazilians in the northeast region and particularly in Bahia.

During her ethnographic forays into Bahia in the late 1930s, Landes was impressed to find that Candomblé was a domain ruled over by women, with priesthoods that were “all but exclusively female. Tradition says baldly that only women are suited by their sex to nurse the deities, and that the service of men is blasphemous and unsexing” (1940:387-88). Landes also found that Candomblé was a central and extremely important aspect of the lives of the Afro-Brazilians, and this led her to conclude that given their privileged status within the religion, in Bahia “women are the chosen sex” (1947:202). She furthermore painted a picture of women, and especially of Candomblé priestesses as fierce and indomitable in all aspects of life. Her description of one famous *mãe de santo*, Pulcheira the Great, evokes visions of a powerful matriarch who would not let any challenge, material, spiritual, or otherwise, stand in her way:

people said she had been a fiery crusader in her time and had wrenched protection for her people from the police. In those days when people could still vote, candomblé groups were alternately wooed and persecuted in the interest of one political machine or another.... Pulcheria had determined to put an end to this abuse” (Ibid.:81).

The image that Landes presents of the fiery and indomitable Afro-Brazilian matriarch provides an interesting explanation as to why the *baianas*² I encountered had such an easy time writing off the overt *machismo* of the men in their lives. On the other hand however, this image comes into stark contrast with many of the stories I heard of the incredible female suffering and sacrifice that came as a result of a patriarchal system that more often than not seemed to be stacked against the interests of women. In light of these stories, I turn to Sarah Hautzinger’s interpretation of women’s “powers” in Salvador as valuable caveat to Landes’ vision of Bahia:

Salvador da Bahia might be just as reasonably called *no* city for women... particularly from empirical materialist or feminist perspectives. Women’s ‘powers’ in a place like Bahia might just as reasonably be termed survival strategies, particularly when they are measured primarily in terms of men’s marginalization and disempowerment. (Households led by women or reliant solely on women’s earnings, for example, are hardly ‘empowered’ when their children remain destitute and undereducated)” (2007:9).

By bringing in Hautzinger’s caveat, I do not mean to trivialize the importance or deny the existence of the spiritual superiority that women in Bahia enjoy. The women I encountered in Bahia can and should be categorized as seeking the various forms of mobility that they feel entitled to in their quests (past or present) for sterilization. Their spiritual superiority endows them with a particular kind of power that often allows them to endure and carry on in these quests, even in the face of seemingly insurmountable difficulty. In my experience however, that sense of spiritual empowerment was not enough to achieve material and social empowerment, as these women must also simultaneously navigate the very real challenges of a marginalized and impoverished life

as they seek out sterilization and, by extension, upward economic mobility. What comes to the fore in these quests for sterilization then is that the spiritual superiority that women do enjoy cannot always elevate them to the levels of the “fiery crusader” who determinedly defends herself, her kin and her people from abuse and impoverishment if they do not have the material, social and political capital to support such positions. Unlike the powerful and well-known *mães de santo* of Landes’ “City of Women,” the women I knew in Cajueiro were everyday women, without access to that kind of capital.

Thus, sterilization becomes a means for women to not only sustain themselves, but also to reify, to a certain extent, the spiritual superiority they are entitled to. Without funds, education or stable and reliable relationships with partners and kin, with too many mouths to feed and oftentimes failing health due to multiple high-risk pregnancies, sterilization presents a “survival strategy” and an opportunity for women to eliminate many of the challenges that poverty and marginalization present, in order to begin moving towards a more stable and mobile future.

Spiritual Superiority and the Life Trajectories of *Nervoso*

Evidence of the fact that the spiritual superiority *baianas* enjoy is not enough to sustain women without material backing is clearly demonstrated in Miriam Rabelo and Iara Souza’s discussion of the life trajectories of working-class women in Salvador who suffer from the condition of *nervoso* (nerves). According to them, nerves are “understood as a powerful idiom for the expression and negotiation of distress that relate to relations of domination and inequality within the domains of the family, work and even the state” (2003:334).

In the course of their fieldwork, which was conducted in Nordeste de Amaralina, a densely populated working-class *bairro* in Salvador, Rabelo and Souza found that a woman's deterioration due to *nervoso* was related to the weakening or loss of three crucial and defining resources in a woman's life.

The first was the loss or inability of the women to define themselves "unambiguously" as wives and mothers: "They were cheated and abandoned by their partners, neglected by their own parents and kin, made the sole bearers of the responsibility of providing and caring for their children. The ideal family model based on clear-cut relations between the domains of men and women remained distant from their lived experience" (2003:353).

The second was the loss of their beauty and vitality: "When they refer to bodily decay the women are not simply pointing to a natural process of aging but to something that was forced on them by preoccupation, deceit, work and by the violence that was inflicted on their bodies. This decay involves a transformation of the active body-subject... to the passive body, cut off from the world, now an object of sickness and therapy" (Ibid.).

The third was an overall loss of self-determination: "The accounts... are, in a certain sense, stories of strong women that end up sinking under the weight of troubles that do not cease to grow. Their *nervoso* emerges as a difficulty in maintaining a certain self-image, as a sense that one's project has lost its way" (Ibid.).

The women that appeared in Rabelo and Souza's study shared very similar life circumstances to the women I encountered in Cajueiro, and their narratives share many similar qualities and themes. For various reasons however, the women of Nordeste de

Amaralina were unable to sustain themselves and eventually succumbed to the deterioration associated with *nervoso*. Thus the outcomes of their narratives are very different from those I found in Cajueiro.

Nevertheless, even as the women of Cajueiro used sterilization as a tool to move on paths towards greater empowerment and self-determination than the women depicted by Rabelo and Souza, the circumstances of their lives that led them to sterilization can still be traced by the fear of these three losses, and the hope that sterilization would sustain them and bring them the kind of mobility that all of these women desire.

Motherhood: The Struggle to Own Their Roles

Like the women that appear in Rabelo and Souza's article, the women I knew in Cajueiro also felt that their ability to define themselves as wives and mothers, and particularly as "good" mothers had come under threat. Given the life circumstances surrounding their positions of poverty and marginalization, they were often abandoned by their partners and kin and left the sole responsibility of raising and caring for their children, without the support of an "ideal family." When talking about the particular life conditions that motivated them to seek sterilization, almost every woman I spoke to touched on the themes of abandonment and sole responsibility for children in one form or another.

While most of the women emphasized abandonment by their male partners and the fathers of their children, Nathalia also lost the support of her parents when she became pregnant for the first time out of wedlock:

When I said I was pregnant [the first time] it was a war. Unmarried, I wasn't married, I was just dating, but I got pregnant like that. It was an agony in the house when [my mother] found out about my first girl. I cried so much. As much with my father as with my mother. It was a discussion. Heck... I got pregnant for the first time at 23, something like that.

Alone and pregnant at 23, Nathalia was forced to find a way to support herself and her unborn child. When I interviewed her, she counted herself as lucky that she had a steady partner, though she was not legally married. She emphasized however, that she is not fool enough to believe that her partner can necessarily be relied on for his help and support in raising her two children, only one of which is his. She must pay for everything her children need including education and a costly health insurance plan for her highly allergic son. Nathalia told me it was because of the financial burdens associated with giving her children a “good” life and because she knew she could not rely on her partner to help her that she was hoping to find a doctor who would be willing to guide her through the bureaucracy of the SUS and perform the surgery.

During the focus group interview I facilitated with the four women who volunteer as street sweepers, the ideas that men cannot be relied upon to help raise children, and that women must shoulder this responsibility alone was also strongly and repeatedly emphasized:

Eugênia: I think like this: for a man it's easy. She's pregnant, he can pick up and leave. It's [because] of this that I think it's the women's opinion [that matters], she's the one that has to want [ligation]. Because the man, if he leaves, for him it doesn't matter (*tanto faz como tanto fez*). Then, who gets hurt, it's us.

Lia: His only aim is for himself (*ele so visa a parte dele mesmo*).

Leah: So it's the responsibility of the woman to take care [of the children]?

Eugênia: Yeah, we take care [of them], it's medicine, it's the doctor, everything [the woman] alone (*tudo sozinha*).

Josefina: It's difficult, after a separation, for [the man] to keep giving.

Eugênia: Even being separated or together, it's just a little [that they give].

Lia: Out of 100 [men], only one will [give] (*Uns 100, só tira um*).

Wilma: It's hard.

Josefina: Because the relationship [between] two is super hard.

Eugênia: It's up to us to decide.

Wilma: It's more us.

Lia: The problem isn't theirs, it's ours.

Eugênia: For them we create 100 [children], make a soccer team (*time de futebol*).

Josefina: But we have to take care of ourselves.

Here, the women affirm the idea that despite societal ideals of “clear-cut relations between the domains of men and women” in family life, this relationship is nearly impossible to achieve, and thus the “good” motherhood that is expected to result from such relationships is also endangered. As single mothers, and with no reasonable expectation of obtaining a reliable male partner to take on fatherhood, these women must find a way to assert their motherhood outside the domain of traditional gender and family roles.

Despite this shared threat to the role of motherhood however, the life trajectories of the women I knew in Cajueiro were markedly different than those that appear in Rabelo and Souza’s study because they were able to successfully renegotiate and reaffirm their previously threatened role as mothers by achieving sterilization. Jennifer said it clearly when she told me “I wanted it, just to free myself of having too many children, putting children [in the world] one after the other without having the conditions to care for them.” Since she too was a single mother, she balked at the idea of having more children without the proper “conditions” to give them a good life. The only reasonable solution then, and the one that affirmed she was a good mother concerned about the welfare of her current and potential children, was to guarantee that having more children with insufficient conditions would never again be an option.

Fernanda also echoed a similar refrain. One of the first women I interviewed, she was 54-years-old and had given birth to 18 children, but only 14 of them were living. She had never had a steady partner or steady employment and she relied entirely on Bolsa Família, to survive. Like Jennifer, Fernanda viewed her decision to become sterilized in terms of her ability to reassert herself as a successful mother. When I asked her why she

had chosen sterilization, she told me: “I put it in my mind to do this because if I hadn’t done it, I would still be birthing today.” For her, particularly in light of her precarious financial situation, having more children than the 14 she already had would have been a sign of her failure as a mother because she had neither the funds nor the help of a steady partner to support them. Thus, by choosing sterilization, Fernanda was able to reaffirm her role as a mother who would be able to support and care for the children that she already had.

What is peculiar about the use of sterilization to reclaim or reaffirm threatened roles as mothers, is that it seems counter-intuitive that women would be protecting their interests as mothers by ending their ability to become mothers to more children. In her Master’s thesis for the Gender Studies department at the Central European University, Cristina Onica explores a similar tension that arises for Moldovan women who leave their children behind when they migrate to Italy for higher paying jobs. Though the media in Moldvoa has created a discourse of “bad motherhood” around these women, Onica argues that they “try to find *alternative* ways to adjust to the hegemonic social perceptions of motherhood... by employing various adjusting techniques, such as... constructing an alternative gender order” (2008:1-3).

For Moldovan women, like Brazilian women, part of constructing a new gender order for the sake of the successful “performance of motherhood” involves sacrificing a certain social status and “moral satisfaction” in order to preserve the well-being of their children (Ibid.:44). While Moldovan women sacrifice their professional value at skilled jobs in favor of domestic work abroad, which is higher paying but unskilled, Brazilian women sacrifice their fertility, which in many ways is a vital part of their social

constructions as women. On the other hand, these painful sacrifices for both groups of women open them up to successful motherhood in alternative, less literal ways.

Furthermore, like the women I spoke with, and especially like the women in the focus group, Moldovan women “engage in a discourse of *non-abandonment* in order to justify their non-traditional practices of mothering. They often oppose their image of a *good mother* against that of a *bad* or *misfortunate father*, thus constructing themselves as resourceful mothers and strong beings, despite their sex and against traditional gender expectations [emphasis in original]” (Ibid.:40). This type of non-abandonment discourse is also a strong justification for such a non-traditional mothering strategy as sterilization, particularly when having more children means abandoning, to a certain extent, the needs of the ones a mother already has. Like Fatima emphasized when she said that for those who have many children, you must “take the milk from the oldest to give to the one that was just born,” the essential responsibility of a good mother is to her *living* children.

Healthy Bodies, Healthy Lives: The Loss of Beauty and Vitality

In addition to a threat to their roles as mothers, the women I worked with also often experienced a threat to the integrity of their physical bodies through the loss of their beauty and vitality. Rabelo and Souza define this loss as “a transformation of the active body-subject... to the passive body, cut off from the world, now an object of sickness and therapy” (2003:353).

The fear that women express of sinking into a state of passivity as a result of sickness and a deteriorating body presents a seeming contradiction to the way in which female passivity is valued in the constructions of female sexuality that I discuss in Chapter one. I want to point out however, that while women are expected to be passive

with result to their own sexualities, they were still active with regard to the sexual pleasure of their partners. Thus, an active female body is valued to the extent that it can serve others, which I believe to be the case here. Women fear sinking into passivity due to sickness and the deterioration of their bodies because it means that they lose even more mobility, and are unable to care for themselves, and by extension, their children.

This transformation that women experience is usually related specifically to multiple high-risk pregnancies, or simply to the drain of pregnancy in a context of poverty, where access to quality healthcare before, during and after birth is precarious at best. The loss of beauty and vitality that women experience can also be related to a slew of other factors, but especially to their frequent adverse reactions to other forms of birth control in their efforts to prevent further difficult, draining or high-risk pregnancies.

When Paula spoke to me about some of her motivations for wanting to become sterilized, she became visibly upset. Her desire to end her reproductive ability stemmed, in large part, from the fact that she had carried a number of children to term, who then died soon after. Of her first four pregnancies, all of the children died, three because of complications during pregnancy and birth and one because the child was hit by a car in the street: “I couldn’t have more children because my births were such complicated processes, it was a health risk too.... So I asked to do a ligation because I didn’t want more, and also I had a risk of dying together [with the child], understand? So, I didn’t want more.”

Although Paula had already determined to become sterilized because of the health risks associated with her pregnancies, her final experience in the maternity ward giving birth to her youngest child only confirmed that she was making the right decision. The

birth of Paula's daughter and her ultimate sterilization came only after having spent seven days in the maternity ward waiting for a Caesarean section. When she arrived at the clinic, they could not perform the surgery because she had eaten beforehand. The doctors then left her in the ward with only an IV drip, but no solid food or liquids, and they repeatedly delayed her Caesarean. At the time, the non-medical staff members at the clinic were also on strike, so Paula also spent the majority of the waiting time without proper attendance. When it was finally her turn, she had had enough: "so... when I entered the operating room, I asked the doctor, Dr. Luciano at the time, if he would do my ligation because I didn't want anymore. I did the ligation at the same time as the Caesarean. At the same time, he did it."

What was particularly frustrating in Paula's case was that she had specifically chosen the clinic where her Cesarean and sterilization were performed because it was a private clinic with an excellent reputation. Since she paid for her care, she had expected to receive a higher standard of care than she would have through the SUS, yet she was still neglected, even as a high-risk patient.

Although their pregnancies and births were not nearly as complicated as Paula's, Nathalia and Lane also tell stories of the bodily decay that resulted from the use of other types of birth control. Nathalia's two children are ten years apart, and she reports having used an oral contraceptive (the pill) to prevent pregnancy during those ten years. She also reports however, that she "got weaker and sick [to her stomach] (*passava mal*)" and that she soon became careless about taking the pill regularly, and then got pregnant with her second child. After the birth of her second child, she began using an injectable contraceptive, which she was still using at the time of the interview. "But I don't want to

keep taking contraceptives,” she told me. “I’m already full of pain, full of pain in my legs, I think it’s my circulation, I don’t know, I think the contraceptive hurts me, doesn’t do me good.”

Lane reported a similar fear of bodily injury and decay when she told me about her experience using an IUD³. Although she never experienced any personal injury herself, she witnessed the injury of another woman, and it scared her enough to stop using the IUD and begin actively seeking out sterilization, which she achieved a few years later: “I got terrified because once I went to do a follow-up for the IUD, and there was a person there that went in with a hemorrhage because of it. The IUD had gotten out of place, I don’t know, I think she didn’t do regular check-ups, something like that, and hers, she had some bleeding and it got like that. I got scared and asked to take it out.”

In these cases then, as well as for many of the other women I spoke with, sterilization has important stopping power for the trajectory of decay of health and vitality. For Paula, it was not only an incredible physical and mental relief to be freed from demanding and draining trials of pregnancy and birth, but sterilization also served as a life-saving procedure, in the sense that it salvaged and preserved her vitality so she could continue in the daily struggle of her existence with all of her physical and mental strength. For Nathalia, sterilization represents the end to the physical suffering that she attributes to hormonal contraceptives, and the preservation of her vitality. For Lane, sterilization eliminated her need to use an IUD, and thus saved her from the various physical trials that she believed such a contraceptive method would cause.

In addition to preserving one’s vitality, sterilization is also extremely important as a means to preserve physical beauty, which is linked, in many ways to the pervasive

sexual culture in Brazil. As Richard Parker explains in his ethnography on the sexual culture of Brazil, being beautiful and having a beautiful body is part of being erotic, which is part of being Brazilian and being a woman (or man): “The body is constructed... as an object of desire and a source of pleasure. The cultural configurations that shape this erotic body characterize it in terms of its beauty and its sensuality, its erotic potential” (1991:111-12). The importance of having a beautiful body to one’s sense of erotic personhood in the Brazilian context helps to explain, in part, why sterilization was also often linked to another surgical procedure, this one purely cosmetic.

Lane was the first woman to mention her *plástica* to me, but at the time I did not understand what she meant when she said “I also did *plástica* at the same time.” I understood that *plástica* meant plastic surgery, but I could not imagine what kind. I thought it must have been related to the appearance of the scar left behind from the sterilization procedure.

Later I found out that she was referring to a cosmetic procedure that “closes” the vagina, thus tightening the vaginal opening and reducing its size to the original circumference pre-birth. Although it is a separate procedure, *plástica* of this kind has a significant relationship to sterilization, especially with regard to preserving or salvaging a woman’s bodily beauty and sensuality. This is a common procedure in Brazil, but it is, in some ways, a particular privilege for sterilized women, who have the exclusive confidence that their vaginas will not be stretched and “opened” again during childbirth. Once they eliminate their fertility, they have the liberty to also restore their bodies to a virgin-like state because the possibility no longer exists of deforming their genitalia, the center of their “erotic anatomy” (Parker 1991:112).

Like with their affirmation of their roles as mothers through sterilization, it is sometimes difficult to understand how women can reasonably claim to be preserving their bodily beauty and vitality through a procedure that not only cuts the body, but also destroys the natural function of a reproductive organ. It is important to remember however, that while the female body is necessary to the process of reproduction, a woman's body is also necessary for a whole other set of important tasks and functions, which would not be possible if the body has decayed from over-use in reproduction. Given that women are more often than not single mothers with the sole responsibility of raising and caring for their children, there is much in the daily lives of the women in Cajueiro that points "to the salience of the human body in women's daily concerns... and to the body as a basic tool with which not only to act on the world around one but also to think about it" (Popenoe 2004:136).

If this tool is broken or malfunctioning, women can sink under the weight of their daily lives and lose their way in their attempts to survive and persevere. A healthy, functioning and beautiful body is a necessary complement to women's spiritual superiority in order for them to truly utilize their "powers." As Rebecca Popenoe points out in her ethnography on the practice of fattening among Azawagh Arabs in the Sahara, "we bring forth worlds, or make our lives meaningful, not only with language, rituals, and works, but also in and on our very bodies" (Popenoe 2004:137).

Defining a Life for Themselves: The Loss of Self-Determination

The threat to their role as mothers and the loss of beauty and vitality that Brazilian women experience contribute, along with many other life circumstances, to an overall loss of self-determination, which the women I knew in Cajueiro fought hard to overcome.

Souza and Rabelo describe this loss of self-determination for women with *nervoso* as something that happens to otherwise “strong women who end up sinking under the weight of troubles that do not cease to grow. Their *nervoso* emerges as a difficulty in maintaining a certain self-image, as a sense that one’s project has lost its way” (2003:353).

Most of the women I spoke to usually described these “troubles” that drown their self-determination in terms of financial difficulties. If a woman was unable to obtain and keep steady work and earn a significant income, those conditions alone would be enough for her “project” to “lose its way.”

Elizabeth Jelin highlights the importance of a woman’s economic activities to the household in her article on the *baiana* in the labor force in Salvador. She points out that the “degree of commercialization” of a household and a woman’s activities depends on the family’s income, and that a high need for cash will result in more commercialization (1976:139). Although it is true that a woman’s economic activity depends almost entirely on the financial situation of her household, Jelin’s observations were mostly about married women, who ostensibly have a partner they can rely on to work, and who therefore have the luxury of commercializing their domestic activities so that they can simultaneously care for their children and make some extra cash for the family.

For the women in Cajueiro, commercializing domestic activities is not enough because they rarely if ever have partners who are reliable breadwinners or caretaker. The onus is on the women then, as I have already discussed, to both raise the children and make enough money to support them. Thus, it is almost always necessary for women in this position to take on work outside of the home because the ultimate reality is that “the

urban family cannot survive without a minimum cash income,” and commercializing domestic activities does not produce this “minimum” (Ibid.).

Giovanna’s experience before sterilization particularly highlights the importance of a sufficient income in women’s ability for self-determination. Originally from the rural interior of Bahia, she lived with her partner and their two daughters. She survived as a day laborer on the farms of wealthier families nearby, making an income of between 70 and 80 reais (between about \$38 and \$44) a month. She had the help of her parents, but her partner was a heavy drinker and was not reliable either for income for the family because he spent it all on *cachaça*, or as a caretaker of their two daughters because he was rarely coherent enough to look after them. As she said of her life before sterilization, “heck, my life was awful.... When we needed money we had to go to the farms of others to earn a daily rate. At the time... I think it was a daily rate of 7 reais, 10 reais (around \$4 to \$5).”

With this meager income and a drunken partner, Giovanna found that she was barely even able to pursue a life “project,” other than working hard to fulfill immediate financial and material needs. Though she was later able to salvage the sinking ship, it took a tremendous amount of effort, energy and emotional drain for Giovanna to be able to bring her life to a place of stability where she could define her future and the future of her daughters for herself.

Similarly, Fatima reflected on her life before sterilization as a time of immense struggle and difficulty: “Now, when I think about that time, I find that I suffered a lot.... So, it’s hard, this life, but it improved a lot. And now, compared to what I used to do,

what I used to be, now I am rich. But before, no. Because I depended on the affairs of others, not for health, but to survive. It was a difficult life.”

Although the financial difficulties of both Fatima and Giovanna had a great deal to do with their status as poor, black and uneducated women, their prior inability to make enough money to define their lives in the way they would have liked was also intimately related to their fertility and motherhood. This is not only because women are often left with the sole responsibility of raising and supporting their children, but also because when they are pregnant or have small children in the house, it is simply more difficult for them to find work.

Ben Selwyn conducted a study on gender and wage work in Northeast Brazil and found that permanent jobs were more likely to be “allocated to men because they are considered more reliable as they are unencumbered by family duties” (2010:51), and that managers frequently expressed that they did not want to hire women because women are entitled to three months of maternity leave if they are pregnant, and one month of vacation time per year, which comes to four months out of work during years when a woman is pregnant (2010:63). Given these circumstances, sterilization then becomes an important way for women to regain control of their financial situations and their self-determination.

When Giovanna gave birth to her third daughter, she was sterilized and soon afterwards she separated from her partner and migrated to Salvador to seek more lucrative work. Once she found work and a place to live, she began bringing her daughters to live with her in Salvador one by one. She says of her life after sterilization and migration: “after I arrived, I started to work, and [things started] improving, you

know? They didn't improve 100 percent, but they improved, they were improving little by little.”

Giovanna also iterated to me that now that she was sterilized and did not have to worry about missing work to take care of small children, or for maternity leave, she could pick up any job at any time: “If this (i.e. her fertility) complicated my work, thank G-d I'm free... [Now] I do these events, any event. I have a colleague who calls me to work... I work as a waitress, serving. And sometimes, I also work in security also for events.”

Although Giovanna does not have a *carteira assinada*, she is still able to make a steady income because she can pick up any work whenever her colleague calls her in for an event without having to worry about leaving small children uncared for, or having her income disrupted by an unwanted pregnancy.

Fatima also felt that sterilization had helped her to gain control of her life. Although she did not describe the details of how she was able to obtain a steadier income and a more stable life after the surgery, she expressed her feelings quite emphatically: “The ligation for me was like the lottery, as if I had won the *mega*⁴... For me it was really important, like winning the lottery.”

Although the spiritual superiority that women in Bahia enjoy is an important and significant aspect defining their lives, it is clear to me from their stories, that spiritual superiority alone is not enough to overcome material difficulties, especially when one does not enjoy the same kind of power and prestige as a well-known *mãe de santo*. On the other hand, these women are incredibly strong and determined, and they sought out

sterilization as the extra boost they needed in order to achieve the kind of stability and upward mobility that they sought.

Through the use of a procedure that helped to reaffirm their roles as good mothers, salvage and preserve their beauty and vitality and secure their ability for self-determination, the women of Cajueiro took great steps towards a life in which they could reap many more of the benefits that their position as the “chosen sex” implies.

Conclusion

In December 2012, four months after the conclusion of my fieldwork, I returned to Salvador in a much less formal capacity: I was on vacation. Though I returned to Salvador to take advantage of the beautiful beaches and some of the more touristic opportunities that I had missed on my last visit, I was unable to complete my trip without returning to visit the Union in Cajueiro.

After two weeks of enjoying the festive atmosphere that surrounds Christmas and New Year's in Bahia, I called Rosana to let them know I was coming, and then boarded a bus that would take me from the beachside *bairro* where I was staying, out to the *fim do mundo*. As the scenery outside the bus' windows slowly transformed from posh condos, shopping malls and beautifully constructed single-family houses into the sloping, sprawling mass of shacks that makes up Salvador's *subúrbio*, I felt the familiar tightening in my stomach, a combination of fear and excitement, that had accompanied me on every journey out to Cajueiro.

An hour after boarding the bus, I descended sweaty and nervous onto Cajueiro's main *avenida* in front of the same supermarket where Rosana had always come to meet me in the first few weeks of my research. I turned down a side street and made my way as quickly as I could to the gates of the Union office.

When I arrived, I was greeted by Rosana, the President of the Union and several other office volunteers with bone-breaking hugs, kisses and cries of "*saudades!*". Once I had distributed Christmas presents amongst the Union volunteers and everyone had stopped admiring the other's gift, we all settled down to discuss the Union, the neighborhood, and the women.

For the most part, everything was the same. In my four months of absence, the three-month long teachers' strike that had halted all public school education had finally ended and all the neighborhood kids were back in school. Elections for city councilmen and the mayor of Salvador had also taken place, though no one had anything to report about their new representatives. "They're all the same," Rosana told me. "They make promises and then they get into office and forget about us." Despite the opportunity that an election presents for women to gain access to sterilization through a politician, Rosana also told me that no one she knew of had been successful in that regard. Those I had interviewed that were seeking a sterilization procedure were still battling the bureaucratic SUS in order to obtain the surgery.

Then Rosana's expression turned conspiratorial. "They were asking for you, you know," she said.

"Who?" I asked her, curious.

"The women. A rumor went around after you left that you were orienting women for the surgery."

I was taken aback at this news. When I first arrived in Cajueiro, Rosana had originally asked me if I would be able to direct women to a doctor or clinic that would perform the surgery, but I quickly explained to her that not only was I not qualified to provide that kind of information, but that even if I knew where to send women, it would be against the ethics of my study to facilitate their actualization of a sterilization procedure.

"I hope you told them I can't do that," I said to her. She assured me that she had, and that eventually the rumor had died out, but that nevertheless for weeks after my

departure there had been a steady trickle of women asking for my services to help them obtain the surgery.

At first I was frustrated by this news. It seemed to me to be a symptom of the fact that Portuguese is my second language and that I struggled to communicate with many of the women who could not understand my accent, and who themselves spoke the heavily accented Portuguese of the interior, littered with colloquial terms with which I was unfamiliar. Perhaps I had just failed to make myself properly understood when I explained who I was, where I was from, and why I was conducting the research.

Rosana reassured me that the rumors likely had nothing to do with my language ability, however. Rumors of that kind were common, and people frequently came to the Union office asking for a “so-and-so” who could help them obtain some much needed, but highly elusive service. These rumors usually started when a politician came by the Union office on a campaign route, and they were almost always unfounded.

“It’s sad, you know? But we have to dream, otherwise we get hopeless,” Rosana told me.

The rest of my visit to the Union office was uneventful. Since I arrived in January, which is summer in Bahia, traffic was slow and none of the women I had known stopped by. I left a few hours later, feeling tired and heavy, not knowing when I would be back to see them again.

Once I left and had a better chance to reflect on my reunion with Rosana and the rest of the Union volunteers, I realized that the rumor about my alleged abilities to orient women for sterilization was perhaps a symptom of many of the themes of agency and power that I had been exploring in my literary research rather than of my poor language

abilities. Indeed, the fact that some women believed I could be an avenue to obtaining sterilization in some ways exemplifies the mutually constitutive interaction that occurs between women's agency in their decision to become sterilized and the power structures that place them in a situation where they must make such a decision.

Though I did not intend it to, my presence as a white woman from the United States carried with it connotations of power that had more to do with race relations and the history of Brazil's relationship to the United States than with any actual power I had. Given my representation of power, imagined or otherwise, and the fact that I was engaged in a discourse about sterilization, it was in some ways logical that some women might have come to the conclusion that I could help them to obtain the surgery. While these women use sterilization as a tool for betterment, change, and upward mobility, actually achieving the surgery usually means first interacting with, appealing to, and sometimes acquiescing to people in positions of power, whether they be doctors, politicians, or others. Thus, my projected representation of power and my interest in sterilization meant that despite my best intentions, I came to represent an avenue to achieving the surgery for some women.

Though I acknowledge that achieving sterilization often means submitting to people in positions of power, this is not to say that I do not view the women of Cajueiro as shrewd and highly effective in their quests to forge a better life for themselves and their children. The nature of their position as poor, urban, black, and marginalized citizens however, means that without proper education on their bodies and their rights and fair and equal access to resources, most decisions they make, including that of

sterilization, will ultimately maintain the power structures that marginalize them, even as they do build better lives for themselves.

It is for this reason that I advocate for continuing research on issues that affect women's empowerment and independence, particularly issues related to reproductive health and decision-making. In a context such as Cajueiro where most women are mothers, some at a very young age, and where most mothers shoulder the whole responsibility of caring for and raising children, access to and knowledge of reproductive services are vital for a woman's ability for self-determination in all aspects of her life. Specifically, I advocate for research on practical solutions for empowering women to take charge of their bodies, their reproductive abilities, and by extension, their lives. An analysis such as mine that addresses the ways in which individual women's decisions interact with structures of power will always be vital for understanding the politics of power and marginalization, but without practical solutions for women to take on these structures of power, change will never be possible.

Although Cajueiro sits at the *fim do mundo* and is largely invisible, even to many of the inhabitants of Salvador, in many ways the *bairro* sits at the center of the world of feminist politics and struggles. The women of Cajueiro and other *bairros* like it are at the front lines of women's ongoing struggle for empowerment and recognition, and they are very often fighting for such things with their bodies—the only weapon that is clearly and definitively theirs.

Notes to the Introduction

¹ When I say sterilization, I am referring to the method of tubal ligation, which is the most common and popularly available method in Brazil, and certainly the only method available for low-income women who rely upon the public health system to obtain the procedure. There are a number of ways in which tubal ligation may be performed, however in Brazil, the procedure usually involves making an incision somewhere in the abdomen to encounter the fallopian tubes, cutting both tubes, and then tying each of the four ends to prevent the tubes from reconnecting. This method blocks the avenue through which a woman's egg can descend from the ovary to the uterus, and thus insemination becomes impossible.

² While the methods for performing a tubal ligation have advanced a great deal in the last several years, the women I interviewed had been sterilized anywhere between 30 and five years prior, and the methods used on them, particularly with regard to the incision made, varied a great deal. For the younger informants, the procedure was performed through a tiny incision in the bellybutton, while older informants had large scars on their abdomen from the procedure. By recent modern medical standards, a tubal ligation is considered a relatively safe and easy procedure, but given the large variance in the method and quality of care that my informants experienced, and that they do not have access to other safer and less invasive methods of sterilization, I describe the procedure as invasive, even if it might not be considered as such by an obstetrician/gynecologist in the United States today.

³ I use the terms district and neighborhood interchangeably, as they are both acceptable translations of the Portuguese term *bairro*. All three terms refer to a relatively self-contained area of a city that is more or less demographically homogenous and may or may not be organized into a more structured and formal community.

⁴ Michael Sommers. 2011. *Brazil*. Chico: Moon Handbooks.

⁵ In order to protect the identities of my informants, I use pseudonyms for the neighborhood in which I worked and the names of all the women. All specific identifying markers have also been altered.

Notes to Chapter One

¹ The word for "movement" in Portuguese, *movimento*, implies not just the physical movement of people as in a crowded place, but also the transactional movement of money. If one wanted to ask the proprietor of a shop or restaurant how his business was for the day, one might ask, "did you have much *moviemento* today?"

² Juliana is referring to several restrictions on one's eligibility for a sterilization procedure through the SUS, Brazil's public health system, which are stipulated in a law passed in 1997. The law legalized both male and female sterilization for the first time, in accordance with the right of all Brazilians to have access to the full range of modern contraceptive methods afforded in the Constitution. At the same time however, it restricted those who are eligible for sterilization to people who have at least two living children, are at least 25 years of age, and have the consent of their partner, or who require sterilization out of medical necessity.

Notes to Chapter Two

¹ James Brooke. 1993. "Gunmen in Police Uniforms Kill 7 Street Children in Brazil." *New York Times*. July 24, 1, 3.

² "Dead End Kids." 1992. *Newsweek*, May 25, 12-19.

³ Nicole Veash. 2000. "Violent Death Claims Survivors of Brazil's Child Massacres." *The Guardian*. September 9.

⁴ Paulo Carriel. 2001. "23 mil Crianças Ainda Vivem nas Ruas no Brasil." *Gazeta do Povo*, March 22, 2011.

Notes to Chapter Three

¹ The term *idiota* has a particularly infantilizing and patronizing connotation, more so than the cognate term "idiot" in English. I often found the term *idiota* to be far more offensive because it did not just imply that a person was behaving stupidly, but also that he was small-minded, sheltered and childish, and that he could not be held responsible for his actions because he simply did not know better.

² Although the term *baiana* can be defined and used simply as the feminine form of *baiano*, one who was born in Bahia, it also often elicits images of a more specific type of woman: a large, voluptuous black woman dressed in the flowing white skirts and headscarves traditional of Candomblé initiates. It also elicits a particular connotation of strength and spiritual force.

³ IUD stands for Intra-Uterine Device. The device most commonly available in Brazil, as in the United States, is a small cross or "t," which is inserted into the uterus and prevents the implantation of a fertilized zygote to the uterine wall. Although the IUD is considered by the medical profession to be one of the safest (because it need not use hormones, though some devices do emit a low dose of hormones as an added precaution) and most cost effective (because it need only be inserted once and then lasts for up to ten years, unlike oral or injectable contraceptives, which must be purchased every month to three months) forms of birth control, there is a great deal of fear surrounding the use of the IUD, more so than with other methods. While Lane claims she witnessed a woman hemorrhaging due to an IUD, I suspect that she may have misunderstood the situation and interpreted it as a life-threatening result of an IUD because of other stories she may have heard previously. Another common story I heard (though I never met anyone to whom this happened, or who personally knew someone to whom this happened) was of women who used an IUD, became pregnant and then gave birth to a child that had the device stuck in various different body parts.

⁴ The *mega* is a lottery game with the largest "jackpot" available.

Glossary of Portuguese Terms

BAIRRO Meaning district, neighborhood or borough, this term is used to describe the various geographical subdivisions of a Brazilian city.

BOLSA FAMÍLIA The Brazilian social welfare program, which provides direct cash transfers to low-income families on a conditional basis. If a qualifying family has children, they are required to vaccinate the children and send them to school in order to receive payments. Payments are calculated based upon the income of a family and the number of persons in a family who are dependent on these payments.

CACHAÇA Liquor made from fermented sugarcane juice, and the most common and popular liquor found in Brazil. *Cachaça* is so popular in fact, that the word is often used to refer to all alcohols. If one were to say that someone is out “*tomando cachaça*” (drinking *cachaça*), it means that the person is out getting drunk, though not necessarily or specifically on *cachaça*.

CARTEIRA ASSINADA A document signed by one’s employer indicating that one has a permanent, full-time contract.

ESCOLA DE SAMBA A school of samba is a group of musicians and dancers, often associated with a particular neighborhood, whose main function is to perform samba, an Afro-Brazilian dance, during the parades of the annual Carnival. These groups usually also hold public performances throughout the year in preparation for Carnival.

FAVELA A *favela* is an urban slum or shantytown that is usually made up of shacks constructed by its inhabitants, who are also often squatters on land that does not belong to them. Generally these slums are located on the least desirable plots of land in a city, like the iconic *favelas* of Rio, which wind their way up the sides of the steepest slopes. Since most *favelas* are entire neighborhoods of squatters, the government often does not provide them with basic amenities like electricity and running water. The inhabitants of *favelas* are generally the poorest members of society and are most often black. Additionally, given the reputation of the *favela* for being a center of violence and criminal activity, having an address in a *favela* is usually quite prejudicial for its inhabitants, who can be denied employment and basic services based on their address alone.

FAZENDEIROS Meaning literally “farmers,” and stemming from the word *fazenda* for “farm,” this term usually refers to large landholders, who historically owned vast parcels of land that were farmed by slaves and later by tenant farmers.

GRINGO/A A term used to describe foreigners in general, but one also often used to describe white North Americans in particular.

INVASÕES Meaning “invasions,” this term refers to large swaths of land that are occupied by squatters. Many *favelas* constitute *invasões*.

MÃE DE SANTO The high priestess in charge of a *terreiro de Candomblé*, a *mãe de santo* is the spiritual leader of the community surrounding the *terreiro*, as well as a healer and the primary link between the initiates and followers of the particular *terreiro* and the *orixás* (deities). A *terreiro* can also have a priest or *Pai de Santo* as its leader.

MINHA FILHA Literally “my daughter,” this phrase can be used as a term of endearment for any woman who is younger than the speaker. It can also be used to refer to someone with whom the speaker has a teacher-to-student or mentor relationship.

SAUDADES Although this word is usually translated to mean “missing,” this is a mistranslation. The true meaning of *saudade* includes the sentiment of missing someone or something, but it also includes feelings of longing or pining and strong connotations of nostalgia and physical absence.

SOTEROPOLITANO/A A term used to refer to a person who was born in and is a native of the city of Salvador. *Soteropolitanos* are also *bahianos*, people who were born in and are natives of the state of Bahia.

SUBÚRBIO The outlying periphery of the city of Salvador, made up of several large *favelas*. Unlike cities in the United States where the poorest areas can usually be found in the inner city, the *subúrbio* constitutes the poorest and most marginalized area of Salvador because new migrants to the city squat on the unoccupied land at the periphery of the city when they arrive.

SUS This acronym stands for the *Sistema Única de Saúde*, or the Unified Health System. The SUS is the free, public health system of Brazil, the provisions for which are included in the new 1988 constitution. Under the SUS, all citizens and residents of Brazil are guaranteed the right to free healthcare.

TERREIRO Although this term can be used to describe a square or central plaza, in Bahia it is most frequently used to refer to the houses of worship of the Afro-Brazilian religions of Umbanda and Candomblé.

Works Cited

- Abu-Lughod, Lila. 1990. "The Romance of Resistance: Tracing Transformations of Power Through Bedouin Women." *American Ethnologist* 17(1):41-55.
- Ahearn, Laura. 2000. "Agency." *Journal of Linguistic Anthropology* 9(1-2):12-15.
- Biehl, João. 2007. *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press.
- BEMFAM/DHS 2006. *Pesquisa nacional sobre demografia e saude: 2006*. Rio de Janeiro: Calverton.
- Brooke, James. 1993. "Gunmen in Police Uniforms Kill 7 Street Children in Brazil." *New York Times*. July 24, 1, 3.
- Caetano, André J. and Potter, Joseph E. 2004. "Politics and Female Sterilization in Northeast Brazil." *Population and Development Review* (30)1:79-108.
- Carriel, Paulo. 2001. "23 mil Crianças Ainda Vivem nas Ruas no Brasil." *Gazeta do Povo*, March 22, 2011.
- Dalsgaard, Anne Line. 2004. *Matters of Life and Longing: Female Sterilization in Northeast Brazil*. Copenhagen: Museum Tusulanum Press.
- DaMatta, Roberto. 1991. *Carnivals, Rogues and Heroes: An Interpretation of the Brazilian Dilemma*. Notre Dame: University of Notre Dame Press.
- Davis, Paul and Fort, Meredith. 2004. "The Battle Against Global AIDS." In *Sickness and Wealth: The Corporate Assault on Global Health*. Meredith Fort, et al, eds. Pp 145-157. Cambridge: South End Press.
- "Dead End Kids." 1992. *Newsweek*, May 25, 12-19.
- de Bessa, Gina Hunter. 2006. "Medicalization, Reproductive Agency, and the Desire for Surgical Sterilization Among Low-Income Women in Brazil." *Medical Anthropology* 25:221-263.
- de Carvalho, José Alberto Magno and Wood, Charles H. 1988. *The Demography of Inequality in Brazil*. Cambridge: Cambridge University Press.
- Diniz, Simone Grilo, de Mello e Souza, Cecília and Portella, Ana Paula. 1998. "Not Like Our Mothers: Reproductive Choice and the Emergence of Citizenship Among Brazilian Rural Workers, Domestic Workers and Housewives." In *Negotiating*

-
- Reproductive Rights*. Rosalind P. Petchesky and Karen Judd, eds. Pp 31-68. London: Zed Books.
- Eisenstadt, S.N. and Roniger, L. 1984. *Patrons Clients and Friends: Interpersonal Relationships and the Structure of Trust in Society*. Cambridge: Cambridge University Press.
- Ford, Nicholas John and Vieira, Elisabeth Meloni. 2004. "Provision of Female Sterilization in Ribeirão Preto, São Paulo, Brazil." *Cadernos de Saúde Pública* 20(5):1201-1210.
- Foucault, Michel. 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage Books.
- Goldstein, Donna. 2003. *Laughter out of Place: Race, Class, Violence and Sexuality in a Rio Shantytown*. Berkeley: University of California Press.
- Graham, Sandra Lauderdale. 1988. *House and Street: The Domestic World of Servants and Masters in Nineteenth-Century Rio de Janeiro*. Cambridge: Cambridge University Press.
- Hautzinger, Sarah. 2007. *Violence in the City of Women: Police and Batterers in Bahia, Brazil*. Berkeley: University of California Press.
- Jelin, Elizabeth. 1976. "The Bahiana in the Labor Force in Salvador, Brazil." *Sex and Class in Latin America*. Nash, June and Safa, Helen Icken, eds. Pp 129-146. New York: Praeger Publishers.
- Lamb, Sarah. 2000. *White Saris and Sweet Mangoes: Aging, Gender and Body in North India*. Berkeley: University of California Press.
- Landes, Ruth. 1940. "A Cult Matriarchate and Male Homosexuality." *Journal of Abnormal and Social Psychology* 35:386-397.
- , 1947. *The City of Women*. New York: Macmillan.
- Lears, Jackson. 1985. "The Concept of Cultural Hegemony: Problems and Possibilities." *The American Historical Review* 90(3):567-593.
- Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham: Duke University Press.
- Lock, Margaret M. and Scheper-Hughes, Nancy. 1987. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology." *Medical Anthropology Quarterly* 1(1):6-41.

-
- Mahmood, Saba. 2001. "Feminist Theory, Embodiment, and the Docile Agent: Some Reflections on the Egyptian Islamic Revival." *Cultural Anthropology* 16(2):202-236.
- McCallum, Cecilia. 2007. "Women out of Place? A Micro-Historical Perspective on the Black Feminist Movement in Salvador da Bahia, Brazil." *Journal of Latin American Studies* (39)1:55-80.
- O'Dougherty, Maureen. 2008. "Lia Won't: Agency in the Retrospective Pregnancy Narratives of Low-Income Brazilian Women." *Journal of Latin American and Caribbean Anthropology* (13)2:414-446.
- Onica, Cristina. 2009. *Women's Migration from Post-Soviet Moldova: Performing Transnational Motherhood*. M.A. thesis, Department of Gender Studies, Central European University.
- Parker, Richard G. 1991. *Bodies, Pleasures and Passions: Sexual Culture in Contemporary Brazil*. Boston: Beacon Press.
- Popenoe, Rebecca. 2004. *Feeding Desire: Fatness, Beauty and Sexuality Among a Saharan People*. New York: Routledge.
- Rabelo, Miriam and Souza, Iara. 2003. "Temporality and Experience: On the Meaning of *Nervoso* in the Trajectory of Urban Working-Class Women in Northeast Brazil." *Ethnography*. 4(3):333-361.
- Selwyn, Ben. 2010. "Gender Wage Work and Development in North East Brazil." *Bulletin of Latin American Research*. 29(1):51-70.
- Serruya, Suzanne. 1996. *Mulheres Esterelizadas: Submissão e Desejo*. Belém: UFPA-NAEA.
- Sommers, Michael. 2011. *Brazil*. Chico: Moon Handbooks.
- Stevens, Evelyn P. 1973. "Marianismo: The Other Face of Machismo in Latin America." *Female and Male in Latin America*. Ann Pescatello, ed. Pp 89-110. Pittsburgh: University of Pittsburgh Press.
- Veash, Nicole. 2000. "Violent Death Claims Survivors of Brazil's Child Massacres." *The Guardian*. September 9.
- Walkowitz, Judith R. 1980. *Prostitution and Victorian Society: Women, Class and the State*. Cambridge: Cambridge University Press.