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**Women's Experiences of Sterilisation in Brazil: Negotiating
Reproductive Discourses, Institutional and Intimate
Relationships, and Contraceptive Practices**

Aoife S. McKenna

PhD Population Health Sciences

The University of Edinburgh

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Abstract

The dramatic drop of the fertility rate in Brazil, from 6.2 births per woman in 1960 to 2.5 in 1996, has been attributed to women's increasing use of sterilisation. Despite the fact that sterilisation was illegal, Brazil had the second highest rate in the world in 1996, at 40.1%. Political concerns regarding the abuse of the operation led to the legalisation of sterilisation in 1997 to provide regulation of the procedures. Subsequently, rates of reversible contraception have increased, and sterilisation rates dropped to 21.4% by 2013. Sterilisation in Brazil is thus a useful case study to examine how changing socio-legal contexts can influence experiences or understandings of this contraceptive technology.

This research is based on semi-structured interviews conducted in 2013 with 35 women from a variety of socio-economic and ethnic backgrounds in Rio de Janeiro. This thesis is informed by a sociological perspective on health technologies that takes account of the social context and of lay users' views of their experiences. Several different domains of social life that have an influence on participants' understandings of sterilisation are thus examined, including: wider reproductive discourses, family and intimate relationships, the medical institution within which contraception is provided, and prior experiences of reversible contraceptive technologies.

The thesis demonstrates the importance of examining sterilisation as a socially-mediated practice. At the institutional level, my analysis illustrates how women navigate the shifting ambiguous socio-legal context, as well as the systemic barriers to healthcare, when accessing sterilisation. The influence of intersections of gender, race and class are highlighted in this process, and is evident in women's experiences of family and intimate relationships. At the embodied and individual level, the significance of the design of contraceptive technologies is emphasised, as well as women's prioritisation of their own emotional and physical wellbeing and sexual pleasure. Furthermore, the analysis highlights how reproductive discourses intersect with cultural notions of family ideals and everyday practices, to

influence both decisions about and understandings of sterilisation. Overall, the thesis illustrates how sterilisation is a socially mediated practice that varies dependent on macro contexts of cultural reproductive discourses, as well as institutional, interactional and individual levels.

Lay Summary

The dramatic drop of the fertility rate in Brazil, from 6.2 births per woman in 1960 to 2.5 in 1996, has been attributed to women's increasing use of sterilisation. Despite the fact sterilisation was illegal, Brazil had the second highest rate in the world in 1996. Political concerns regarding the abuse of the operation led to the legalisation of sterilisation in 1997 to provide regulation of the procedures. Subsequently, rates of reversible contraception have increased, and sterilisation rates dropped to 21.4% by 2013.

This research is based on interviews conducted in 2013 with 35 women from a variety of socio-economic and ethnic backgrounds in Rio de Janeiro. It examines several different aspects that influence women's understandings of sterilisation, including: family and intimate relationships, the medical institution in Brazil, and prior experiences of reversible contraception.

My analysis illustrates how women accessed sterilisation before and after it was legalized, and despite encountering barriers to accessing healthcare. The influence of gender, race and class on these experiences is highlighted. When dealing with both reversible contraception and sterilisation, this research shows how women prioritise their own emotional and physical wellbeing and sexual pleasure. Finally, the analysis highlights how wider cultural notions of reproduction intersect with women's everyday family lives and hopes, and how this influences their decisions about and understandings of sterilisation.

Declaration of Originality of Submitted Work

In accordance with University regulations, I hereby declare that:

- (a) This thesis has been composed solely by myself;
- (b) It is entirely my own work; and
- (c) The work has not been submitted in part or whole for any other degree or professional qualification.

Signed: _____

Date: _____

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CHAPTER 1. WHY FEMALE STERILISATION IN BRAZIL?

1.1 Introduction: Aims and Background

This research sets out to explore the understandings that women have about their use of contraceptive technologies, with a particular focus on sterilisation in Brazil. The dramatic drop of the fertility rate in Brazil, from 6.2 births per woman in 1960 to 2.5 in 1996, has been attributed to women's increasing use of sterilisation. Despite the fact that sterilisation was illegal, Brazil had the second highest rate in the world in 1996, as 40.1% of contraceptive users were sterilised (BEMFAM/DHS 1997).¹ Political concerns regarding the abuse of the operation led to the legalisation of sterilisation in 1997 to provide regulation of the procedures and to increase the availability of alternative contraception methods. Subsequently, rates of reversible contraception have increased, and sterilisation rates dropped to 21.4% by 2013 (United Nations 2018).

Sterilisation in Brazil is thus a useful case study to examine how changing socio-legal contexts can influence experiences or understandings of this contraceptive technology. This thesis highlights the importance of understanding sterilisation as a relational practice embedded within women's everyday lives and relationships. This research thus shows that sterilisation should be conceptualised in relation to alternative contraceptives, as well as wider reproduction discourses. The continuing institutional barriers to accessing sterilisation despite its legalisation, and the

¹ Measured as women married or in a consensual union and of reproductive age (15-49 years old).

link to persistent intersecting health inequalities, is also emphasised. Additionally, the findings illustrate the usefulness of applying both indigenous concepts and concepts from the broader field of the sociology of reproductive technologies to the case of contraceptive sterilisation. In doing so, this thesis contributes to more nuanced theorisations of the agency-structure debates, both on sterilisation in Brazil and within the wider scholarship on the medicalisation of reproduction.

This thesis is based on semi-structured interviews conducted in 2013 with 35 women from a variety of socio-economic and ethnic backgrounds. These interviews were conducted within two reproductive health clinics in Rio de Janeiro. While conducting this research, I was very fortunate to attend the Institute of Social Medicine at the State University of Rio de Janeiro. Through this research group, I was able to draw upon the expertise of a wide variety of supportive scholars and becoming familiar with the contemporary research in fields relevant to this research. The details of the research process will be discussed in further detail in Chapter 3.

The development of contraceptive technology over the last 80 years has had profound consequences on the construction and conception of nations, families, gendered social relationships and bodies. Equally, gendered power relationships through both global and local levels have had implications for the ways that contraceptive technologies are developed, distributed and used. Contraception is thus simultaneously an embodied practice, a technology, and a social construct, working differently at different levels within society.

A sociological perspective recognises the fact that contraceptive practices take place in the context of a whole range of reproductive and sexual health concerns, acts and events. These can be studied at various levels; from pharmaceutical companies that develop contraceptive technologies, to policy makers who incorporate them into their plans, the health professionals who provide them at local services, and the millions of people worldwide who use them. These levels often have conflicting interests and values, both between and within them. For instance, this can be seen in the contradictory interests of population control and birth control in the international development health agenda. It is thus important to examine how sterilisation is understood in terms of wider social discourses, institutions, social relationships, as well as individuals' embodied experiences and beliefs.

My approach is informed by a critical sociological perspective on health technologies that takes account of the social context and of lay users' views of their experiences. Several different domains of social life that have an influence on participants' understandings of sterilisation are examined, including: wider reproductive discourses, family and intimate relationships, the medical institution within which contraception is provided, and prior experiences of reversible contraceptive technologies. The analysis aims to demonstrate how each of these domains come together to shape participants' experiences and understandings of sterilisation. As such, the thesis constitutes a weaving of individual, interactional, institutional and ideological threads through various domains of Brazilian social life. This research thereby aims to avoid a reductionist narrative that obscures the complexity of these various, interacting aspects of contraceptive sterilisation.

The thesis demonstrates the importance of examining sterilisation as a socially-mediated practice. At the institutional level, my analysis illustrates how women navigate the shifting, ambiguous socio-legal context, as well as the systemic barriers to healthcare, when accessing sterilisation. The influence of intersections of gender, race and class are highlighted in this process, and is evident in women's experiences of family and intimate relationships. At the embodied and individual level, the significance of the design of contraceptive technologies is emphasised, as well as women's prioritisation of their own emotional and physical wellbeing and sexual pleasure. Furthermore, the analysis highlights how reproductive discourses intersect with cultural notions of family ideals and everyday practices, to influence both decisions about and understandings of sterilisation. Overall, the thesis illustrates how sterilisation is a social practice that varies dependent on macro contexts of cultural reproductive discourses, as well as institutional, interactional and individual levels.

This research was initially designed to explore the concept of enhancement through a sociological examination of the case of sterilisation in Brazil. Enhancement is generally described as involving the "use of medical interventions aimed at improving the mind, body or performance" (Conrad and Potter 2004). A sociological examination of enhancement involves a critical approach to health technologies, examining how these things are shaped by social, economic and political factors (Pickersgill and Hogle 2015). In this context, scholars have focused on the different meanings of health and illness, understandings of the body, the significance and implications of

different healthcare systems, and the different meanings and views of technology (Lock, Young et al. 2000).

Given the complex history, associations and practices around sterilisation in Brazil, it was originally proposed that this case study could further understandings of the concept of enhancement. However, during data collection and analysis, it became apparent that the concept was not useful for interpreting the data, and so the original focus on enhancement was dropped. For instance, participants were more interested in issues of accessing the operation and the health system than in the operation itself and its effects on the body. Still, my initial interest in the concept did shape the research as it prompted me to situate sterilisation within an examination of other types of contraceptive technologies, as well as understandings of health and the health system more broadly.

The background context to the thesis will be introduced in this first chapter. I outline the importance of examining contraceptive technologies as well as my decision to focus on the case of female sterilisation in Brazil. I provide some details on the changing contraceptive trends in Brazil, particularly focusing on the ambiguous legal and procedural context regarding sterilisation. I also outline some relevant information on the health system and health inequality in Brazil. I then briefly introduce a significant debate around sterilisation within the wider social science literature, as well as a key concept used in this thesis. Finally, the chapter ends with an overview of the structure of the thesis.

1.1.1 Contraception: International Agendas and Trends

While there is much sociological interest in assistive or new reproductive technologies (NRTs), there are fewer such studies of fertility control and contraceptive technologies. This is despite the fact that a large number of people use contraception technologies daily all over the world. The latest data from the United Nations indicates that worldwide, 63% of women of reproductive age and in a union use contraceptive methods. In addition, contraceptive use is above 70% in Europe, Latin America and the Caribbean, and Northern America (United Nations 2017: 1).² Latin America and the Caribbean is the region with the highest levels of contraceptive prevalence in the world in 2017,³ with South America as the highest sub-region at 77% (United Nations 2017: 6). Within Latin America and the Caribbean, the most populous countries in the region—Brazil, Colombia, Mexico and Peru—all had contraceptive prevalence levels of 70% or more, contributing to the overall highest levels of contraceptive use among all regions (United Nations 2017: 18).

“Modern”⁴ contraceptive methods comprise the majority of family planning use in 2017. Fifty eight percent of in-union women of reproductive age used

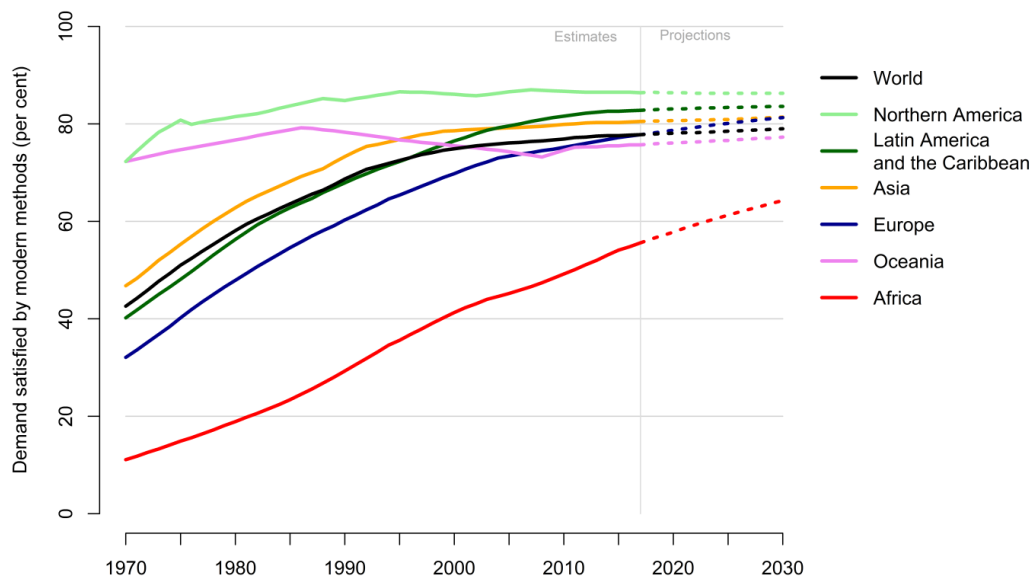
² Compared to contraceptive use rates below 25% in Middle and Western Africa.

³ Contraceptive prevalence is defined as: ‘the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception.’ It is usually reported for married or in-union women aged 15 to 49. WHO. (2018). "Sexual and Reproductive Health: Contraceptive Prevalence." Retrieved November, 2018, from https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/.

⁴ U.N. research report (2017) defines the following methods as “modern”: sterilisation, implant, injectable, IUD, pill, condoms, vaginal barrier, lactational amenorrhoea method (LAM), and emergency contraception. This definition excludes

a modern method of contraception worldwide, constituting 92% of contraceptive users. In addition, the amount of contraceptive users globally has been growing and is expected to continue increasing in the near future (see Figure 1.1 below). The worldwide number of in-union women using contraception technologies is projected to rise by 15 million, from 778 million in 2017 to 793 million in 2030 (United Nations 2017: 6). The widespread, changing and increasing use of contraceptive technologies, particularly modern methods, indicates that further research on these “every-day” technologies of fertility control is necessary.

Figure 1.1 Demand for family planning satisfied by modern contraceptive methods among married or in-union women, by region, from 1970 to 2030



From: United Nations (2017: 12). Data Source: United Nations, Department of Economic and Social Affairs, Population Division (2017b). *Model-based Estimates and Projections of Family Planning Indicators 2017*. New York: United Nations.

“traditional” methods such as rhythm and withdrawal. For a social science critique of this definition see Russell, A., M. Thompson and E. Sobo (2000). Contraception Across Cultures: Technologies, Choices, Constraints. Oxford, Berg Publishers.

Furthermore, universal access to a full range of safe and reliable fertility control methods, by use of modern technologies in particular, is a central goal of the United Nations General Assembly 2030 Agenda for Sustainable Development (United Nations 2017: 2). Therefore, the U.N., the “international community” and other recent global partnerships,⁵ aim to increase the “health and well-being of the population” (Goal 3) and improve “gender equality and the empowerment of women and girls” (Goal 5) (United Nations 2017: 2). The U.N. intends to achieve these goals by focusing on:

Universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes (target 3.7) (United Nations 2017: 2)

Contraceptive technologies, practices and knowledges are therefore being actively shaped and spread with particular agendas at multiple levels of society. However, feminist, anthropological and sociological studies of reproductive and sexual rights, as well as biomedicine and technology, demonstrate that such top-down goals and change are rarely understood and implemented uniformly, or straight-forwardly, across various cultural and national contexts (Russell, Thompson et al. 2000, Adams and Pigg 2005).

The U.N. (2017) report, *World Family Planning – Highlights*, also illustrates this point by demonstrating how contraceptive use and unmet need for family planning differs widely across countries. The variety is large, not only by

⁵ Such as Family Planning 2020, Every Woman Every Child, and Adolescents’ Health.

geographical region, but also within income classification groups. Economic development does not explain the dissimilarities in the proportion of women using modern contraceptive methods across countries as there is a large heterogeneity within income groups (United Nations 2017: 16). Upper-middle income countries, for instance, usually have higher modern contraceptive prevalence, including: China, Brazil, Costa Rica and Thailand. However, on the opposite end are Bosnia and Herzegovina and Equatorial Guinea, with modern contraceptive prevalence of 19% and 14% respectively (United Nations 2017: 16-17). These differences illustrate how crucial it is to research the complex array of cultural, political and social practices that shape contraceptive practices.

1.1.2 Sterilisation: A Gendered Technology

The complex influences that shape contraceptive practices can also be seen to shape the specific technology of sterilisation. Sterilisation is the most common form of contraception in the world and is highly gendered. Female rates of sterilisation are higher than male in every country in the world apart from five, despite the fact that it is a more complex and risky operation than a vasectomy (EngenderHealth 2002). Female sterilisation rates were as high as 47.4% in the Dominican Republic in 2007, 40.1% in Brazil in 1996, and 33.7% in India in 2006.⁶ Within those countries with higher rates of male sterilisation, there are also a variety of trends, with some as high as 21% and others as low as 4.5%.

⁶ Measured as contraceptive prevalence among women in a union and of reproductive age (15-49) (UN 2018 World Contraceptive Use: *Information Note*).

Figure 1.2 Most recent sterilisation data highlighting gendered rates

Country	Year	Female Sterilisation	Male Sterilisation
Dominican Republic	2014	40.7	0.2
Puerto Rico	2002	38.5	5.3
India	2015	36	0.3
Bhutan	2010	7.1	12.6
New Zealand	1995	14.6	19.5
United Kingdom	2008	8.0	21.0

Source: *World Contraceptive Use* (United Nations 2018)

These figures illustrate how sterilisation rates are both highly gendered and vary greatly between countries and across time. For something so prevalent and yet extremely varied, it is thus somewhat surprising how little sterilisation has been studied. Sterilisation is one of the oldest modern methods of fertility control, dating back to 1881 (Speert 1996: 591-2), and it is still the most widespread form of contraception in the world, despite the increased availability of other methods (EngenderHealth 2002: xi). Crucially, however, sterilisation rates in Brazil have also varied greatly over time and between genders, as will be outlined in section 1.3 below.

Before focusing on the details of the case of sterilisation in Brazil, the following section will provide some wider context regarding health and contraception within Brazil.

1.2 Brazilian Socio-Political Context: Health and Contraception

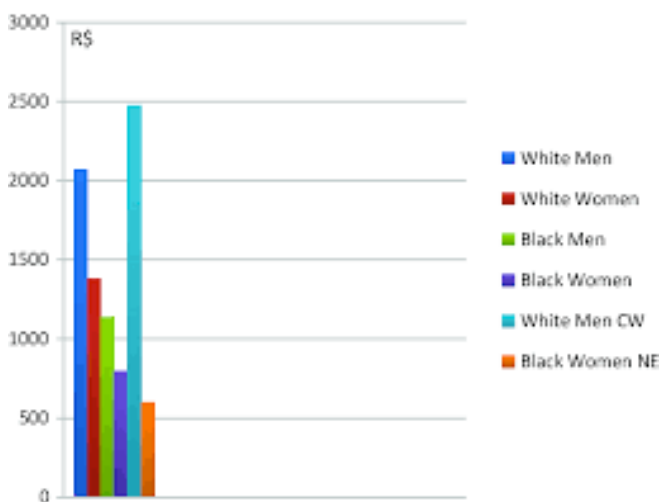
Brazil has often been described as a country of contradictions, created by both a wide cultural and ethnic diversity, as well as extreme socio-economic inequalities (Levine 1997, Corrêa, McIntyre et al. 2005). The average income a month in 2002 was R382.6, with the lowest 10% on 29 *Reais*, and the highest on R1803 (Coes 2008). There is also a strong racial dimension to class divisions in Brazil, as 70% of the poorest 10% are black (IBGE 2000, cited in UNDP, 2005).

Progress was made more recently after the Workers Party came into power in 2003. During the administrations of former President Lula da Silva (2003–2010) and the first administration of President Dilma Rousseff (2010–2014), economic growth and pro-poor policies significantly reduced inequalities (Costa 2017). During this period, GDP per capita increased by 64%, poverty rates declined from 48.4 to 23.9%, and social policy expenditures rose from 12.7 to 16.8% of the Brazilian GDP. Furthermore, unemployment rates declined from 11.7 to 5.4% among the economically active population (CEPAL 2014). Additionally, between 2002 and 2013, income inequality as measured by the Gini coefficient decreased from 0.59 to 0.53. Despite this improvement, income inequality in Brazil is still high, as the richest quintile possess 53.6% of all income. Brazil thus remains the most unequal Latin

American country when it comes to income concentration by upper classes (Costa 2017: 66).

Inequalities associated with racial and gender categories remain high, but there was a significant decrease in income asymmetries during the administrations led by the Workers' Party. In 2002, women's total average income represented only half of the male average income, whereas in 2012 this percentage rose to 58% (Costa 2017: 66). A comparable alteration can be seen for racial income inequalities. In 2002, the average income among blacks corresponded to 47% of whites' average income. Yet in 2012, this percentage amounted to 55% (ibid: 67). A similar reduction in regional inequalities also occurred. Yet regional inequalities still matter, particularly when combined with gender and race-related inequalities, as the figure below shows:

Figure 1.3 Average monthly earnings in Brazil, 2012



Average earnings from the main occupation of the population over 16 years old. Calculated for the intersection of inequality factors: sex, race, and region (figures in Brazilian *Reais* as of September 2012). NE: Northeast, CW: Centre West. Data Source: Brazilian Institute of Geography and Statistics (IBGE) (2012). Figure from Costa (2017: 67).

These disparities are reflected in health inequalities and an important aspect to bear in mind when examining the health system and access to contraception in Brazil (see Chapter 2).

1.2.1 Military Dictatorship and Re-Democratisation: (Reproductive) Health 1960s – mid 1990s

This subsection provides a very brief overview of the earlier influence of the military dictatorship government on the health system and the use of contraception in Brazil. It also describes how the re-democratisation period led to the creation of the public health system and how reproductive health policies influenced access to contraception. This context is necessary in order to fully understand women's accounts of both the health system and sterilisation in this thesis.

Studies critical of the military dictatorship in the early 1980s described Brazilian social politics as characterised by centralised federal decision-making, resistance to social participation in decision-making, inadequate and socially-regressive financing and privatisation of the public sphere (Santos 1979). While this socio-political organisation was present before the military dictatorship, which ruled from April 1964 to March 1985, research has illustrated how this regime reinforced this pattern (Santos 1979). Giffin interprets this 'privatisation' of social policy as being part of a conservative modernisation strategy dominated by elite groups (Giffin 1994). She argues that this process was rooted in "clientelistic public bureaucracies" (Giffin 1994: 355) and agrees with Vianna that it "instrumentalizes cooptation, stimulates corruption and blocks any reform" (Vianna 1989). This process

and its effects were particularly evident in the case of private health and education networks at the time.

Historically, the Brazilian government maintained an explicitly pronatalist position due to strategic interests regarding its territories and industrialisation. These interests converged with a conservative “maternalism” associated with the Catholic Church (De Bessa 2006). Despite these considerations, the Military government assumed an ambiguous laissez-faire attitude towards family planning organisations (Fonseca Sobrinho 1993). Due to the lack of official policies related to fertility control,⁷ private, internationally-supported family planning agencies began operating in Brazil after 1965. These agencies often promoted programmes that were physically located in public hospitals and health posts. However, they remained completely unintegrated in administrative, technical and political terms (Giffin 1994).

Research on fertility in Latin America in the 1960s reported high rates of contraceptive use in Brazil.⁸ In the mid-1960s fertility rates started to decline in the wealthiest regions of Southern Brazil and among upper-middle classes. In the following decade, fertility rates dropped in all regions and

⁷ Due to conflicting ideologies of the Catholic Church, military authorities, medical establishment and other political groups. See Canesqui, A. M. (1985). "Planejamento familiar nos planos governamentais." Revista brasileira de estudos de população 2(1).

See also: Wegner, R. and V. de Souza (2013). "'Negative' eugenics, psychiatry, and Catholicism: clashes over eugenic sterilization in Brazil." Historia Ciencias Saude-Manguinhos 20(1): 263-288.

⁸ Refuting expectations linking contraceptive practice as a result of development, as mentioned above.

classes (Bozon and Enoch 1999). These studies revealed a relatively widespread use of abortion, higher rates of fertility control among higher economic class women, and growing rates of contraceptive practices among working-class women (Iutaka 1965, Mogeey 1971).

The influential Brazilian women's movement emerged from the increasingly widespread critique of the military regime and wider social engagement in issues of citizenship in the late 1970s and early 1980s. Despite concerns regarding the threat of demographic control, the movement reached an agreement on the need for public provision of contraception. This led to a Health Ministry proposal in 1983 for a progressive programme of comprehensive healthcare for women (PAISM) (Pitanguy 1994). The programme included an advanced model of care, including: women's healthcare during adolescence and menopausal care; attention to all aspects of health, such as cancer prevention, STI care, and infertility; the first public mandate for contraceptive methods; and the organisation of multi-professional teams.

Furthermore, the PAISM programme also aimed to prevent the excessive imposition of medical practitioners' authority, and allow women to act as conscious decision-makers in matters related to their own health. Thus, consciousness-raising through group education was recommended for both women clientele and in the training of health professionals. This programme was widely debated by both health professionals and the women's movement, and members of the latter group initially became active

collaborators in the implementation of PAISM, at both the federal level and across the country (Pitanguy 1991, Giffin 1994: 356).

In addition, the public healthcare system or *Sistema Unico de Saude* (SUS – Unified Health System) was established in 1990 as set out by the 1988 Constitution. It defined health as a right and guaranteed reproductive freedom of choice and access to family planning. The health system therefore also formed part of a wider political project aiming to guarantee more civil rights to the population. The constitutional changes aimed to promote universal low-cost medical care, along with a greater focus on preventive care and community participation (WHO 1985, Béhague, Gonçalves et al. 2002). The health system was proposed as a universal, integrated institution with built-in public accountability through health councils at national, state and local levels (Corrêa, McIntyre et al. 2005: 76).

However, Brazil experienced a further political institutional crisis during the late 1980s and early 1990s. This crisis negatively affected the relationship between civil society and the state, particularly in the area of reproductive and sexual health (Corrêa, McIntyre et al. 2005). As a result, the status of the National Council on Women's Rights was downgraded in 1989, and the PAISM programme and the 1988 Constitution's improvements for the public health system were also delayed.

1.2.3 The Public Health System: 1994 - 2013

After the political crisis mentioned above, a period of unusual political and institutional stability occurred in Brazil during President Cardoso's

administration (1994 – 2002). This context led to the establishment of a comprehensive series of mechanisms for social accountability as well as the legitimisation of a national policy agenda on human rights (Corrêa, McIntyre et al. 2005). However, Brazil also experienced erratic economic growth during this era with periods of financial instability, leading to: high unemployment, low income, increased everyday violence, and a lack of public investment in many social policy areas.

Despite these negative trends, health policy improved during this era, particularly due to the health system safeguards drawn up by the 1988 constitution. In addition, from 1993, the health system began the process of decentralisation, and its managerial structure, operations and accountability were tightened. Since 1994, the institutional environment has favoured the expansion of primary healthcare and the use of sophisticated systems for health information collection and policy monitoring. These structural elements contributed to the extremely effective policy response to HIV/AIDS in 1992-93, as well as the revival of the Programme for the Comprehensive Care of Women's Health in 1997-98 (Corrêa, McIntyre et al. 2005: 75). The contemporaneous debate on sterilisation will be addressed in further detail in the following section 1.3 below.

Now around 80% of the Brazilian population depend on the SUS for healthcare. Alongside these reforms, several types of private hospitals have also expanded. The remaining 20% of the population therefore pay for private healthcare, which is generally of a much higher standard. In 2012, 66% of the country's hospitals, 70% of its 485,000 hospital beds, and 87% of

its 723 specialized hospitals belonged to the private sector. In the area of diagnostic support and therapy, 95% of the 7,318 establishments were also private (Ministry of Health 2012). Healthcare access is therefore very much marked by class and consequently, by race. This imbalance in resources between the public and private healthcare facilities is an issue raised by participants in the narratives on healthcare access addressed later in the thesis.

Although the SUS made healthcare more accessible to the general population than before, the high ideal of free healthcare for all is still frequently undercut in reality by lack of funding, support and mismanagement. The SUS is a frequent topic in the news, which discusses issues such as health policies, new clinics and particularly problems with and scandals about hospital care. During my data collection period, for example, scandals included an instance where an elderly woman, Ms. Maciel, died because soup was injected into her veins (Gavazzi 2012) and two children who received 3rd degree chemical burns when given acid to drink instead of medicine (G1 O Globo 2012). After Maciel's death, there was public outrage and many journalistic investigations into hospital malpractice. An example of this would be *Época* magazine's edition of the 26th November, where the headline of the front cover was: 'What the Hospitals Don't Tell You,' and the article was titled 'What they don't tell you, and how you can protect yourself' (*Época* 2012: 94). Vocal dissatisfaction with the healthcare system in Brazil was therefore widespread at the time.

In addition, from April to July 2013, halfway through my data collection, Brazil experienced the largest public protests since the early 1990s. Around two million people protested in over 100 cities and diaspora locations around the world. Began by the Free Fare Movement (*Movimento Passe Livre*) in order to protest the increase in public transport prices, it rapidly grew to encompass other public services such as healthcare and education, along with political corruption scandals and spending on international sport events. The June protests were the largest, and shaped or expressed public perception and discourse on social services and political mismanagement. This context is crucial to understand the data in this research, as there is clear evidence of the widespread critique of the health system found in participants' narratives, as well as the associated link with wider issues of inequality in society and political corruption.

1.2.4 Recent Trends: Health Inequality Focus

While there have been many improvements regarding health in recent years, such as the reduction in maternal and infant mortality rates (Corrêa, McIntyre et al. 2005), wider axes of inequality are still reflected in health trends in Brazil. Health inequality has long been documented in Brazil, particularly the North-South divide, and persists today. The wealthier southern states have higher life expectancy and lower infant mortality (Duarte, Schneider et al. 2002). Variations by area within cities have also been documented, reflecting socioeconomic and residential inequalities (Caiaffa Waleska, Almeida Maria Cristina de et al. 2005). In Rio de Janeiro, studies have documented an association between adverse health outcomes and residential concentrations of poverty, as the worst health indicators are found within the *favela* communities (Szwarcwald, Bastos et al. 2000).

Over the past four decades, studies on health aim to explore 'quality of life' alongside mortality rates, following the WHO definition of health as a 'complete state of physical, mental and social wellbeing.' Recent research in Brazil has also followed this trend. In Rio de Janeiro for instance, Szwarcwald, da Mota et al. (2011) examined 'healthy' life expectancy where health is established by degree of functional limitation. They found that life expectancy varied by as much as 13 years between the richest sectors of the city compared to the poorest *favela* areas. Results regarding healthy life expectancy increased the inequality considerably, as it was shown to be almost twice as high in wealthy areas compared to the *favelas* (Szwarcwald, da Mota et al. 2011: 522). In addition, women have far higher rates of disability and lost years of healthy life than men.

These results demonstrate high social inequalities in health that are particularly marked by residential variation, and that experiences of health are deeply embedded within local social contexts. These class and race divisions also shape reproductive healthcare, as for instance, white women had higher rates of caesarean delivery than any other ethnic group, both in areas of low and high access to hospital delivery (Freitas, Drachler et al. 2009). Due to the prevalence of health inequalities and how this is shaped by both class, race and gender, issues around accessing healthcare and the public health system are contentious and highly debated in Brazil.

1.2.5 Recent Trends: Contraceptive Practices

There have been several recent dramatic changes in contraceptive trends in Brazil. General usage, however, is still clearly shaped by gender, class, race, and the particular cultural and medical context. For example, contraception was generally accessed without prescription at the time, although emergency contraception is still a much debated and stigmatised issue (Brandão, Cabral et al. 2017). It is important therefore to provide some background regarding broader contraceptive trends, as these can be seen in relation to sterilisation use in Brazil.

As indicated above, Brazil's dramatic fertility decline influenced the wider increase in contraceptive use in South America between 1970 and 2000. Brazil has one of the highest rates of contraceptive use in the world, increasing from 66.2% in 1986 to 80.2% of in-union women of reproductive age in 2013. The preferred methods, however, have varied greatly during this period. Female sterilisation rates, for instance, increased from an estimated 26.8% in 1986, to the second highest rate in the world in 1996 at 40.1% (see Figure 1.4 below). This dramatic increase then reversed, lowering to 29.1% in 2006, and reducing further to 21.4% by 2013. Sixteen countries now have higher female rates of sterilisation than Brazil, the majority of which are located in Latin America and the Caribbean. In contrast, during the same period in Brazil, male sterilisation reached a maximum rate of 5.1% in 2006, again illustrating how sterilisation is a highly gendered technology.

The decreasing rates of sterilisation have been linked to the increasing availability of reversible contraception. Reversible contraception rates

increased during the same period, particularly the hormonal pill, which increased from 25.2% to 34.2%. These changing rates of contraceptive use are the result of a variety of complex cultural and socio-legal factors that will be explained in detail in the following section 1.3.

Figure 1.4 Contraception Rates 1986 - 2013, Brazil

Year	Female Sterilisation	Male Sterilisation	Hormonal Pill	Injectable	I.U.D.	Male Condom
1986	26.8	0.8	25.2	0.6	1.0	1.7
1996	40.1	2.6	20.7	1.2	1.1	4.4
2006	29.1	5.1	24.7	4.0	1.9	12.2
2013	21.4	4.2	34.2	5.3	2.0	10.3

Percentage of women of reproductive age (15-49) and in a union who use contraception. Source: *World Contraceptive Use*, (United Nations 2018)

1.3 Sterilisation in Brazil

This section aims to clarify the conditions under which the participants of this research accessed sterilisation.

1.3.1 Sterilisation Before Legalisation

This subsection will detail the legal status, policy and practices around sterilisation in Brazil before the operation was legalised in 1997: more than half of the women who participated in this research were sterilised during

this period. This policy context shaped the sterilisation law itself and also influenced women's experiences of the operation after it was legalised.

Brazil's dramatic fertility decline, from roughly six births per woman in 1965 to 2.5 births in 1996 (Goldani 1999:29) occurred in a context where state family planning policy was absent (Vieira and Ford 1996), where abortion was illegal, and sterilisation had a quasi-legal status. Yet by 1996, Brazil had the second highest number of operations in the world recorded at the time, as more than one-quarter of Brazilian women of reproductive age and in a stable union had chosen to be sterilised (Berquó 1999:119). This rapid drop in fertility surpasses those of Mexico and India, which both had official family planning policies at the time (Martine 1996).

As outlined in section 1.2.1, family planning was introduced 'unofficially' in Brazil on a large scale by private domestic and international organisations in the 1960s (Pitanguy 1994: 113), usually through the domestic family-planning organisation ABEPF (The Brazilian Association of Family Planning Entities); itself funded by USAID (United States Agency for International Development) and International Planned Parenthood Federation (De Bessa, 2006: 230). Domestic agencies trained professionals on tubal ligation, and offered free sterilisation at 150 affiliated hospitals and clinics (O'Dougherty, 2008: 417-418). Lisboa (a former Brazilian Health Minister Advisor) affirmed that from 1985 to 1988, Brazilian NGOs in the field of family planning received US\$ 32 million (Guerra 1991, cited in Costa 1995: 72). This widespread implementation of fertility control therefore indicates a de facto anti-natalist policy. Researchers, such as De Bessa (2006) and Serruya (1996),

link this to a sociocultural change involving the expansion of capitalism and a push for 'modernisation.' Studies have linked the fertility drop to the daily *telenovelas* (soap operas), depicting modern, small, middle-class families (Faria and Potter 1999, Ferrara, Chong et al. 2012).

Within this ambiguous context, sterilisation was both legally restricted and condemned as unethical by Brazil's medical code of ethics (Janowitz, Covington et al. 1982, Rutenberg and Ferraz 1988, Vieira and Ford 1996, Correa and Avila 2003). Although there was no specific law prohibiting sterilisation, it was considered illegal by many jurists due to article 129/2 III of the 1940 Penal Code, which considered any type of "serious bodily lesion resulting in the loss or incapacity of the reproductive function" as a crime (Berquó 1993: 375, Faúndes and Cecatti 1993). Sterilisations were, however, performed under "exceptional circumstances" where a woman was considered to be at risk if she became pregnant (article 52/6 Medical Ethics Code). Sterilisation was, therefore, not covered by the public health system nor by private health insurance.

To further complicate the matter, the legal status of sterilisation also became ambiguous due to conflicting parts of the 1988 Constitution. One section of the constitution states that each couple is free to select any contraceptive method in order to regulate fertility. However, the article relating to the permanent loss of function of a "member, sense or function" in the Penal Code was not updated (Rutenberg and Ferraz 1988: 62). As a result, the Health Ministry officially ignored the existence of sterilisation as the most widely-used form of contraception (Giffin 1994).

Women with previous caesarean deliveries, however, were considered to be at risk if they became pregnant again (Janowitz, Covington et al. 1982). The Brazilian medical code recommended that all future deliveries be by caesarean once one birth had been a caesarean. Furthermore, until the late 1970s, physicians were compensated at higher rates for caesarean births than for vaginal births (De Bessa, 2006: 224), and even though the pay rates were later equalised, the health system still supported surgical deliveries in the late 1980s and early 1990s (Faúndes and Cecatti 1993). This, along with the routine practice of sterilisation after three caesarean deliveries (Barros, Vaughan et al. 1991) increased the frequency of tubal ligations. The so-called exceptional circumstances thus became unofficially routine, as for example, four out of five tubal ligations were unrecorded procedures following caesarean delivery (Rutenberg and Ferraz 1988).

Combining these operations allowed for payment, anaesthesia and concealment of the unauthorized procedure (Potter, I.H.O. Perpetuo et al. 2003). Research shows that caesareans were performed very frequently in Brazil partly to camouflage the numerous privately, and informally paid-for tubal ligations (Janowitz, Covington et al. 1982, Giffin 1994, Vieira and Ford 1996, Berquó 1999, Hopkins 2000, McCallum 2005). Brazil had one of the highest rates of caesarean sections in the world by the early 2000s, as around 30% of births in public hospitals and 70% in private hospitals (Potter et al. 2003) were by caesarean section. Although sterilisation was initially a privilege of the rich in Brazil, accessible through private health clinics (Barroso 1984), it gradually became more accessible to the poorer sections of society (Dalsgaard 2004: 213). Researchers have argued, therefore, that

sterilisation and caesarean sections have become mutually reinforcing procedures and consumer services (Berquó 1993, Therborn 2004: 283).

The widespread but unofficial and legally ambiguous nature of sterilisation in Brazil led to various kinds of unregulated and illegal activities associated with the operation. For instance, there is evidence of sterilisation being exchanged for favours such as political votes, doctors being paid to reach a certain number of sterilisations, and sterilisations performed without consent (Caetano and Potter 2004). Despite this ambiguous status, sterilisation became the most common form of contraception in the country.

The pervasive but unregulated access to sterilisation was eventually addressed and the law introduced, predominantly due to the alarm raised by black feminist activists (Roland 1995, Edu 2015). The activists were concerned that (poor) black women were the most frequent victims of forced sterilisations, leading to fears that the unregulated operation was resulting in, what they termed, a type of 'genocide' (Geledés 1991, Berquó 1999, Correa and Avila 2003). A Parliamentary Inquiry Commission into eugenic practices was eventually set up to research the operation in 1991. This research found that women were not always given consent forms to sign before the procedure, and that a small number of poor and indigenous women had been sterilised against their will. It also found that some employers asked women to provide a sterilisation certificate before they could start working (Caetano and Potter 2004; De Zordo 2012: 209).

The results of this investigation into potentially racist aspects of sterilisation were vague (Berquó 1994). A later analysis found higher rates of sterilisation among women who identified as brown (*parda*) than white (*branca*) or black (*preta*). These results suggest that there were differential barriers to accessing sterilisation (Caetano and Potter 2004: 242). The commission did, however, find higher rates of sterilisation among: women with lower education, young women with multiple pregnancies, as well as women whose first pregnancy occurred at a young age (Berquó 1999, Vieira 1999, Osis, Faundes et al. 2003).

Finally, research at the time also found a low rate of sterilisation regret among a minority of women. The initial research conducted on regret after sterilisation in Brazil provided paradoxical results. Several studies have demonstrated that rates of regret were high in Brazil (Costa 1995: 21). All of these studies show that low age and few living children at the time of sterilisation are statistically significant (Hardy, Bahamondes et al. 1996, Vieira and Ford 1996). Other reasons stated include: remarriage, poor counselling and limited knowledge about, or access to, reversible contraceptive methods (Hardy, et. al., 1996). In contrast, other studies have shown that women were satisfied with sterilisation (Osis, Faúndes et al. 1999).

De Bessa point out that these earlier levels of regret are relatively low considering the large number of women that had undergone sterilisation (2006: 233). She gives a figure of 17% in a study by Vieira and Ford (2006: 234). However, the authors themselves state that although the majority seem satisfied with their choice, “an important proportion of women (24%) were

not” (Vieira and Ford 1996: 37). Research that is more recent, however, demonstrates a low level of regret (Potter, I.H.O. Perpetuo et al. 2003). The contradictory results of this research on regret appears to vary according to methodological issues such as: the researchers’ definition of what regret is, what constitutes a low or high level, the questions asked, the indicators accounted for, and the sample chosen. Concern over sterilisation abuse and regret was therefore part of what led to the legalisation of sterilisation in 1997.

1.3.2 1997 Legalisation of Sterilisation and Recent Health Policy

The 1997 legalisation of sterilisation aimed to regulate the operation, preventing hidden and forced operations. Law 9.263/96 allows voluntary sterilisation for women and men who are 25 years old or who have at least two living children. The legislation also stipulates a 60-day waiting period, counselling, and a signature of consent from the partner. Postpartum sterilisation (i.e., sterilisation within 48 hours of delivery) was banned in 1999, except for women with a history of multiple caesarean sections. Penalties for operations outside of these restrictions were also introduced (Caetano and Potter 2004). The waiting period and counselling were introduced to avoid regret following the operation, which was a major concern at the time⁹.

Only licensed hospitals complying with these requirements receive reimbursement for tubal ligations (De Bessa 2006: 233). Potter et al. (2003) point out that the new law itself creates some barriers for a procedure in high

⁹ The new and updated Penal Code was eventually implemented in 2003.

demand. They also note that despite its intentions to de-link tubal ligations from caesarean deliveries (and thus reduce unnecessary medical risk), the new law may not succeed in doing so, because, ironically, multiple caesarean deliveries is still an eligibility criterion for sterilisation (De Oliveira and Hoga 2005). Consonant with Brazil's two-tiered healthcare system, the law therefore mandates governmental controls over poor women's access, while leaving free-market regulations for private healthcare (Vieira and Ford 1996: 1431).

More recently, discourses around 'sexual and reproductive rights' and 'gender equality' that were dominant in political and media debates, led to important policy changes regarding reproductive health. At the time of data collection, the '*Rede Cegonha*' or 'Stork' programme had a significant influence on reproductive health and contraceptive practices. This programme, initiated in 2011, aimed to implement policy changes to reproductive health in line with these more recent agendas, with a particular focus on 'humanising birth.' This policy emphasised the use of long-term reversible contraceptives for women, alongside pre-natal care, the inclusion of their partner in the process, the choice of 'natural birth centres,' and the role of midwives. This contemporaneous policy therefore places more of an emphasis on contraceptive technologies other than sterilisation. This may have influenced the further drop in rates of sterilisation, from 29.1% to 21.4% between 2006 and 2013.

The 1997 law on sterilisation was shaped by previous socio-legal practices, feminist critiques regarding barriers to access and racist abuse, as well as

concerns regarding regret. Some of the stipulations probably derive from feminist and democratic perspectives on increasing education, awareness and decision-making capabilities, as outlined in subsection 1.2.1 above. The necessity of a partner's written consent and policies aimed at reducing regret appear to increase barriers to access. Furthermore, the fact that there has been a continuous, wide gap between high female sterilisation and low male sterilisation rates means that the requirement of a partner's signature reinforces sexist gender dynamics in practice. Thus, the law reduces women's bodily autonomy in effect, as men legally have significant control over women's reproductive and sexual lives. More broadly, recent reproductive and sexual health policies have further implemented the aims set out by the PAISM programme. Maternal healthcare has improved and access to reversible contraceptives has increased.

Overall, this section on sterilisation in Brazil details how the operation became so widespread despite the shifting political ideologies and aims. The following section will shift the focus to examine some significant approaches to sterilisation within the social science literature, both more broadly and within Brazil.

1.4 Introducing a Key Social Science Debate & Concept

This section provides a brief introduction to significant theoretical approaches to sterilisation within social science literature, as well as a key concept that is used later in the thesis.

Historically, sterilisation has often had quite clear, negative connotations linking it to eugenics programmes and human rights abuses. The rise of the welfare state in the late nineteenth century coincided with increasing international interest in family planning (Rodgers 2002: 250-273). In the early decades of the 20th century, both right-wing and left-leaning politicians, policy-makers and scientists became concerned about the effects of medicine and social safety nets on the quality of the human gene pool (Duster 2003). As a result, many countries (including the USA, Canada, Australia, Sweden, Denmark, Finland, and Switzerland) implemented state-sponsored eugenics programmes, which infringed to various degrees on individual rights (the most famous of which was instituted by the Nazi regime in Germany) (Duster 2003).

This concern with the size and characteristics of the population was evident in Brazil since the beginning of the Empire, throughout the republic and the more recent military dictatorship and democracy periods (Fonseca Sobrinho 1993). Before the transition to democracy in Brazil in the 1980s, mass migration from the poorest regions of the country to the cities in the south, along with widespread diseases causing deformities, were a cause of concern for the political elite. In this context, family planning was proposed as an “instrument of preventive medicine” (Coutinho 1998: 82), the cheapest answer to the high infant and maternal mortality rates, as well as to overpopulation, poverty and urban criminality. Contraceptive practices therefore formed part of a eugenic perspective, which aimed to create healthy, productive citizens in order to develop a modern nation (De Zordo

2012)¹⁰. In this perspective, poor women in particular had a moral responsibility to control their reproduction, and were often blamed for wider social ills if they did not. Scholars such as Souza (2016) and Boarini (2002) provide an overview of the particular elaboration of 'hygiene' in Brazil, as well as the debate over and eventual rejection of sterilisation as a tool of eugenics.

Issues relating to the abuse of sterilisation, therefore, have been discussed at length in the social science literature on the topic. Many studies of sterilisation are historical accounts concerned with the issue of eugenics, in countries such as the U.S. (Schoen 2005), Germany (Bock 1984) and India (Tarlo 2003). Consequently, scholars have also analysed the issue of agency in relation to sterilisation, particularly in the (post) colonial context, as for example Briggs' (2002) study of sterilisation in Puerto Rico. This focus on agency, however, is also related to wider theoretical concerns around the medicalisation of reproductive health technologies in general. These theoretical concerns around contraception and sterilisation will be discussed in further detail in the following Chapter 2.

1.4.1 Agency and Sterilisation in Brazil

Echoing the studies on sterilisation in other places and times, much of the literature in Brazil has also focused around the question of women's agency.

¹⁰ For work on the distinction between positive eugenics (e.g. welfare programmes) and negative eugenics (removal of certain populations), see Cunningham-Burley, S. and A. Kerr (1999). "Defining the 'social': towards an understanding of scientific and medical discourses on the social aspects of the new human genetics." Sociology of Health and Illness 21(5): 647.

The legally ambiguous status of sterilisation in Brazil, along with the dramatic rates of female sterilisation, prompted intense interest in the interplay between individual choice and structural constraints. Thus, scholars have wondered whether the desire for sterilisation indicates an attempt at greater autonomy or whether it is a last desperate resort (Giffin 1994, Osis, Faúndes et al. 1999: 523).

These earlier works can be situated within broader approaches to reproductive and sexual health, where binary conceptualisations of agency see it as in opposition to, and falsely separate from, structure; instead of a dynamic, interactive relation (Carter 1995, Coole 2005). Several more recent qualitative studies on sterilisation in Brazil move beyond the dualistic conceptualisation of active agency (voluntarism) versus passive, subjected ones (determinism). These works find ways to represent the agency of women as embedded within and “responding to a social economic and political field” (O’Dougherty 2008: 423). These qualitative studies examine sterilisation in Brazil with regards to the state management of reproduction (Corossacz 2009), kinship, (Dalsgaard 2004), medicalisation (De Bessa 2006), agency (O’Dougherty 2008), heterosexual relationships (Cabral 2011) and race (Edu 2015).

These works will be discussed in further detail in Chapter 2, however, the main point to mention here is that they succeed in conveying more nuanced approaches to the active agency of their research participants. To varying degrees, these studies “represent the women as social actors who generate and produce effects, even if they do not resolve the complex and contradictory circumstances of their broader context” (O’Dougherty 2008: 423) (McNay 2000: 102). Much of this research, however, is based on data collected in the early 2000s and even mid-1990s. There are, as yet, fewer in-depth qualitative

studies on sterilisation and contraception since the more recent dramatic reversal in trends of contraceptive use (for exceptions see Cabral 2011 and Edu 2015).

The participants of this research also raise issues of agency with regards to their experiences of sterilisation. This thesis, however, attempts to build on these later approaches to sterilisation, moving beyond the dualistic notions of structure and agency. I draw on concepts from narrative analysis and STS in particular to address conceptualisations of agency when they arise within the data. Nonetheless, as stated above, this thesis attempts to avoid a reductive approach to sterilisation in Brazil, as issues of agency were not the primary focus or original aim of this research. Instead, my analysis attempts to illustrate the interweaving of various social domains within women's lives in relation to sterilisation, and how elements of these domains contribute to the enactment of sterilisation as a multi-level and shifting social practice.

1.4.2 A Key Concept: the 'Brazilian Way, or' *Jeitinho*

As this thesis aims to trace the institutional and legal influences evident in participants' accounts of sterilisation, my analysis draws on the Brazilian concept of the *jeitinho*¹¹. The *jeito* (way) or *jeitinho* (little way) is a common practice in Brazil, and is generally understood as a means of social navigation and a way of accomplishing something by bending or bypassing the rules (DaMatta 1991). The *jeitinho* usually requires the use of resources such as money, social savviness and social networks. The historian Levine, for instance, describes the *jeitinho* as a "way to grease the wheels of government or the bureaucracy, so as to obtain a favour to bypass rules

¹¹ Diminutive, pronounced *jay-tchEE -nho* [zej'tʃĩnu].

or regulations” (Levine 1997: 81). This concept, therefore, is a particularly useful means of understanding participants’ perceptions of accessing healthcare in general and sterilisation.

Due to the ambiguous nature of the status of sterilisation in Brazil, the *jeitinho* has been previously raised as a means to understand the ways that women accessed the operation (Dalsgaard 2004, Edu 2015), although the concept itself generally does not form a significant part of these works. Furthermore, as my initial focus was more around enhancement and the embodied understandings of the operation, and as it had been around 16 years since sterilisation was legalised, I did not expect issues of access to still be a major concern for this research. However, it soon became clear that concerns around access formed a major theme in participants’ narratives when discussing healthcare in general, reversible contraception and sterilisation. The women’s repeated use of the words *jeito* or *jeitinho* in the context of these access narratives helped me to refocus my analysis. This concept is therefore used in this thesis as both a category raised by participants and as an analytic category, where I use it to indicate similar practices related to the majority of *jeitinho* narratives.

There are a variety of cultural associations as well as differing theorisations of the *jeitinho* in the literature, reflecting the complexity of this social phenomenon and the discourses surrounding it. The following Chapter 2 will discuss these varying approaches to the *jeitinho* in more detail; nevertheless at this point, it is useful to explain that this thesis limits use of the concept to concrete examples of practices dealing with the access of

healthcare, contraception and sterilisation. The *jeitinho* is an important mechanism by which this research moves beyond the agency-structure binary, allowing an examination of the particularities of the enactment of postionality and power as represented in participants' narratives.

1.5 Structure of the Thesis

This thesis sets out to explore Brazilian women's accounts of sterilisation in Rio de Janeiro. In the main empirical part of the thesis, several different domains of social life that have an influence on participants' understandings of sterilisation are first examined. The wider context of both the family and the health system are thus detailed in the first two chapters, before examining women's experiences of reversible contraception in Chapter 6. The final two data chapters focus in detail on women's sterilisation accounts.

The following Chapter 2 provides a detailed account of the theoretical resources that influenced my analysis; particularly drawing upon concepts from the fields of the sociology of medicine, the sociology of science and technology, and the sociology of reproductive and contraceptive technologies. Chapter 3 extends this discussion by explaining how these theoretical positions relate to the methodology of the thesis. Informed by both epistemological and ethical concerns, I present a critical and reflexive account of my research practice; particularly regarding my approach to language and translation issues. This chapter also explicates further key methodological decisions that I have made, such as my choice to use semi-structured interviews and narrative data analysis. Additionally, it provides essential information on the characteristics of the sample.

The core body of the thesis is comprised of five empirical chapters. Chapter 4 introduces the participants of the research, providing an overview of their work and family lives. The chapter demonstrates the importance of collective notions of family, particularly as support networks. Several characteristics of the family are elaborated within this collective context, including: the ideal number of children as 'a pair' (*um casal*); the centrality of matrifocal families and the importance of consanguine ties.

Chapter 4 also details participants' understandings of parenthood and the importance of motherhood in particular. Significant themes that emerge here include notions such as the 'home and street' and the 'fighter' discourses; concepts that will be discussed later through the lens of sterilisation. Finally, the chapter outlines participants' experiences and notions of conjugal relationships, highlighting a discourse on the unreliability of male partners. The highly gendered nature of participants' accounts of family and relationships is highlighted throughout the chapter. Intersections of class and race are also evident, as participants' emphasise the difficulty of precarious living conditions and inequality that most face in their daily lives.

Chapter 5 examines participants' understandings of wellbeing and the healthcare system in Brazil. As mentioned above, the public healthcare system is unevenly developed, and analysis in this chapter focuses on the strategies that the women use to access healthcare within this context. As such, the chapter examines women's descriptions of the obstacles that they face, including both structural and interactional challenges. Issues around a

lack of infrastructure, inefficient bureaucracy, insufficient facilities and doctor-patient relations are outlined.

In Chapter 5, the concept of the *jeitinho* is drawn upon to illustrate how participants' narratives develop a critique of power and inequality. This concept also serves to demonstrate how participants experience a position of precarity and their active attempts to navigate these conditions. An examination of accounts of positive understandings of healthcare further highlight how these experiences are shaped by intersections of class, race and gender. This chapter illustrates how health inequalities are both experienced and enacted; reinforcing existing socio-economic disparities. Chapter 5 therefore introduces themes of power, positionality and agency in healthcare that are a crucial context for the later chapters on sterilisation.

Chapter 6 examines participants' accounts of their experiences with reversible contraceptive technologies. Following on from the focus on relationships and the health system in the previous two chapters, Chapter 6 now focuses on how these social and health contexts can be seen to influence participants' use and perceptions of contraception. Most participants talked about how their experiences of reversible contraception influenced their decision to obtain sterilisation. However, this chapter illustrates how their accounts reveal a variety of understandings and experiences of these technologies.

How participants learn about and access contraception is examined first, particularly regarding the role of family silence, the *jeitinho* and the

reproductive health clinic. Various dimensions of participants' contraceptive use are then explored in detail, as most talked about using contraception irregularly at one point in their lives for a variety of reasons. This chapter thus focuses on women's accounts regarding the influence of intimate relationships, daily obligations and the physical effects of contraception technologies.

Several themes emerge in these accounts, including participants' conceptions of trust alongside the discourse on male infidelity as outlined in Chapter 4. In addition, the gendered nature of contraception negotiation, as well as the significance of participants' sexual priorities, are also emphasised. Furthermore, the unsuitability of contraceptive technologies for fluid intimate relationships and unstable or precarious life conditions in Chapter 6 thus demonstrates how contraception is relational, social, and embedded within class, gender and race dynamics. At the same time, however, I also illustrate how the physical 'otherness' of both barrier and hormonal contraception is likewise often emphasised.

Continuing the discussion of accessing healthcare and contraception technologies, Chapter 7 sets out to explore participants' accounts of accessing sterilisation. The context and themes outlined in Chapter 5, such as systemic barriers to healthcare and health inequalities, play a crucial role in this chapter. The chapter compares accounts of participants who were sterilised before it was legal, after legalisation, and those planning to sterilise at the time of the interviews. Alongside the issues and practices outlined in Chapter 5, the case of sterilisation thus adds a further emphasis on the

influence of the legal and policy context. The combination of structural issues with the health system, along with the legally ambiguous status of the operation, increase the difficulty participants have accessing sterilisation.

Chapter 7 details how participants' employ *jeitinho* practices to pursue sterilisation in this complex context. Doctor-patient relationships are shown to be complicated and uncertain, and involve various ways of carefully negotiating power dynamics. Health inequalities are further re-enacted, as these experiences are generally shaped by social categories such as class, race and gender. The analysis illustrates how the women's narratives also critique issues of positionality, power relations and inequality, and how a wider discourse on regret appears to have been codified by the law. I suggest that Cussin's (1996) concept of 'ontological choreography' helps to illuminate these processes of objectification, highlighting when they are experienced as fulfilling agency and when they are experienced as a denial of agency. This concept helps to move theorisation of agency in this context beyond the limiting 'agency versus structure' binary conceptualisations evident in much of the earlier debates on sterilisation in Brazil and reproductive health technologies.

Chapter 8 is the final data chapter and it focuses on women's decision and evaluations of sterilisation, as well as the broader discourses in their accounts on the right to sterilise. This chapter refers back to each previous data chapter, demonstrating how elements of each social domain already addressed contribute to participants' broader understandings of sterilisation. Following on from the women's point about unsatisfactory reversible

contraception influencing their decision to sterilise as discussed in Chapter 6, this Chapter examines the broader reasons participants gave for their decision to sterilise. These accounts draw on the context described in Chapter 4, as it outlined participants' discussions of the difficulty of 'life conditions' and of parenthood. I illustrate how the combination of gendered cultural ideologies of the family and wellbeing, alongside conditions of inequality and particularly precarity, work together to shape contraceptive practices. Sterilisation is depicted here as a way of managing living conditions and as a means to achieve personal goals.

Chapter 8 also widens the lens on sterilisation further to examine participants' perceptions of the 'right to sterilise.' Women draw on two different reproductive discourses when discussing this topic. A discourse on reproductive rights emphasises personal autonomy and women's decision-making capacity, but is also framed in relation to the wider discourse on regret that was raised in Chapter 7. A second, neo-Malthusian reproductive discourse is also drawn upon to discuss, what participants term, the irresponsible reproduction of the poor - including issues such as poverty, violence and forced sterilisation policies. This discourse, however, is tempered by an emphasis on the structural violence inherent in precarious living conditions.

A further discourse, related to the reproductive rights one, around the 'fighter' as discussed in Chapter 4 and in themes related to accessing healthcare, is also taken up in relation to sterilisation. This narrative places the blame on the system rather than poor women. These discourses

intermingle in some accounts, differentiating between self, a specific other and society in general. This reflects how sterilisation works differently across various macro and micro levels. Finally, Chapter 8 also examines women's evaluations of their sterilisation. These short accounts of participants' personal experiences highlight how the operation increases women's wellbeing, by reducing worry and improving sexual satisfaction. Overall, this chapter highlights how sterilisation is conceptualised differently across different conceptual levels.

Finally, Chapter 9 provides a concise review of the main findings outlined in the thesis. This final discussion draws these themes together and discusses the findings in relation to previous research. It then outlines some implications of the findings in relation to policies and practices around contraceptive sterilisation. Finally, the chapter concludes with a review of the limitations of the thesis and makes suggestions for potential future research avenues to explore.

CHAPTER 2. LITERATURE REVIEW

2.1 Introduction

My intention in this chapter is to outline the concepts and theories that inform the analysis in the later empirical chapters. Due to the conceptual approach outlined in Chapter 1, this literature review is quite broad ranging, and draws upon several bodies of work. This review aims, therefore, to emphasise conceptual issues relevant to the analysis, rather than provide an exhaustive review of each area. Following on from the outline of the broader issues regarding health and the health system in Brazil in the Introduction, the first section of this chapter examines social science studies of health inequalities and healthcare. The second part of the chapter provides an overview of the literature on the Brazilian concept of the *jeitinho*. The third section examines social science approaches to reproductive and contraceptive technologies. The final section outlines critical studies of sterilisation, providing a brief overview of wider social science literature on the operation, and then focusing on studies of sterilisation in Brazil.

2.2 Sociology of Healthcare

To examine participants' understandings of the health system and their accounts of accessing healthcare, I drew upon sociological studies of healthcare and medicine. This research has examined various related issues such as: how culture shapes experiences of health and illness, how individuals understand and experience medical treatment, and the role of healthcare systems. This section begins by briefly introducing the sociological research on health inequalities and social difference, followed by an overview of the literature on health institutions and doctor-patient relationships. Themes raised in this discussion include the social shaping of

health, interactional and structural elements of health systems, and issues of power and positionality.

2.2.1 Health Inequalities and Intersecting Oppressions

One of the central concerns of medical sociologists over the last 60 years has been to document and explain gender, socioeconomic and ethnic differences in health (Williams and Sternthal 2010). Earlier research on these patterns examined the disparities in the distribution of health services among social groups and much research focused on systematic differences in access to healthcare. Research on how health and medicine is shaped by gender¹² has examined issues around power, agency, the commodification of healthcare and medicalisation (Demos, Kronenfeld et al. 2003). Studies have examined, for instance, the significant gender differences in help-seeking with regards to health (Green and Pope 1999), and how men are more likely to receive better treatment than women for the same condition (Lockyer and Bury 2002). Additionally, research has illustrated how health-related beliefs and behaviours are social practices that occur in daily lives and are implicated in the social structuring of gender and power (Courtenay 2000). Overall, these studies illustrate how the social patterning of gender and health is multifaceted and highly responsive to social contexts and to social change.

¹²Using this term, as well as 'sexuality', with the awareness that they are now treated by gender theorists as performative accomplishments instead of as fixed characteristics. See Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. New York, Routledge.

Furthermore, decades of studies by sociologists demonstrate that there is a strong link between social class and health.¹³ Research, for example, shows that people with less education and income face greater obstacles accessing health services than people who are wealthy, despite having higher healthcare needs (Williams and Collins 1995, Graham 2009). In addition, studies in the U.K. show how life expectancy has increased for both men and women across all social classes, though the improvement has been more rapid for those at the top of the hierarchy than for those at the bottom (Graham 2009). The relation between wealth and health is particularly clear regarding international health inequalities, including the so-called global 'North/South' divide (WHO 2008). Sociologists such as Navarro (2002), for instance, have argued that class relations should be held accountable not just for inter- and intra-national health inequalities, but also for the widespread failure of governments to tackle them effectively and for persistent flaws found in many healthcare systems. As mentioned in the previous chapter, health inequalities have long been documented in Brazil, particularly focusing on class divides. These studies examined regional differences in health such as the wealthy South and poorer Northern states, as well as socioeconomic variations within cities (Duarte, Schneider et al. 2002).

Research on health inequalities has also examined how experiences of health intersect with ethnicity or 'race.' Sociological research on ethnicity is concerned with understanding how ethnic and racial groups become social realities, the relationships between them and the causes of social inequalities between them. Within this work there is agreement that the concept of 'race'

¹³ How class is defined and measured is a longstanding debate outwith the scope of this thesis. For more on the debates around class and health, see Scambler, G. (2002). Health and Social Change: A Critical Theory. Buckingham, Open University Press.

as reflecting genetically distinct groups, does not have scientific validity, i.e. people cannot be divided into races based on genetic differences. In contrast, ethnicity reflects an identification with cultural traditions that provide (fluid) boundaries between groups (Nazroo 2013). Sociological studies on ethnicity take into account that the cultural traditions associated with ethnicity are historically located and context dependent.

Some elements of these discussions of ethnicity have been adopted by sociological research on ethnicity, race and health. Differences in health across ethnic groups, for instance, have been documented in the U.S. and in the U.K. (Smedley, Stith et al. 2002, Sproston and Mindell 2006), with higher morbidity and mortality rates for ethnic minorities. Still, within these broad trends, studies show that health disadvantage varies across ethnic groups and by condition (Modood, Berthoud et al. 1997, Nazroo, Falaschetti et al. 2009, Lakhanpaul, Bird et al. 2013). For instance, Karslen and Nazroo (2002) show how both the experience of racial harassment and the perception of the U.K. as a racist society are strongly related to poor health. Additionally, research by Atkin et al. (2014) illustrates how racism may be structuring the experiences of black students with sickle cell disorder at school even in the absence of specific accounts by young people. Furthermore, Bridges' (2011) ethnography shows how race is socially constructed among women using the public health system in the U.S. for reproductive healthcare, illustrating how they are marginalised by the assumptions and practices of the clinic staff.

Until recently, most public health research in Brazil on health rarely measured race as a variable, as until 1996, Brazil did not require the collection of health data by race (Hogan, de Araujo et al. 2018). The lack of

racial data in health records and the national census probably stemmed from the structural racism underpinning Brazil's national image during the 20th century as a “racial democracy.”¹⁴ The dearth of studies focusing on racial health disparities and the health of the African-descendant population was also due to a corresponding tendency to focus on social class as the primary division in Brazilian society, as mentioned above. Currently, for instance, race is still inconsistently included in health records (Corossacz 2009). Still, recent studies provide increasing evidence that black Brazilians experience poorer health and lower life expectancy rates in comparison to white Brazilians (Filho, Beltrán-Sánchez et al. 2014). Additionally, maternal mortality rates are significantly higher for black women across most states (Martins 2006, Volochko 2010).

Since the 1970s, black women health activists pushed for the acknowledgment of racial health disparities and policies that impacted on Black women's health (Fonseca Sobrinho 1993, Santos 2012). These activists and scholars, for instance, were influential in calling for the use of the epidemiological category *Negro* (Black) in health research. This challenged the government's previous tendency to divide African-descendant people into two colour categories in health records, *Pardo* (Brown) and *Preto* (Black), which impeded clear analysis regarding the effects of race/ethnicity on health (Telles 2004, Martins 2006). Additionally, feminist research on women's reproductive health, particularly sterilisation, often took account of issues around gender, class and race (Geledés 1991) (see Chapter 1 and section 2.5 below).

¹⁴This discourse downplayed Brazil's history as the country with the longest involvement in racial slavery in the Americas.

Since then, wider critical discussions concerning institutional racism in the Brazilian health system have gained increasing attention (Laguardia 2006, Kalckmann, Santos et al. 2007). These studies have particularly highlighted the impact that discriminatory treatment has on black women. Researchers have emphasised differences in pregnancy-related care by health professionals between black and white women (Leal, Gama et al. 2005, Domingues, Nascimento et al. 2013). The use of the concept of institutional racism in these works represents a move away from the previous lack of dialogue around structural and systemic racial inequalities in Brazil (Caldwell 2017).

While my analysis of social difference and health inequalities in the following chapters builds upon the studies above, I also draw on the concept of intersectionality. This concept was originally elaborated by Crenshaw (1989, 1991) and derives from the work of black feminists in the U.S. (Lorde 1989, Hill Collins 1991). Intersectionality is a mode of analysis that examines how various forms of identity (such as age, ability, class, gender, race or sexuality) are mutually constitutive. This allows an analysis of how multiple forms of oppression interact to shape the life experiences of marginalised groups of people.

The sociologist Patricia Hill Collins, for instance, used an intersectional framework in her historical analysis of representations of Black sexuality in the U.S. (Hill Collins 2005). She links these understandings of Black sexuality to a history of coerced sexual reproduction during slavery, and demonstrates how race, gender and sexuality are interconnected in these constructions.

The concept of intersectionality, therefore, facilitates an examination of a structural view of oppression, one that takes account of the:

“vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms - in short, the normal processes of everyday life” (Young 1990 p.41, quoted in Hogan, de Araujo et al. 2018: 98).

Furthermore, since the early 2000s, an increasing number of researchers have used the concept of intersectionality to examine issues around health in the U.S. and the U.K. (Weber and Parra-Medina 2003, Hankivsky, Reid et al. 2010).

Although the concept of intersectionality is valuable for research that involves participants with multiple, intersecting identities, some qualifications must be made regarding how the concept is drawn upon in this thesis. General scholarly usage of intersectionality has now moved beyond the original premise of the concept that social categories of identity, such as gender or race, are fixed and stable (as mentioned above; see also Puar 2012). Furthermore, the use of this concept as the sole framework for analysing issues of social difference can reproduce a Euro-American feminism bias (Yuval-Davis 2006), thereby omitting the contributions of feminist scholars from the global South, as well as transnational and postcolonial feminist scholars (Grewal and Kaplan 1994, Mohanty 2003). To avoid this, I have drawn upon the particularities of the (Black) feminist movement and concerns in Brazil (Carneiro and Santos 1985, Hahner 1990, Roland 2009). I also employ approaches developed by a variety of global

South, postcolonial and Brazilian scholars (Corrêa 1989, Spivak 1999, Priore 2011), and more broadly, disciplines that have developed postcolonial critiques (e.g. Holmes, Marques et al. 2014, Harding 2016). These theories will be outlined in the following sections, as well as Chapter 3.

2.2.2 Healthcare Systems

Much of the early research in medical sociology examined diverse facets of healthcare organisations. These studies stressed the challenges involved in the organisation of healthcare services, such as the depersonalisation and undervaluing of patients; the predisposition toward bureaucratic medical treatment and decision-making; and the relational dynamics between doctors and patients (Goffman 1961, Goss 1963, Freidson 1970). Strauss et al. (1963), for instance, focused on how hospitals are social organisations that result from processes of negotiation between members regarding the division of work and the functions of institutional roles. Later research focused more on medical work and healthcare professions, such as Strong's (1979) work on the ritual forms of medical consultations.

As mentioned above, the sociological study of the relationship between healthcare professionals and patients has a long history (Parsons 1951). An influential study by Szasz and Hollender (1956) proposed three types of doctor-patient relationships, including: activity-passivity, guidance-cooperation, and mutual participation. They argued that these types were fluid, changing over time and depended on the particular illness, and suggested that the third type was the ideal relationship to aim for. Their work had a significant influence on research during the following decades (Balint 1957). Thus, subsequent studies tended to view doctor-patient relations as a site where doctors exercise power over patients. This lack of

collaboration has been analysed from a variety of perspectives (Waitzkin 1991, Conrad 1992, Charles, Gafni et al. 1997). Freidson's (1970) work, for example, pointed out that the doctor-patient relationship contains an inherent conflict. He argued that doctors aim to apply general knowledge to an individual, whereas the patient seeks to retain acknowledgement of their individuality and thus control over their future.

Much scholarship within medical sociology has also drawn upon the influential work of Foucault (Foucault 1979, Atkinson 1995, Foucault 2003), particularly his concept of "biopower," for example. Biopower refers to the historical shift that allowed political authorities to wield influence through the production of knowledge and regulation of information about vital processes such as life and health (Foucault 1979). This concept has been used to examine the intersections of states, institutions and individual experiences, as well as strategies and procedures for governing life. Rose (2007) shows how politics is tied to the task of managing life and calls this "the politics of life itself." Biehl's (2005) work, for example, draws upon this approach to describe the "biopolitical subjects" that are created when biomedical expertise intersects with "the social and bureaucratic practices that socialise subjects of the modern welfare state" (Ong 1995, 1243; see also Petryna 2002). His research will be discussed in further detail below.

Another approach to the matter of doctor-patient relations is evident from sociologists influenced by conversation analysis (Boden and Zimmerman 1991, Hindmarsh and Pilnick 2007). This research has demonstrated how an asymmetry in interaction is not automatically derived from institutional processes, but can also arise from both doctor and patient (Maynard 1991). From this viewpoint, the patient may actively choose to listen to the doctor

and take advantage of the doctor's greater knowledge (Have 1991). The analysis in the following chapters draws upon these theories to conceptualise participants' accounts of their encounters with doctors. Related approaches from narrative analysis,¹⁵ for instance, are used to address issues of positionality in participants' accounts of navigating unequal power relations; both within the health system in general and in relation to the process of accessing sterilisation.

Research has also moved beyond a narrow focus on the doctor-patient relationship to include other healthcare professionals (Allen 1997), as well as acknowledging the increasing intricacy of healthcare systems and medical work. The functions of healthcare systems are more widely distributed than before and more medical activities take place outside the hospital, such as in out-patient or community clinics (Armstrong 1998). Researchers have examined the diversity of settings and activities within this context, also moving beyond the focus on diagnosis and treatment. Pilnick et al. (2010) point out that visits to health services may be therapeutic in nature, administrative or related to training. These approaches conceptualising the health system more broadly are useful for this research, as the later empirical chapters show how participants discuss a wide variety of activities and encounters related to the health system.

Research has addressed the increasing complexity of health systems and biomedicine in a variety of ways. Focusing more on specific types of structural power and how it affects individual's agency, another strand of sociological research began to examine the concept of medicalisation. Zola

¹⁵ See Chapter 3.

provided an earlier, influential perspective on medicalisation, defining it as a “process whereby more and more of everyday life has come under medical dominion, influence, and supervision” (Zola 1983: 295, Conrad 1992). This was seen as particularly pertinent for women as: “a plethora of female conditions has come to be either reconceptualised as illnesses or [...] understood in ways that connote deviation from some ideal biological standard” (Riessman 1983: 9). Furthermore, the concept of biomedicalisation, as proposed by Clarke et al. (2003), describes the transformation of biomedicine that began in the 1980s, as “increasingly complex, multisited, multidirectional processes of medicalisation, both extended and reconstituted through the new social forms of highly technoscientific biomedicine” (2003: 161).

These concepts have been employed by researchers to emphasise the gendered and racial dimensions of postmodern biomedical technoscience (Clarke, Fishman et al. 2010). For example, Edmonds’ (2007) research on plastic surgery in Brazil illustrates how problems with different social roots manifest as aesthetic defects, which are then diagnosed and treated surgically by the beauty industry. He argues that these marketing and clinical practices mobilise a racialised ‘beauty myth’ as part of a key trope in national identity. Additionally, work by Edmonds and Sanabria (2014) shows how both plastic surgery and sex hormone therapies are used for non-medical purposes such as: modulating affects or physical strength at work, opening social doors, emulating Playboy models, boosting desire, or protecting a marriage” (2014: 204). They argue that the uses of these technologies are “rooted in Brazil’s regulatory context and societal expectations placed on medicine as a means for managing women’s reproductive and sexual health” (2014: 202).

Furthermore, scholars have also examined the complexity of health systems in terms of the relationship between public and private health sectors (McKinlay, Potter et al. 1996, Mechanic 2001, Harley, Willis et al. 2011); often exploring how these types of systems can affect health inequalities (Smedley, Stith et al. 2002). Social scientists frequently focus on the wide gap between the public and private health sectors in Brazil, particularly the inefficiency of the public health system (SUS), as will be discussed below. These issues are particularly relevant considering the 1988 constitutional recognition of health as a right for the people and duty of the state in Brazil, as mentioned previously.

In this context, researchers have examined the operation of the health system in Brazil in various ways. Biehl's (2005) influential ethnography, for instance, traces the complex interactions of family, medicine, state, and economy that lead to and constitute the abandonment and pathology of a young woman. Another way that scholars have examined the consequences of a dysfunctional health system has been to focus on the judicialisation of the right to health (Ferraz 2009); examining pharmaceuticalisation trends and how patients are using the courts to access prescribed medicines (Biehl, Petryna et al. 2009). This research shows how health litigation became an alternative pathway for Brazilians to access healthcare medicines that were previously only available through the market (Biehl and Petryna 2011). These works examine the role of the neoliberal government as drug purchaser and distributor; facilitating relationship of subjects of interests (rights) to the biomedical market in the form of technology access (2011: 380).

Finally, sociological studies of science and technology (STS), have examined how medical work is accomplished across multiple systems and technologies. Research has explored, for instance, the use of support systems to generate routines, efficiency, standardisation and institutional control (Casper and Berg 1995). Berg's (1997) study shows how these new technologies and systems both reframe and transform medical work. In addition, Mol (2002), for example, focused on the nature of medical work in hospitals, examining how the complexity of medical objects is managed in order to reach a singular medical problem that can be institutionally dealt with. Lastly, STS scholars have also examined how people sometimes deal with the complexity or inefficiency of systems by using 'workarounds.' The topic of workarounds will be discussed in further detail in the following section on the *jeitinho*.

2.3 The *Jeitinho*, or Brazilian 'Way of Doing Things'

As mentioned in the previous chapter, the *jeitinho* is a widespread practice in Brazil that involves bypassing the rules to deal with problems in a variety of social contexts. This section provides an overview of some of the literature on the concept of the *jeitinho*. The concept will then be discussed briefly in relation to the sociological work on bureaucracies, as well as the sociology of science and technology work on 'workarounds.' Drawing upon the *jeitinho* concept allows an analysis of themes already raised in the previous section, such as issues of positionality and power relations regarding the role of bureaucracy and doctor-patient dynamics.

There are a variety of perspectives evident on the *jeitinho* within this literature, as well as in wider public discourse on the topic. Earlier studies on

the *jeitinho* proposed that it operates as a 'para-legal institution,' (Campos 1966) and that it emerged as a central social category and strategy in order to deal with the excessive formalism of Brazilian society (Ramos 1966). Other scholars conceptualised the *jeitinho* more broadly in relation to Brazilian national identity. Torres (1973), for instance, argued that the *jeitinho* is a life philosophy and a 'peculiarly Brazilian way of being' involving the capacity to adapt to unexpected difficulties due to specific historical conditions. Furthermore, the well-known public figure and anthropologist, DaMatta, proposed that the *jeitinho* is a Brazilian style of 'social navigation' that deals with wider impersonal norms by relating in an empathetic or humane way with others (DaMatta 1984).

More recently, the *jeitinho* has also been studied by psychologists as "an indigenous process of informal influence (Smith, Huang et al. 2012), and "central to the collective psyche of a whole nation" (Ferreira, Fischer et al. 2012). Additionally, the *jeitinho* has been examined within organisation studies as an informal mechanism to counteract bureaucratic rigidity (Amado and Brasil 1991, Duarte 2006).

The anthropologist Barbosa examined the various ways that the *jeitinho* is perceived and represented in Brazilian society (Barbosa 1992). Duarte (2006) outlines Barbosa's definition of the *jeitinho* as follows: it is used for unforeseen situations; it is a conscious act of breaking the rules; it is a short-term solution to a problem; it is normally self-serving but can also be altruistic; it can be used between strangers but works better between people who know each other; and it requires techniques that foster the interpersonal

attribute of *simpatia* (Duarte 2006: 511). *Simpatia* is valued by many in Brazil, and means that a person is perceived as charming, warm, friendly and “in tune with the wishes and feelings of others” (Albert 1996: 333, Duarte 2006). Barbosa distinguishes the *jeitinho* from a favour, which requires direct reciprocity. The *jeitinho*, in contrast, involves a broader type of diffuse reciprocity, where anyone can receive the benefits of a *jeitinho* that was not necessarily granted to them specifically. From this view, *jeitinhos* can be given to anyone who needs them when the opportunity arises (Barbosa 1992: 34).

In contrast to this relatively positive perspective on the *jeitinho*, Levine maintains that a *jeitinho* is generally a symptom of inequality and corruption. He argues that *jeitinhos* are often granted by someone who is not a personal acquaintance and must be accompanied by a tip or even a larger payoff (Levine 1997: 81). He points out that several behaviours are associated with the *jeitinho*, such as: people employing subterfuge to evade a legal obligation; officials not performing a legal duty; faster completion of paperwork for an acquaintance or in return for a bribe; officials skirting an unreasonable or economically prejudicial legal obligation; failing to enforce rules or laws because they think that the law is unrealistic or unjust (Levine 1997: 82). Levine acknowledges that the last two cases fall into a grey area where public purposes are arguably served by evading legal obligations (Rosenn 1984: 3-4).

Barbosa seems to view the *jeitinho* as a double-edged sword, representing Brazilian warmth and flexibility even though it simultaneously corrupts and

undermines individualistic and egalitarian institutions. Whereas DaMatta argues that there is an ongoing negotiation between the personalism of the *jeitinho* mode and the egalitarianism of the institutionalism of the state (Hess and DaMatta 1995: 295). Levine strongly critiques those who accept the *jeitinho* as an essential characteristic of the Brazilian character, arguing that these positions imply acceptance of the unfair advantage given to those who know how to bypass the system when resources and payoffs are involved (Levine 1997: 84).

In contrast, Rosenn's (1971) influential work considered the *jeitinho* more narrowly, examining how it functions in relation to the legal system in Brazil. He argued that in this context the *jeitinho* acts as an 'institutional by-pass' that aims to overcome obstacles in overly-bureaucratic systems. Rosenn traces the *jeitinho* back to 17th Century colonial Brazil and the absolutist rule of the Portuguese Empire. He proposes that the formalism in Brazilian society arose from a mixture of centralised power in the figure of the King, along with a complex and rigid legal system (1971: 517). Additionally, the *jeitinho* has been widely linked to the personalism within Brazilian society, which can also be traced to the relationship between masters and slaves in colonial times (DaMatta 1991, Hess and DaMatta 1995, Freitas 1997, Levine 1997). Prates and Barros (1997) acknowledge that personal loyalty is central to social cohesion within Brazil and necessary to overcome bureaucratic inefficiency:

The more formalism is reinforced, the more personal loyalty is strengthened, in order to provide the conditions for the system to flow. The solution to institutional rigidity lies in personal networks." (1997: 65, quoted in Duarte 2006: 514).

Duarte (2008) provides a review of the sociological work on bureaucratic dysfunctions in the workplace. She discusses Merton's work on how dysfunctions arise in bureaucracies due to excessive bureaucratic formalism, where formality is a "social ritual which symbolizes and supports the 'pecking order' of various offices"(Merton 1952 [1940]): 261-2). In this view, bureaucratic formality displaces organisational goals, causing systems to develop rigidities, 'red tape' and an inability to adjust to new situations (Merton 1952: 365). The emergence of informal practices and networks to deal with the effects of excessive bureaucratic formalism has been examined extensively by organisation scholars (Roethlisberger and Dickson 1952: 255). Scholars such as Crozier (1963) have shown how informal networks of relationships between workers are necessary for effective work as well as resistance and the co-optation of power (Selznick 1949, Gouldner 1954). Vieira and colleagues, for instance, conducted research with 20 officials at different bureaucratic levels in Rio de Janeiro during the early 1980s. Their study concluded that the *jeitinho* occurs when people have to deal with hierarchies of power and rigid bureaucracies, and that it is a strategic "recourse to power"(Vieira, Costa et al. 1982).

Duarte establishes a link between the operation of the *jeitinho* and wider sociological conceptions of social capital (Bourdieu 1993). Putnam defines social capital as consisting of 'norms of reciprocity and networks of civic engagement' based on trust (Putnam, Leonardi et al. 1993: 167). For individuals, social capital enables access to social connections that assist in the process of 'getting by' or 'getting ahead.' Specifically, Duarte argues that the presence of social capital increases the probability of successful *jeitinhos* in the workplace.

As mentioned in the previous Chapter 1, this thesis does not address broader issues of a general Brazilian character or national identity regarding the *jeitinho*. Instead, as it is used in the analysis regarding the access of healthcare and sterilisation, theories that focus on the relationship between the *jeitinho* and legal or bureaucratic systems will be drawn upon.

I also draw upon several decades of research by sociologists of science and technology studies (STS) on ‘workarounds.’ Workarounds are attempts to fix a problem, working in ways for which a technology, knowledge system, or power structure are not designed. They are part of the “informal temporary practices for handling exceptions to normal workflow” (Bouskill, Smith-Morris et al. 2018: 2). STS scholars have examined how technology is used for purposes other than those for which it was intended, and how the networks (Pollock 2005), logics (Berg and Mol 1998, Berg and Timmermans 2000) and representational practices (Suchman 1995) form contextually specific workarounds. These workarounds allow people to use their discretion, to resist systems that constrain their work and enable them to meet the responsibly and demands of care (Pollock 2005, Timmermans and Freidin 2007).

Research has approached the issue of workarounds in a healthcare context in a variety of ways. Whooley (2010) for instance, examines how psychiatrists develop workarounds to carve space for autonomy in their practice that undermines the official standards set out by the Diagnostic and Statistical Manual of Mental Disorders (DSM). These practices include using alternative

diagnostic typologies, fudging official paperwork and negotiating with patients. Other scholars argue that workarounds in health systems need to be understood in relation to facilitators and barriers created by local, state and federal policies and regulations (Bouskill, Smith-Morris et al. 2018). This body of work can therefore be useful for conceptualising the *jeitinho* as a particular kind of workaround. Although it is not used specifically to deal with technological issues in this research, it does enable individuals to circumvent problematic rules, particularly by sidestepping overly complex or structured systems (Debono, Greenfield et al. 2013).

2.4 Reproduction and Contraception Technologies

This section outlines relevant trends in the wider literature on reproductive technologies, as well as contraception, which have influenced the analysis in the following chapters. The first part focuses on shifting approaches to the question of medicalisation and agency. The second focuses more specifically on approaches to contraception that account for women's agency, as well as those works that situate contraceptive practices within their social and cultural contexts.

2.4.1 Agency in Reproduction and Contraception Research

Extensive scholarship in the social sciences on reproduction has examined understandings of family and family formation. Research has explored, for instance, the role of the state in shaping relationships and family values (Cunningham-Burley and Jamieson 2003), intimacy in various types of relationships (Jamieson 1998, Rebhun 2007), and families as "relationship processes" rather than "entities" (Campling, Cunningham-Burley et al. 2005). Moreover, research has also focused more specifically on reproduction and

understandings of family. These works have explored issues such as the organisation, politics, and variability of birth practices across cultures (Davis-Floyd and Sargent 1997). From this perspective, the creation of persons through reproduction and birth is closely tied to the production of mothers, fathers, viable children, and families (Ginsburg and Rapp 1995). Strathern's influential work (1988), for instance, argued that persons are "partible" rather than autonomous or self-contained. This scholarship approaches reproduction itself as a "key site for understanding the ways in which people *reconceptualise* and *reorganise* the world in which they live" (Van Hollen 2003: 5).

Within studies of reproduction, a vast body of work has focused upon the role of biomedicine and reproductive technologies. From the late 1970s onwards, feminists have argued that both technoscience and biomedicine are implicated in understandings of the fluid categories of sex and gender. A fundamental subject in the sociological and feminist scholarship on the relationship between women and technology has been the extent to which women are (dis)empowered by their use of medical technological interventions. As mentioned above, a major concern regarding bio/medicalisation is that medical influence constrains the autonomy of people, particularly women. A power differential occurs, for example, when medical experts' views are prioritised and patients' perspectives are excluded (Malterud 1993).

Much earlier feminist historiographies tended to produce top-down accounts of reproductive medicine (Correa 1988). From this perspective, medical knowledge and practices result from the medical profession or the state's patriarchal interests in regulating women's reproductive behaviour. The

process of medicalisation is therefore positioned as something that opposes women's agency. Ehrenreich and English (1989 [1978]), for instance, portray a world where male experts are part of a patriarchal conspiracy, as: "from a masculine point of view the Woman Question was a problem of control" (1989: 4). Medical institutions and health professionals are depicted as acting on behalf of a monolithic and deliberately oppressive institution, and women's only available identity is that of its victims (Correa 1988). Klein's (2008) article drawing on the work of international feminist resistance to "test tube women" provides a more recent example of this approach.

Regarding contraception, this tendency to position bio/medicalisation as in opposition to women's agency can still be seen in some more recent research. Many of the studies that emphasise medicalisation over women's agency focus on the pharmaceutical industry, medical establishment or provider perspective (Olsen 2007, Medley-Rath and Simonds 2010). Tempkina's (2015) study of gynaecologists' medicalisation of contraception, for instance, discusses women's role as objects of the Russian state's demographic policies aimed at increasing the population. Yet, Mamo and Fosket (2009), who researched the advertising of Seasonale contraception, allow space for women's agency when they acknowledge that they cannot fully account women's perspective or experiences, given their methodological choices.

More contemporary sociological and feminist work has pointed out that it is necessary to consider the creative, as well as the oppressive implications of reproductive medical practices. Such practices do not impose straightforward constraints on the forms of existence open to women, but also generate new forms of existence with which individual women engage actively and reflexively (Sawicki 1991, Riessman 1998, Rapp 2000). These

studies therefore highlight the importance of taking lay perspectives into account, focusing on women's understandings and experiences of reproductive healthcare. For example, Ashline's (2014) study of women's sexuality and their interaction with healthcare providers demonstrates both women's sexual agency and selective participation in medicalisation. In emphasising the perspectives and agency of women who engage with reproductive medicine, feminists have also had to take seriously the ways in which it is "about dreams as well as oppression, and about women's aspirations as well as those of male doctors and scientists" (McNeil 2007: 71).

Building upon these approaches, researchers focusing on the technological aspects of reproduction and family formation have explored New Reproductive Technologies extensively. This work has examined technologies of procreation in relation to issues such as kinship (Strathern 1992, Franklin and McKinnon 2001, Luna 2005), biopolitics (Edwards, Franklin et al. 1999) and "stratified reproduction" in the context of state power (Rivkin-Fish 2005). Additionally, studies have explored the ways in which diverse ethnic, cultural and religious identities impact upon understandings of technological solutions for infertility and associated treatment experiences within Western societies (Culley, Hudson et al. 2009). More recently, research on biomedicalized family formation has also explored how new family forms are being created within the context of globalised assisted reproductive technologies. Hudson's (2017) work, for instance, shows how the highly medicalized and commercialised process of transnational assisted reproduction is an example of the "intensification of parenthood practices" (Beck-Gernsheim 2002, Layne 2015).

Additionally, the sociology of science and technology also focuses upon the materiality of technology and reproductive bodies (Haraway 1985). These approaches also address issues of bio/medicalisation or structures and agency. For example, I draw upon Cussin's (1996) concept of ontological choreography, as it is helpful for understanding this complex play of structural constraints on autonomy and personal agency. In her work on In Vitro Fertilization (IVF), Cussins proposes that agency and authenticity are not necessarily in opposition to technological objectification, and explores the role that technology can play in the construction of personhood (Thompson 2005). The concept of ontological choreography describes the processes of producing functional forms of compatibility that "create and maintain the referentiality between things of different kinds," such as persons and reproductive technologies (1996, 575). Furthermore, Cussin's work demonstrates that when objectification is antithetical to personhood, it occurs in specific circumstances that can be traced and understood.

This more nuanced approach regarding the issue of agency can be seen in some recent studies of contraception, which show how women engage in both "selective resistance and selective compliance" (Lock and Kaufert 1998: 2). Jones' (2011) research on medicalisation and the hormonal pill and menstrual suppressant Seasonale in the U.S. includes both structural constraints on women's choices and their experiences negotiating with and navigating within this context. Husain et al. (2013) discuss the medicalisation of contraception from the opposite perspective, as they examine how wealthy, educated and urban women in the U.S. are resisting medicalisation by using behavioural family planning methods.

Several more recent articles discuss the relation between biomedicalisation and the adoption of the pill as a lifestyle medication. These studies discuss hormonal contraception in relation to understandings of health and wellbeing. Mamo and Fosket (2009), for instance, examine Seasonale as part of an ongoing biomedicalisation process that focuses on risk management and the transformation of health itself. This study illustrates how discourses around freedom, empowerment, and personal development are associated with contraception. The authors thus argue that the lines between health and illness are blurred, and that gendered subjectivities and forms of embodiment are produced. Moreover, Jones's work (2011) also examines Seasonale from the perspective of proponents, physicians and users. She argues that discourses on optimisation and control are evident in the advertising and the explanations of her participants, and links these to the 'flexible' subjectivities of a modern, 'risk society' (Harvey 1989, Rose 2007). These studies demonstrate how the changes that the hormonal contraception produce are socially meaningful in their aim to improve life in general, including relationships, comfort, and pleasures.

This thesis builds upon these perspectives on contraceptive technologies that provide a more complex view of the wider institutional and technical influences that shape women's experiences of contraception, as well as taking into account individual agency and understandings of these technologies. This move beyond a falsely positioned women's empowerment/choice versus simplified social objectification is also evident in some contemporary research on contraception in Brazil. These studies on contraception reframe questions regarding empowerment versus control as: how and under what circumstances women are able to appropriate

technologies to reshape their bodies, minds, and practices as they see fit (Bell 1995). These examples will be examined in more detail in the following subsection.

2.4.2 Contraception: Situated Gendered Sexual Practices

Contraceptive technologies straddle various domains of both family and intimate relationships. Contraception can be used, for instance to shape family formations, such as control timing/spacing of births, as opposed to overall fertility limitation (Bledsoe 2005). Bledsoe et al.'s (1998) study in Gambia illustrates how it can also be used to compensate for "losses in maternal reserves" such as miscarriages, infant deaths or other "reproductive mishaps." In addition, contraception is used to protect individual's health and wellbeing by preventing Sexually Transmitted Infections (STIs). As such, these 'everyday' technologies can also form part of and shape everyday intimate, sexual relationships.

Contraceptive decision-making has been researched extensively within both biomedical and the social sciences. One common theme that women discuss is the inconvenience or discomfort of various types of contraceptive technologies. Noone's (2003) qualitative study based in Hawaii highlights how an important lifestyle and access factor for a contraceptive method is whether it interferes with a user's typical activities by necessitating follow-up visits (Erickson 1994, Sadana and Snow 1999). Themes on the aesthetics of the method are also found in previous research on women's experiences of contraception. Many women, for instance, refer to barrier methods as messy or uncomfortable (Bernat 1993, Choi, Roberts et al. 1999). Interference with

sexual spontaneity and with sexual pleasure were also issues, particularly regarding barrier methods (Erickson 1996).

Social science perspectives on contraception, however, view these technologies as practices that are shaped by everyday relationships and socio-cultural norms. Luker's (1975) influential study of contraceptive 'risk taking' argues that medical institutions and women have differing perceptions of the meaning of contraceptive practices and unwanted pregnancy. She points out that clinicians assume that the most significant 'cost' of 'unprotected' (hetero)sex is an unplanned pregnancy, while also minimising the costs of contraception and stigmatising women who do not use it as 'ignorant' or 'irrational' (Luker 1975: 140). Instead, Luker's research demonstrates that when contraception is situated within the lived context of its use, its non-use becomes a rational act. Costs of contraception can include, for instance, the routine interactions with clinicians that they can necessitate, costs to identities and relationships, and the 'side-effects' of hormone-based contraception. An unplanned pregnancy, in contrast, represents a possible, 'unknown' future cost (Luker 1975: 138).

Later studies on contraceptive practices have expanded further upon Luker's work, moving beyond a focus on rational self-interest to demonstrate how these practices are shaped by cultural norms. Cross-cultural studies have thus demonstrated how the meaning and organisation of reproduction is highly variable (Petchesky and Judd 1998). Anthropologists have illustrated how reproduction and contraception are key arenas for the articulation of identity, and that the meaning of contraceptive practices can only be

understood within certain political, social, economic and cultural contexts (Russell, Thompson et al. 2000, Simonds and Ellertson 2004). For instance, Paxon's (2004) study illustrates how women's use of contraception in Greece has been oriented towards maintaining gender norms regarding dominance and passivity in sexual relations. Contraceptive technologies that require women to be active in advance of sex challenge these relationships dynamics. In this context, planning fertility control produces stigma as it necessitates that women transgress local gender norms.

Furthermore, one of the earliest examples of a study on contraception discussing sexuality is Santow's (1993) analysis of withdrawal, which explores how gendered relationship dynamics shape the use of contraception. He demonstrates how the dominance of men, women's shame regarding sex and their bodies, and the minimising of the importance of sex in a relationship, all can lead to inconsistent or low use of contraception (see also Kuss 1997). Additionally, the concepts of fidelity and promiscuity have a significant influence on contraceptive use in several studies. For Cambodian women, Sadana and Snow (1999) found that condom use would not be considered as a method for married couples because it was associated with prostitution. The condom is particularly avoided among Davids' (2000) research participants, as it is a symbol of distrust and is associated with STIs. However, this perspective seems to be changing among younger generations, where condom use is on the rise (Davids 2000: 152). There are, however, strong reasons not to use them, even in cases where users believe condom use is appropriate or a matter of life and death.

Different results have been observed by Brandão (2009) in her study of youth contraception in Brazil. Factors such as a strong sense of fatherhood found in the working classes, and unpredictable use of condoms with “unknown” female partners, contribute to ambiguous perspectives on contraception. Brandão investigates the difficulties that young people have adopting a continuous form of contraception. In contrast to the studies on marital fidelity outlined above, participants described fluid relationships as contributing to inconsistent use of contraception, where there are “relapses” (Brandão 2009) or the unexpected resumption of broken or paused dating, without proper protection. These results demonstrate varying approaches to and understandings of relationships, and their resulting effects on contraceptive practices. Cabral (2011) also examines contraceptive use in Brazil through the situational and relational dimensions of heterosexuality, examining how reasons for (non)use go beyond access to information or proper methods. She illustrates how looseness in contraceptive practices are important at the initial stage of a sexual relationship, problematising the idea that condoms are used less frequently later on. Her study also demonstrates how the management of contraception when sexual life is regular is shaped by gender inequality.

The analysis in the following chapters builds upon the insights of these studies, where contraception often involves more complex issues than a simple dichotomy between risky behaviour and rational health protection or pregnancy prevention. This research shows that social values, morality and gendered power relations combine to shape culturally acceptable sexual practices, which has a significant impact on individuals’ perceptions and experiences of contraception.

2.5 Sterilisation Literature

2.5.1 Sterilisation Wider Literature

This subsection aims to provide an overview of the wider debate within critical approaches to sterilisation. It outlines the particular concern regarding sterilisation abuse, and how this led to an emphasis on issues surrounding reproductive rights, power and agency.

As mentioned in Chapter 1, much of the earlier studies on sterilisation focused upon the operation's connection to eugenics programmes and the abuse of human rights in various countries. Research on sterilisation was hence shaped by wider critiques at the time regarding: emerging allegations of sterilisation abuse, especially in Puerto Rico and India (Briggs 2002, Tarlo 2003); the "export" of population control to 'developing' countries (Barrantes, McCarthy et al. 1983); as well as its association with particular groups within the United States (Schoen 2005). Many of these earlier studies on sterilisation define the majority of women's experiences with sterilisation as that of abuse. Gordon (1976), for instance argued that the family planning programmes in Latin America that were initiated by the United States "advocate various kinds of coercion" (Gordon 1976: 398, see also Davis 1981). It is useful to bear in mind that, as the history of sterilisation was so significant in the 1970s it is difficult to understand the earlier policies without having the story refracted through the lens of this later period (Briggs 2002: 143).

Within this historically situated intellectual framing of the debates around sterilisation, various works also generally evidenced a clear concern with

issues around social difference, examining various social categories such as gender, sexuality, class and race. Cary examined sterilisation abuse in relation to gender in the United States, illustrating how different societal forces converged to switch the previous predominance of male sterilisation to female sterilisation after 1928 (Cary 1998: 99). Schoen also focuses on sexuality in the United States, demonstrating how eugenics programmes focused on sexually active single women as those “whose deviation from the desired norm was particularly obvious and disturbing” (Schoen 2005: 76). Furthermore, several studies also examined the intersections of racism and sexism in relation to sterilisation, such as Bock’s (1983, 1984) study of the conceptualisation of motherhood during the Nazi regime in Germany (Chase 1977, Dreifus 1977). Briggs’ (2002) later study of sterilisation in Puerto Rico illustrates how birth control “could be used for capitalist social engineering with racist ends” (Briggs 2002: 143), even though there is clear evidence *against* forced sterilisations.

Relatedly, Briggs demonstrates the racist or colonial elements within the wider critical discourse on sterilisation abuse in Puerto Rico. She points out how anti-colonialist feminists in the United States ironically emphasised the failures and lack of agency of Puerto Rican families and the necessity for American women’s intervention (Briggs 2002: 144). The case of the discourse on sterilisation in Puerto Rico thus highlights the complexity of discussing issues related to agency and sterilisation. Nonetheless, recent research on sterilisation in general continues to focus on sterilisation abuse, often retaining a concern with social difference and inequalities (Lopez 1997). For instance, Sifris’ (2016) study on the involuntary sterilisation of marginalised

women focuses on issues of power, discrimination, and intersectionality (see also Miranda and Yamin 2004).

In contrast to the majority of studies discussed so far, Tarlo's (2003) ethnography of the Emergency in India illustrates that although vasectomies were officially preferred, gender and sexuality were not the main focus regarding sterilisation policies. As this period involved policies of both slum clearance and family planning, Tarlo examines the interweaving of discourses on sterilisation and displacement, focusing on the issues of class and property (2003: 110-111). Tarlo's work is thus primarily a study of the relationship between citizens and the state. It elucidates how "the fact that many people secured their rights to housing through participation in family planning" was the distinguishing aspect of a period that was shaped by concerns regarding overpopulation, poverty and a drive towards 'modernity' (2003: 68-69).

Besides sterilisation abuse, recent studies on sterilisation have begun to examine voluntary or contraceptive sterilisation. Scholars such as Petchesky (1981) critiqued the previous binary explanations of sterilisation as either abuse or free will. They proposed exploring "voluntary" decisions within constrained social contexts, signalling the necessity of focusing on case studies of particular women. Carranza (2003) outlines various examples of works that make use of the interventions by Petchesky, but also highlights how all of these studies focus solely on poor women.

This brief review of the wider literature on sterilisation illustrates how much of the earlier research was focused upon, and shaped by, the link between sterilisation and eugenics. The topic of sterilisation abuse became particularly urgent during the 1970s and was thus shaped by contemporaneous feminist concerns regarding inter/national state powers and reproductive rights. I aim here to illustrate how sterilisation has been conceptualised within this broader scholarship in relation to power, violence, and agency. This provides a context and comparison for the particular case of sterilisation in Brazil, and how it has been examined in the social science research. As indicated in Chapter 1, the themes raised by this discussion will be examined in further detail in the following subsection.

2.5.2 Sterilisation in Brazil

While a vast literature related to female sterilisation in Brazil exists, these studies usually fall into the domain of medical sciences (Minella 1998, 2013); there are fewer qualitative or in-depth studies. As mentioned in the preceding chapter, much of the social science literature on sterilisation in Brazil has focused on the question of women's agency. This debate generally followed the dichotomy set up between agency and structure, as outlined in Chapter 1.

Earlier studies on sterilisation debated whether the high rates of sterilisation indicated women's attempt at autonomy or a lack of agency. Scholars pointed out that at the time sterilisation was not exactly a choice due to lack of options, as well as the wider ideological context and social determinants (Corrêa 1983, Barroso 1984, Corrêa 1994). Scholars have therefore argued (in Brazil and elsewhere) that the decision to be sterilised does not reflect

freedom of reproductive control, but is shaped by social determinism and constraints. These authors outline various structural constraints in these studies, including: lack of investment in reproductive healthcare, a pervasive ideology of population control, and wider social determinants that women have little power to change (Petchesky 1981, Barroso 1984, Lopez 1997). In this setting, researchers described sterilisation as a “refusal of motherhood” by women who face economic constraints (Corrêa 1989: 35-36). Earlier qualitative studies that addressed these topics include research by Vieira (1994) and Citeli et al. (1998), as well as Potter (2003) and Caetano and Potter (2004).

2.5.2.1 Medicalisation and Agency

Within this debate, and as part of the wider social science interest in reproduction, the concept of medicalisation has been widely discussed regarding sterilisation in Brazil. As outlined above, medicalisation is a process by which nonmedical issues that were previously understood as being primarily political, personal or social in nature, become defined and treated as medical problems. Earlier critics of sterilisation point out that the procedure expands the medicalisation of women’s bodies and increases risks to their health (Merrick and Berquó 1983, Giffin 1994), and that women do not understand it fully or have knowledge of other methods (Vieira and Ford 1996). Debates in Brazil about contraception and sterilisation, therefore, tended to emphasise social determination when explaining unplanned pregnancies and the high rates of sterilisation.

One of the earliest qualitative works on sterilisation in Brazil, Serruya’s influential study (1996) raised the issue of women’s own agency and voice in

reproductive decisions. She reports that sterilisation is not a passive act, but is perceived as an active “conquest” (1996: 65). However, her interpretation of the practice is extremely critical. The author states that, with sterilisation, women discard control of their bodies and “annihilate the possibility of new decisions” over their reproduction (1996: 165). Serruya concludes that, “in a perverse manner, the women feel happier after the tubal ligation. Therefore, when the women decide, definitively, not to have more children, their silence speaks of domination and alienation” (1996: 172). She also characterises sterilisation as “voluntary mutilation” and as women’s “desired domination” by biomedicine (1996: 172; quoted in De Bessa 2006: 235). While her study was one of the first in-depth, qualitative works on sterilisation in Brazil, and provides a wealth of information, it also does not take in account women’s interpretation of their own needs, and leaves little room for consideration of women’s agency.

Later studies on sterilisation, however, attempt to highlight the individual dimension, while also taking into account the wider structures of social life that constrain or shape women’s lives. These later works focus on women’s motives for choosing the operation and develop a more nuanced conceptualisation of women’s agency. Corossacz (2004), for instance, conducted fieldwork in Rio de Janeiro among low and middle-class women, and depicts women’s active attempts to redefine their social roles, and take control of their lives (2004: 171). In addition, De Bessa conducted fieldwork in a city in Southeast Brazil between 1996 and 1998, and for two months in 2002. She introduces the topic with a discussion of medicalisation, but she also concurs that sterilisation “represents women’s attempt to gain a measure of control and to construct a better life” (De Bessa 2006:226-227). She

concludes that sterilisation “is a complex response to rapid changes in women’s lives and is indicative of their active negotiation with modernity” (2006: 253).

The third study, by O’Dougherty (2008), provides a more nuanced treatment of agency regarding sterilisation that focuses on gender. O’Dougherty analysed thirty pregnancy narratives of low-income women in the north of Brazil, and attempts to move beyond the agency-structure dichotomy. She proposes that, “perspectives on sterilisation have been impeded by an uneven ability to acknowledge gender inequality and women’s agency” (2008: 437). She argues that Brazilian women only rejected fertility after adherence to the conditions of heterosexual relationship and gender imbalances; and after years of dealing with flawed technologies, and hindering policies and advice, with the result that “fertility is experienced as a violation of bodily integrity and as the failure of gendered agency” (2008: 437). Sterilisation is thus seen as “a belated assertion of autonomous agency” (O’Dougherty, 2008: 430).

Finally, a recent study by Edu (2015) also discusses issues of agency around female sterilisation in Brazil, with a particular focus on race. She conducted her research among predominantly black, popular-class women and their families. Her work draws out the intersections of race, reproduction, gender, sexuality, class, necropolitics and aesthetics. The analysis links Brazilian notions of beauty, desirability and family aesthetics to women’s reproduction. She connects the history and legacy of slavery and racism in

Brazil to the health disparities experienced by women in their attempts to control their fertility.

Edu problematises the notion of examining reproductive choice and agency, and argues that there is an underlying racism in the concept of agency. She questions its validity as a framework through which to understand the decision-making of marginalised groups, particularly the black population within a country with a history of slavery (2015: 106). She argues that “agency, choice, and human rights become language and concepts that further entrench long-standing mechanisms for oppression while diverting attention from more useful questions and opportunities for thinking about and discussing reproduction” (2015: 137).

It is clearly important to remember the conceptual limits of the notion of reproductive choice and associated issues of agency, and how race is implicated in this conceptual framing alongside other intersecting axes of difference. Issues of positionality and agency, however, did arise within participants’ accounts of sterilisation in my research, particularly in relation to accessing the operation. To examine *participants’* understandings of issues related to agency when it appears in their accounts, I drew upon several different theoretical resources. An awareness of issues around power and language prompted me to use concepts from language and translation studies, as well as narrative research. These will be detailed in the following Chapter 3 on Methodology. I also drew upon research within the field of sociology of medicine and further concepts from the sociology of science and technology that focus upon reproductive technologies (as discussed above).

2.5.2.2 Sterilisation and Family Relationships

Some critics argued that female sterilisation in Brazil derives from and sustains inequality in heterosexual relationships (Barbosa and Villela 1995, Goldstein 1996, Vieira and Ford 1996, De Alvarenga and Schor 1998). Others argued that high rates of sterilisation represent women's agency and that it relieves the burdens associated with having sex (Citeli, et al., 1998). Two more recent qualitative studies have examined sterilisation as a practice embedded within women's everyday relationships and lives (Dalsgaard 2004, Cabral 2011). As discussed in the section on studies on contraception in Brazil, Cabral's (2011) research examined contraceptive practices in relation to heterosexual dynamics. As part of this study, she also explored the biographical circumstances and relational scripts of contraceptive sterilisation. She argues that, for her participants, sterilisation is a strategy of stabilising or consolidating a reproductive/contraceptive path.

Dalsgaard (2004) conducted her research on sterilisation in 1997 and 1998 in Northeast Brazil. Her research departs from the previous literature, as she provides a more nuanced study that focuses further on the family relationships of her participants, so it will be examined in more detail here. Dalsgaard vividly elaborates the social relations within which her participants were embedded, as she argues that it is "within the daily coexistence with husband, children and other women that sterilisation gained or lost its motivating importance" (2004: 172).

In Dalsgaard's study, mothers often aided their daughters to obtain sterilisations, as they knew what life with too many children was like (2004:

185). Furthermore, she highlights how the differing reproductive aims between men and women meant that the husband was more likely to oppose sterilisation. She points out that this was because the pride of a man is “very closely related to his capacity to provide life, food and safety” (Dalsgaard, 2004: 77). Regarding relationships, De Bessa also shows how husbands were often the first obstacle for many of her informants to obtaining a sterilisation procedure (2006: 245).

Dalsgaard’s key argument involves placing the wish for sterilisation within the context of the basic human need for recognition, by demonstrating her informants’ “low status lives” (2004: 142). She concludes that despite the operation, “nothing really changed” (2004: 202), as the women were still poor and living in difficult conditions. However, she does acknowledge that, “few women regretted their sterilisation” [as] “to be sterilised meant that one had at least done something” (2004: 202). Although her analysis allows some space for the agency of the women, ultimately she is still highly critical of the medicalisation of their reproductive lives and the social determinants that restrict them.

2.5.2.3 Accessing Sterilisation

Due to the high rates but legally ambiguous status of sterilisation, much of the earlier studies on the operation examined how women accessed it, particularly before it was legalised. This research showed how sterilisation was usually accessed alongside caesareans, and often paid for, or exchanged for favours or votes (Chapter 1). Several qualitative studies have explored questions around accessing sterilisation since the initial legalisation period.

The issues around obtaining the operation, however, did not generally form a significant part of these works.

Dalsgaard's study, for instance, contains a subsection on 'sources of sterilisation' ((2004: 114-118), where she outlines that out of the recent sterilisations: nine were paid for by politicians in exchange for votes; five women who were relatively better off paid for a combined caesarean and sterilisation; and four were sterilised at private clinics because they were covered by private health insurance due to their husbands' jobs. Dalsgaard describes how a local vice-mayor and gynaecologist provided sterilisations in exchange for votes, and how an older woman who worked as a cleaner at a hospital helped her neighbours to obtain the operation (2004: 116). Additionally, Dalsgaard describes how, after this cleaner died, the women had to find someone who knew a physician, worked for a hospital director or was affiliated to a generous patron, in order to obtain a sterilisation. These ways of obtaining sterilisation through informal networks and key gatekeepers appear to be linked to how the *jeitinho* operates within Brazilian society.

A study by de Oliveira and Hoga (2005) outlines the process of accessing sterilisation among women of a low-income community in the city of São Paulo, Brazil. They used an ethnographic research method and collected data in 1999 for six months from seven key and 11 general informants. Their research describes the difficulties women encountered with reversible contraceptive methods, the barriers to obtaining surgical contraception for low-income women, and the beliefs and values women who have undergone

sterilisation. Their analysis highlights that, similar to the situation before the law changed, there were more obstacles to accessing sterilisation at public hospitals than compared to the process within the private health sector. Aside from financial constraints, they point out that public health service surgeons adhered far more closely to the legal limitation on the operation, such as age and number of children. Additionally, these women had to receive authorisation from their husbands for the sterilisation, which was generally not the case for those who paid for the operation. Overall, the authors argue that for their informants, overcoming all the obstacles and being sterilised became the realisation of a "great dream" (De Oliveira and Hoga 2005: 11)

Edu's (2015) study also examined the process of seeking and obtaining a sterilisation among her informants. She describes similar findings, where the law has not facilitated the process of safely securing sterilisation for women. All of her participants had to go to additional lengths, soliciting procedures or paying excesses. Only one woman, who was middle-class and well-educated, was able to successfully navigate the law and negotiate with her doctor to pay for a sterilisation when she desired it (2015: 178). Several women were also unable to access sterilisation, due to their youth or inability to pay for the operation. Edu argues that this is particularly the case for black women, linking these barriers to racism evident in the Brazilian government and lack of funding for both sterilisation and effective reversible contraception (2015: 213).

This social science literature on sterilisation in Brazil illustrates the earlier concern regarding the abuse of human rights and reproductive rights around sterilisation, and the consequent focus on social determinism and how structural constraints were seen to shape the high rates of female sterilisation. Subsequent studies on the influence of medicalisation and the role of women's agency attempted to move beyond these top-down accounts and provide space for women's autonomy regarding the operation. Sterilisation has since been examined as a practice embedded and understood within family and intimate relationships. Furthermore, studies have found the continuing influence of the two-tiered Brazilian health system in creating barriers to accessing the operation, particularly for poorer and black women. This thesis aims to build upon these studies, examining sterilisation across individual, relational and institutional contexts, as well as the wider discourses on the operation in Brazil.

2.6 Conclusion

This chapter has explored a wide range of approaches and conceptual tools from various literatures, in order to address the theoretical aims outlined in the previous chapter. Chapter 1 highlighted the importance of accounting for how contraception and sterilisation operates at various levels within societies. I outlined the specific political and institutional contexts in Brazil that influenced the shifting reproductive and sterilisation policies in the latter part of the 20th century, as well as more current times.

The sociological approaches reviewed in this chapter provide a means to examine the wider healthcare context within Brazil, taking account of issues such as health inequalities, the workings of the health system and doctor-

patient relationships. These perspectives highlight the socio-technical nature of these institutions and interactions. Various ways of examining experiences of power negotiations with healthcare professionals were outlined.

Additionally, research on health systems emphasises the need to conceptualise the complexity and rigidity of health systems, alongside how individuals navigate these bureaucracies. I suggested that the Brazilian concept of the *jeitinho* is useful for examining the issues raised by this wider literature, particularly regarding the negotiation of power dynamics and complex health and legal systems. Social science approaches to the *jeitinho* were thus explored, including how it is conceptualised in relation to sociological studies of organisations, as well as STS approaches to workarounds.

Social science approaches to reproductive technologies, and contraceptive technologies were then addressed. I outlined the shift from top-down analyses of the effects of biomedicine upon women's bodies and reproduction, to more nuanced treatments that allow space for individuals' perspectives and agency. I highlight how research from sociology of science and technology on assisted reproductive technologies enables us to conceptualise agency as potentially being enacted through objectification, rather than in opposition to it. Studies on contraception that examine women's 'selective resistance or compliance' to medicalisation were outlined, providing further perspectives on these technologies in relation to notions of wellbeing, freedom or control. Additionally, sociological and anthropological research on contraception that highlight how it is culturally embedded and understood in relation to local and relational contexts was outlined.

Finally, I examined research on sterilisation, both more broadly and in Brazil. I highlighted how debates within the wider areas of the sociology of healthcare and contraception influenced approaches to sociological studies of sterilisation. These concerns and debates include the abuse of reproductive rights, medicalisation and agency (including the role of the state, health institution and doctors). The broader shift from top-down accounts focusing on medicalisation and the lack of women's autonomy, towards studies that focus on individuals' perspectives, experiences and agency, was also reflected in the debate on sterilisation in Brazil. Several more recent studies that have also situated sterilisation in relation to socio-cultural contexts were examined, particularly those with a focus on agency, family relationships, and the issues around accessing the operation in Brazil.

CHAPTER 3. METHODOLOGY

3.1 Introduction

The previous two chapters outlined the background of sterilisation in Brazil and the rationale for this research, as well as the theoretical resources that it draws upon. This chapter describes the methods through which the empirical data were generated, including a particular focus on issues of language. The chapter begins by explaining research design issues including the goals of the study and epistemological approach. It also includes an overview of the research undertaken, including recruitment, sample, methods and ethical issues. The remainder of the chapter then provides further detail on the interviews, transcription and analysis process, illustrating how strategies from Translation Studies and Narrative Analysis were drawn upon to address issues of epistemology and ethics in qualitative research.

3.2 Research Design

3.2.1 Fieldwork Overview

I undertook my data collection on sterilisation in Brazil for most of my second year of research. This fieldwork was divided into two phases. The first part was a preparatory one enabling me to learn the language and find a research fieldsite or location, while the second stage comprised the main data collection phase.

I went to Rio de Janeiro in September 2013 for a scoping phase of three months in order to learn the language, become accustomed to the city, and

make connections to facilitate my research. During this phase I learned Portuguese at a language school and got to know different neighbourhoods around the city. I joined a research group at the Institute of the Social Study of Medicine (IMS) at the State University of Rio de Janeiro (UERJ). I attended several seminars and conferences, and met with researchers who focus on issue of gender, reproductive and sexual health. Through the IMS research group, I contacted relevant people at a hospital with a reproductive health clinic and set up meetings for my return in February 2013.

The main research phase started after gaining ethical approval from the State University and the Brazilian National Commission in Research Ethics (CONEP), and narrowing my fieldsite and sample. My initial research design was much broader, as I aimed to conduct: observations, documentary research on the history of reproduction and sterilisation in Brazil, as well as interview women, men and clinicians, and to interview a portion of the women a second time (see Appendices A, B and C). After visiting several reproductive health clinics, I decided to focus on interviewing women who were sterilised or planning to be sterilised, and to gain access to two reproductive health clinics through my connections at the University. Both sites were in the North region of the city, with one clinic situated within a hospital and the other in a community health clinic. I began interviews at the clinics in April and continued them for four months. I took a break from data collection in August to focus on transcribing interviews and writing. I then returned to data collection for the remaining four months, until I left Rio at the end of December 2013.

3.2.2 Recruitment and Data Collection

I used a criterion-based or purposive approach (Ritchie, Lewis et al. 2003) to recruit participants to take part in semi-structured interviews. This approach involves choosing samples because they have particular features or characteristics that enable detailed exploration and understanding of the central themes to be explored (Ritchie, Lewis et al. 2003). I aimed to use 'stratified purposive sampling', which is a hybrid approach that enables the comparison of different subgroups that are each fairly homogenous (Patton 2002). I aimed to conduct between 30 and 40 interviews with women, with a variety of ages, ethnicities and socio-economic backgrounds. I hoped to include roughly two thirds of women from low-income and one third from lower-middle-income areas (Mason 2002) in the sample, in order to reflect a variety of women from various classes who use the public health system.

Throughout March 2013, I met with various gatekeepers and doctors at the clinics. Both clinics focused on reproductive and sexual health with general obstetrics/gynaecology and paediatrics departments, and ran courses on contraception. Various recruitment strategies were discussed with the heads of both the wider health clinic and the reproductive health departments. Both the clinic staff and I aimed to meet the aims of my sample objectives, while also avoiding any unnecessary intrusion into participants' privacy or add stress to their experience at the health clinics.

To meet these aims, I decided to discuss my research with the doctors at the reproductive health clinics so that they could recruit participants on my behalf. Before consulting a patient, the doctors noted on their records if any

were sterilised or planning to have the operation. After the consultation finished, and if the women had time, the doctors then explained my research interests and asked the women if they would be happy to speak to me about it. I provided the women with an information leaflet on the research, and then spoke with them privately in one of the spare cubicles set aside for my use in order to conduct the interview should the woman agree (see Appendix B). Overall, I conducted 35 in-depth interviews with women at the clinics, and these interviews were transcribed and analysed with the aid of qualitative data management software (detailed below).

This recruitment process worked well, as it ensured privacy for those who participated in the interviews, yet was still within the health system setting. Furthermore, those women who were not interested or not able to stay for an interview were able to say so to their doctors without the hassle of speaking to me. Only two participants who spoke to me were interested but had a limited amount of time, so I adapted the interview to allow for the shorter time available. As in all qualitative research, the findings discussed here are not intended to be representative of the wider population. The number of women interviewed reflects the point at which no new research themes were emerging during interviews, in other words, when saturation had been reached.

These interviews were supported by rich contextual research including observation, informal conversations and documentary research. These

supplementary, background data are not included in the thesis.¹⁶ This exclusion was made primarily in order to focus more closely on participants' rich narratives of their experiences, thereby centring the voices and authority of the women, in line with feminist post/de-colonial theory (Harding 2016), as well as translation theory (discussed below). This contextual research did, however, substantially increase my understanding of the social, historical and medical context of sterilisation in Brazil and thus informed my approach to both conducting the interviews as well as analysing the data. For instance, although the observations in the clinics did not provide any specific data regarding doctor-patient relationships, they did help to familiarise myself with the healthcare setting, including the general atmosphere and facilities of the clinics, and an understanding of the interactions between healthcare professionals.

3.2.3 Fieldsite and Sample

As stated above, all interviews took place in two reproductive health clinics, one of which was located within a hospital, while the other was within a community health centre. Both sites were situated on the edge of middleclass neighbourhoods and close to poorer, *favela* neighbourhoods in the North zone of the city (see Figure 3.2 below).

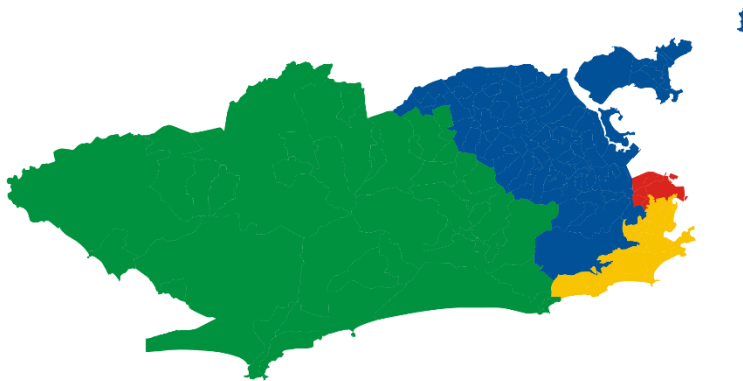
¹⁶ Except for one extract from a discussion with a nurse technician that elaborates on a point in Chapter 5 on the relationship between different healthcare professionals.

Figure 3.1 Map of Brazil, showing major cities



Source: CIA The World Factbook, 2004. Wikimedia commons. Accessed January 2018.

Figure 3.2 Four Zones of Rio de Janeiro City



Showing: West (green), North (blue), South (Yellow), Centre (Red). Source: Noessedotti (Anderson Brito), Wikimedia Commons. Accessed January 2018.

These research sites account for the fact that just over two-thirds of my participants were from poor and *favela* (shantytown) neighbourhoods, of

low-income economic status, and women of colour. These ‘communities’ (*comunidades*)¹⁷ of Rio de Janeiro face historic segregation in access to public services, including healthcare, along with other significant disparities and violence caused by poor governance and lack of investment (Sheriff 2001, Goldstein 2003). For example, I was reminded often by colleagues that one of the clinics was only safely accessible by taxi, bus or lifts, as going by foot meant walking through an ‘abandoned area’ next to a *comunidade* where there was often violence, shootings and an active police presence.

Around one third of the sample, however, were from lower middle-class backgrounds, neighbourhoods and white. They generally had easier access to the local health clinic and other public services, along with a safer and more stable living environment. The data thus include a variety of perspectives, with some participants talking about coming from extremely poor family farms in the countryside when younger, but being mostly well off now and having children who graduated from university. Some also describe studying, having a stable income and home their whole lives, in contrast to other participants, who talk about not having enough to eat or to keep a roof over their heads. Although wealthy *cariocas* (local from Rio) are not among the participants, as they generally pay for private healthcare (Bahia 2018), the majority of the healthcare professionals, particularly the doctors, were white and from more privileged, wealthy areas and backgrounds. The research site and the data therefore represent some aspects of the inequality evident in this ‘divided city,’ as Rio is known by locals, but

¹⁷ *Comunidade* (Community) or *Morro* (hill) terms for these neighbourhoods were sometimes used, avoiding the negative associations of the word ‘*favela*.’

with greater emphasis on the perspectives of those participants from more marginalised backgrounds.

Issues of race¹⁸ appear more prominently in some areas of this research than others. None of the participants spoke specifically about race or racism (similar to research by others, such as O'Dogherty 2008), apart from one (Bruna, 57 *negra*), nevertheless, it was often present implicitly. Race is inextricably intertwined with class, as described in Chapter 1, to the extent that when people and even academic studies in and of Brazil speak of class, they are often coded terms for speaking about race (Sheriff 2001, Edu 2015). Research has shown how the earlier myth of the Brazilian nation as a 'racial democracy' (Freyre 1957) or mixture of races, contributed to the difficulty of speaking about racism (Sheriff 2001). This may have had an influence on the lack of explicit talk about race in participants' accounts. In addition, perhaps some participants did not feel comfortable talking about racism openly with a white foreigner.

The presence or absence of race will be pointed out in the following chapters when relevant. In general, for example, it is more absent when participants are discussing the intimate aspects of their relationships, and more evident when discussing inequality in the workplace and access to healthcare. It is always an important background to keep in mind, particularly due to the significant historical link between race and sterilisation in Brazil.

Participants' self-identified race/ethnicity terms (discussed below) will be

¹⁸ See Chapter 2 describing use of this term as a social category.

used throughout the thesis, along with age, in order to keep this context in mind.

The tables below give a brief overview of the sample. Although simplified, it provides an idea of the range of participants' backgrounds, as well as their number of children and sterilisation status. While most participants were in their 40s and 50s, there was still a wide range of ages within the sample; the oldest woman was 68 (b.1945), and the youngest was 22 (b.1991). At the time of the interviews, most of the younger women were planning to be sterilised; the age range within this group was 22 – 36 years. Of those women who were already sterilised, one had the operation 46 years before, and one just 6 months before the interview. The wide range of ages, as well as the difference between the dates of sterilisation operations, are both significant as they are spread across a wider changing socio-political context¹⁹.

As discussed above, there was also a range of various socio-economic backgrounds within the sample, but the majority of participants were employed in, or retired from, low wage and precarious jobs. Several participants, however, identified as home-makers, and had husbands in higher-paying jobs. Regarding religion, there were a higher number of women who identified as Evangelical, then Catholic, with just a few who identified as Spiritualist, Umbandista or atheist. Self-identified terms from participants regarding race/ethnicity were recorded. Four of the five official terms (used in census and forms) were used, including *branca* (white), *negra*

¹⁹ Including the second Brazilian Republic (1946 – 1964), military dictatorship (1964 – 1985), and re-democratisation (1985 -) periods.

(black) *preto* (black), *pardo* (brown/mixed), *indígena* (indigenous); excluding *amarelo* (yellow). The IBGE itself, however, acknowledges that these categories are disputed and a large proportion of the population dislike them (Sheriff 2001). A further widespread term in Brazilian culture, *morena* (brown/mix) was also included.

Figure 3.3 Sample Outline

Age Range:

20s	30s	40s	50s	60s
6	6	9	9	5

Ethnicity/Race:

Branca – White	Indígena - Indigenous	Morena – Brown/Mix	Negra – Black	Parda – Brown/Mix	Preta - Black
9	1	6	9	7	3

Employment:

Doméstia	Home- maker	Beauty Industry	Catering	Childcare	Secretary	H.R. Manager
17	7	3	3	2	2	1

Number of Children:

1 child	2 children	3 children	4 children	5 children
2 [2P]	16 [2D, 4P]	9 [1D]	5	1

P = pregnant at the time with another child. D = death of a child.

Sterilisation Status:

Sterilized	Planning to Sterilize
26	9

3.2.4 Ethics

All the ethical prerequisites and guidelines required by the Centre for Population Health Sciences at the University of Edinburgh were followed regarding this research. The research was also reviewed in accordance with the research ethics audit process of both the State University of Rio de Janeiro and the Medical Research Council of Brazil. The confidentiality of information gained and the anonymity of respondents was assured as far as possible. This was guaranteed by written consent from participants and through ongoing consultations with clinic staff (see Appendix C) (Guillemin and Gillam 2004).

The complications around and limitations of informed consent were also be taken into account (Crow, Wiles et al. 2006, Shannon 2007). Before each interview, I outlined the interview aims and explained the consent forms for each participant, particularly aiming to take into account the varying levels of literacy that were evident among the women. Participants also had the opportunity to reflect upon a written summary of the study prior to interviews and to ask questions (see Appendix B). All interviews were audio recorded and with additional notes taken by hand by permission. I also made my status as a researcher as clear as possible from the outset, keeping my recorder in view and taking notes visibly, in order to avoid any inadvertent misunderstandings (Dewalt and Dewalt 2000).

Ethical considerations are an “integral part of the ordinary, day-to-day practice” of research (Fluehr-Lobban 2000: 174). My approach to addressing these concerns regarding power relations was informed ethically and

practically by various intersecting resources, such as feminist (Oakley 1981) and narrative methodologies (Riessman 2008) (see below). Prior to data collection, I completed various methods courses, including one entirely focused on interviewing and another on reflexivity in research.

3.2.4.1 Sensitive Topics

As my research involved topics that could be considered sensitive (Lee 1993) (for example, matters related to the body, sexuality or morality), I followed Levy and Hollan's (2000: 351) suggestion of approaching sensitive issues gradually or indirectly. One can ask, for instance: "What do people generally do in these situations?" and then follow on with a more direct question if the person seems comfortable with the topic. This allows participants to adjust to the topic in general before thinking about it in more personal terms.

Regarding contraceptive practices, for example, I usually first asked participants if they knew about contraception when they were younger or where they had learned about it, before asking about their experiences of contraception technologies. In addition, I usually started the interviews on more general topics such as childhood family experiences or their opinions on the health system, before discussing more sensitive topics. Thankfully, sterilisation itself is not a taboo topic in Brazil (Dalsgaard 2004: 108).

3.2.4.2 Positionality and Reflexivity

Throughout my research I have tried to prioritise reflexive practice (Plummer 2001), as discussed in the rest of this chapter. This approach involves acknowledging the ways in which my own personal history and social position influence my research: from design, to data collection and

analysis. Reflexivity is an important part of qualitative research, and sheds light on the importance of issues such as power relations, positionality, and personality. For instance, I am a white, 'Western' 'foreigner', and an educated researcher, which has class implications (Aguilar 2009). I was also unmarried, in my late twenties and had no children. My lower level of competence with the language also emphasised my outsider status. Additionally, the spaces where my research took place also had implications on the researcher-researched relations (Elwood and Martin 2000). All of these issues contributed to the type of data 'created' during the interview process.

In relation to reflexivity, Stanley and Wise propose that "researchers should present analytic accounts of how and why we think we know what we do about research situations and the people in them" (Stanley and Wise 1993: 166). The remainder of this chapter represents an explicit attempt to do this, particularly through the lens of language, translation theory and narrative analysis.

3.2.4.3 Ethics of Translation

In the debate on translation in qualitative methods, Temple and Young (2004) discuss the ethical and methodological challenges of translation in qualitative research, particularly focusing on hierarchies of language power and speaking for people seen as 'other'. They highlight how the issue is therefore not just one of conveying cultural meanings, but also how the pragmatism of translation reinforces the invisibility of the source language. The perspective of one language-using community on another is rarely neutral, and the perceived status of languages rarely equivalent (ibid).

Many of the significant issues in the debate on translation in qualitative research are discussed in the field of Translation Studies (Cronin 2003). Bassnett (1991), for instance, traces the history of translation theory from its emergence as a particular field of study in the 1970s, and the focus on issues of power in the 1980s and visibility in the 1990s. Theorists have drawn extensively from linguistics and anthropology, along with post-colonial, post-structuralist and feminist theory and literary studies. Venuti's (1998) classic work on the topic demonstrates how an "ethics of difference" is now considered central to translation studies, which emphasises diversity, difference and the politics of otherness. These points on the power dynamics around language and the importance of an ethics of difference are essential to acknowledge for my research, as English was generally seen as something very desirable in Rio de Janeiro when I was there. It could indicate a privileged background, good education, and provide better job opportunities. The upcoming World Cup and Olympic Games added a further dimension to the politics around speaking English in Brazil.

As my research included women from different ethnic and economic backgrounds and a non-Euro-American context, these power relations regarding languages must clearly be borne in mind. Spivak's (1992, 1993) politics of translation argues that although transnational hybridity may challenge fixed notions of 'otherness', it is accomplished via a process of 'linguistic and aesthetic assimilation' by Anglo-American writers. The interaction between languages is part of the establishment and maintenance of hierarchical relationships, with English often used as the yardstick for meaning (Corson 1990). Strategies must therefore be chosen so as not to

contribute to the erasure of the 'source' language/meaning as far as possible, particularly in a global South country where speaking English has significant implications. In the remainder of this subsection I will therefore outline my adaptation of a language 'intellectual autobiography' as my main strategy to deal with these issues.²⁰

The main strategy that I adopted for dealing with language difference is reminiscent of Temple's (2008) suggestion to detail the 'intellectual autobiography' of the researcher. As with social constructivist accounts that acknowledge power differences, detailing the position of the researcher is crucial. Stanley's (1990) concept of intellectual autobiography is concerned with the specifics of how we come to understand what we do, by locating acts of understanding in an explication of the grounded contexts these are located in and arise from (Stanley 1990: 62). Studies by linguists and bilingual writers demonstrate that languages can create different worlds for their speakers who feel their selves change with the change in language. As Pavelenko (2006) outlines, studies in psychology and linguistic anthropology show that bicultural bilinguals may exhibit different verbal behaviours and may be perceived differently by their interlocutors in their different languages (Pavelenko, 2006: 27).

I adapt the concept of a 'language autobiography' as a strategy to deal with the ethical and methodological issues of language politics and translation

²⁰ For issues around, and arguments against, using translators see Temple, B. (2002). "Crossed wires: interpreters, translators, and bilingual workers in cross-language research." Qualitative health research 12(6): 844. (2002).

issues outlined above. I use this approach in the following section on translation in interviews by mentioning my previous experience with language-learning and briefly outlining my acquisition of Portuguese. I will then detail the translation process that influenced how the data were reciprocally constructed during interviews. Additionally, in sections 3.3 and 3.4 I will explain how I used concepts from translation studies to think reflexively about conveying 'meaning' when both transcribing interviews and translating quotes. Before discussing issues of language and translation in further detail, a final practical concern on safety in the field will be outlined in the following subsection.

3.2.4.4 Fieldwork Safety

Prior to my data collection phase, I completed methods courses and specialised fieldwork training as part of my Master of Research in Social Anthropology, and the first year of my PhD. I also completed a Fieldwork Planning and Safety course, and a First Aid course organised by the university Health and Safety Department and approved by the national Health and Safety Executive. Safety and ethics were discussed with my supervisors and I followed CPHS fieldwork guidance and lone worker guidance strategies. In addition, while in Rio de Janeiro I wrote up weekly reports for my supervisors, who provided regular feedback and support.

As my research location was inside two clinics, it was not necessary to enter any dangerous areas. As outlined above in section 3.1.4 fieldsite safety was an unforeseen issue while traveling to and from one of the clinics. After one attempt to walk the short distance in question, I realised it was not safe. I

then asked for and followed the advice of my research colleagues and medical staff at the clinic, to either take a taxi or get a lift from staff to bypass the dangerous area. Personal safety also became an issue during the large protests in the summer of 2013, as there were clashes between protesters and police near to my apartment. I avoided traveling in these areas during these periods and kept in close contact with friends. Aside from this political turmoil, I took the usual precautions one would when living in a large city with a high crime rate. So, although I witnessed some violence, I did not encounter any serious issues of personal safety. Keeping regular contact with my supervisors in Edinburgh and research colleagues in Rio was very helpful when dealing with these events.

3.3 Semi-Structured Interviews

3.3.1 Person-Centred, Semi-Structured Interviews

Person-centred interviewing was used as this approach engages the interviewee as both 'informant' and 'respondent' (Levy and Hollan 2000: 335). An informant-type question for this research included, for example: 'Why are women sterilised in Brazil?' as opposed to the respondent-type, 'How did the sterilisation make you feel?' Having a clear conception of these different types of interview modes is useful as it highlights the conflicts or coherences between the conception of the person themselves, and their understanding of the context within which they are embedded (Levy and Hollan 2000: 336). This type of interviewing allows for the maximum amount of flexibility, while still retaining a guided element. The ability to switch between interview modes allows the researcher to guide it into an open in-depth discussion, or switch it to a more 'informant' level, where the interview is semi-structured.

Semi-structured interviews are based upon a pre-compiled interview guide that can allow for the interactive flow of information between the interviewer and interviewee within certain limits (McIntosh and Morse 2015). This type of interview works well when the researcher has already identified specific topics they want to address, as the researcher can decide in advance what to cover while maintaining a degree of flexibility to receive any unexpected information the respondent may offer. This flexible approach allows interviewees to discuss information that they think is relevant that could have otherwise been neglected (Green, Thompson et al. 2002).

The topic guide was influenced by life-story methodologies (Elliot 2005) in an attempt to address ethical issues as discussed in section 3.2.4 above. The guide was loosely based on a type of life-story chronology, starting with childhood family experiences, and following reproductive and sexual or contraceptive health experiences over time (see Appendix D). The interview guide was also designed to elicit stories, such as encouraging participants to relate their experiences of particular events and how they felt about them. Furthermore, the topic guide changed over time, particularly as it became clear that the women were generally more interested in issues around accessing healthcare and sterilisation, compared to my initial focus on the embodied experiences of the operation and notions around enhancement. For instance, it was clear that participants generally perceived sterilisation as a way to improve their life and wellbeing. Additionally, questions about the operation itself generally provoked confusion or explanations that, because it was postpartum, they did not feel or think about it because they were focused on the birth and caring for their newborn at the time.

The use of a flexible interview guide allowed me to elicit respondents' own understandings of the phenomenon in question while still addressing the topics identified beforehand as being of interest to the study, such as family relations, health, the health system, contraception and sterilisation experiences (Hannock, 2002). The flexible nature of the interview aimed to encourage respondents to narrate their own accounts and focus on those areas of importance or interest to them (Silverman 1993, Murphy and Dingwall 2003). This meant that the general life-story chronology of topics was not always followed. This strategy worked well as it meant that when participants spent more time on issues accessing healthcare and sterilisation than experiences of the operation itself, it allowed me to re-focus my research to take account of participants' own interests.

The interviews themselves took place within reproductive clinic hours, among other doctor-patient consultations, in whichever cubicle was free that day. One clinic was spacious, with large cubicles separated by sturdy partitions, whereas the other was quite cramped with only curtains providing privacy for consultations and interviews. Loud air-conditioning units provided relief from the heat and covered over much of the general noise of the extremely busy clinics. Most of the participants were happy to talk at length about the main topics that I raised, and the majority of interviews were around an hour long.

Due to the context and setting of the interviews, I attempted to clarify my outsider and non-expert status, as discussed above. I wore informal clothing

in comparison to the staff white coats, for instance. I also made my lack of knowledge of Portuguese, as well as my inexperience of pregnancy or childcare clear. This approach, along with topics around sex, meant that there were often a lot of jokes and laughter, and many of the older participants referred to me as 'daughter,' by the end of the interviews. Additionally, if a question caused a participant to hesitate, I generally added a follow-up question asking if they had any good or *bad* experiences on the topic, or knew of any others. I attempted to make it clear throughout the interviews that there was no wrong answer, and that it was ok to talk about any kind of experience, or sensitive topic, or to change the subject.

Participants sometimes became upset during the interviews, occasionally around sensitive topics or simply due to their difficult life experiences. As mentioned above, I prepared for these situations through researching approaches to sensitive topics, reflexivity and particularly feminist ethics and methodologies (see 3.2.4 above). From the outset, my intention was to avoid causing participants stress, to acknowledge them as experts on their own experiences, to recognise the importance of how they relate their narratives, and respect their boundaries and privacy. When participants became upset, my priority was to be supportive, respectful and allow them the space to deal with their emotions as they wished. I therefore slowed the tempo of the interview, adding no questions, only reflecting supportive statements.

Several times participants became very upset, while talking about the deaths of their children or about experiencing domestic violence, for example. When this happened I stopped recording and asked if they needed a break, or

wanted to speak about it further, talk about something else, or stop. I also offered them a list of resources that I had compiled before the interviews where women could find support to deal with difficult issues. Most of these women were ok to return to the interview either straight away or after a minute or two. Only one participant, whose brother had been murdered a couple of days before and whose husband had beaten her that morning, needed a few minutes break from the discussion. I went through my notes to give her some space, then mentioned that I had some information on where she could get some support, and asked if she wanted to talk about it more. When she did not want to speak about it further, I gave her copies of the list of resources and then changed the topic when she wanted to return to the interview.

3.3.2 Interviews as Creative Translation

Translation is always a fluid process; however, unlike creating one text from translating another, qualitative research fragments, lengthens and adds further complexity to the enterprise. Some stages of the research process lend themselves more to systematic reflection than others. The data collection phase is very fluid and reflexive, with words, phrases, meanings and connotations constantly being learned, discarded or taken up. This section aims to detail my 'language biography' by briefly outlining my experience of language-learning and my initial acquisition of Portuguese. The remainder of this subsection will then detail the various translation strategies I used during the interview stages.

I have had the privilege of learning several languages other than English, although none perfectly, at various stages and contexts during my life. These experiences made it clear to me that language can be linked to different life priorities, linguistic repertoires, cultural scripts and frames of expectation, autobiographic memories and levels of proficiency and emotionality (see Pavlenko 2006: 27). I began learning Portuguese from Portugal in Scotland before going to Brazil. I then had three months in Rio de Janeiro in order to learn the language and become acclimatised to the city. When I arrived in Rio I spent six weeks at an excellent language school. I also attended several talks and research meetings at the university. Before interviews began I was comfortable using Portuguese in daily life, for general topics, and became more familiar with the language related to my academic field.

When starting the first interviews, I was still learning the way people speak about those topics in a more casual manner. I therefore switched throughout the data collection phase between two approaches: from firstly 'embedded learning and production', picking up words and phrases learned through context and constant communication, and secondly, stepping back to consider language issues in a more systematic manner. The reflection and methodological approach always happened alongside the phases of 'embedded learning and production', and then became the primary approach during the analysis break halfway through and the main analysis phase once interviewing was completed. I will now outline four strategies and levels of translation that occurred during interviews.

One strategy that I used involved consulting other Brazilian researchers on the phrasing of questions and the translation of words during analysis. Furthermore, over the course of the interviews, my general strategy was to note the way my participants spoke about certain topics, the words or phrases they used, and adopt them along the way (Hecht 1998). This facilitated communication, making the interview process more fluid. If the topic had not yet been raised, I would use a more general phrase or slightly more formal one in questioning, sometimes along with a more informal one, and participants would either pick one or switch to another term. For instance, on mentioning sterilisation I would mostly use both a more formal and common informal term, *laqueadura* (ligation) and *ligadura* (to be tied). Or, for example we would talk about health in general, and then I would focus it to 'sexual health' and contraception. Participants would then use phrases such as '*ficar com*' (be with), or '*ter relações*' (to have relations) when discussing sex and contraceptive use. This strategy helped to prioritise the participants' voices, or 'source language' as it is called in translation studies.

A third level of 'within-language translation' occurred during the interviews. If a Portuguese word or phrase came up that I did not understand, I would simply ask participants to explain it. Translation occurs continuously even within a language. In practice, this can be seen whenever someone uses phrases such as: 'what do you mean?' or 'did you mean...' (Roth and Radford 2010). This approach helped the research process, as I was often asking participants to explain important, or taken-for-granted concepts or experiences in more detail. One can also see the reciprocal nature of the interaction; it is a translation because in the uptake, the two voices of the original speech and the reporting speech intermingle.

Finally, many 'self-translations' also occurred during the interviews, on both the part of participants and myself. These can be found when phrases such as 'in other words' are used. Speakers do not have to produce rephrased statements if they assume they are saying the same thing. For example, this happened on occasion when I asked participants to give their opinion on what a healthy person is like. Often it was the nature of 'health' that was difficult to explain. When participants asked me to repeat myself, or asked what I meant, I would then 'rephrase' and ask them instead why they thought some people were healthier than others.

The interviewer and location always frame the research interaction to a certain extent. Nevertheless, the reciprocal nature of the interaction, and construction of meaning, can be highlighted by noting the multiple translations and negotiations of meaning that occurs. The final two strategies mentioned above can occur 'naturally' during interviews, yet using and noting them consciously is a useful strategy when dealing with the issues of power and language.

3.4 Transcription as Translation

As pointed out in the previous section, any divide between data analysis and collection in this research is artificial, however during the first main analysis phase (part of which ran concurrently with the initial data collection), I found some approaches worked better than others for dealing with analysis translation issues. As part of highlighting my 'language intellectual biography,' I will also detail here how switching between languages affected

both my sense of self/belonging and, as a result, also my 'interpretation' of the data.

After the first interview phase, I stopped to review the data and my approach. I transcribed six of the thirteen interviews fully and coded them using Hyperresearch software in order to write up some initial findings. Listening to the recordings helped me reflect on both the meanings and what words were being used in the interviews, informing the next phase of data collection. I decided that, when analysing, I would work from both the original Portuguese recording as well as transcriptions. Aware of the translation process that occurs with transcription (Roth 2013), I wanted to rely on the original audio for analysis and was concerned that my participants' voices would be lost by pinning them down onto text too early. However, I also decided to transcribe several of the interviews and translate them directly into English, as a deliberate translation exercise, and a way to reflect on the meanings and to keep track of my thoughts.

At the same time during this research phase, I also wrote about the history and policies around reproduction and sterilisation in Brazil. This was a surprisingly slow and frustrating process, as I found that I was thinking completely in Portuguese, so when I wrote in English it was, at times, incomprehensible. I frequently used literal translations, and the grammar and sentence structure of Portuguese. Immersing myself as much as possible in English was necessary in order to help the writing (and transcribing/analysis) process. Writing at this stage in English highlighted the significant impact language was having on both the data collection and

analysis processes. I realized that analysing the same data (policy or transcript) while thinking in Portuguese is a different process from doing so while thinking in English.

Stepping back from the interviewing process to write and transcribe increased my awareness of my approach, helped me to refine my questions and made the final phase of interviewing more confident and productive. Translating the audio into English for the transcriptions was very helpful as it forced me to think very carefully about the meanings and words used in the interviews. There were, therefore, clear insights gained from the cut-off itself, as Temple and Young mention when suggesting this strategy (2004). However the main insight that I gained was that thinking in English when transcribing/analysing was much harder than thinking in Portuguese. It also meant that by the end I was thinking more in English and felt somewhat divorced from my surroundings and data (Pavenklo 2006). Changing language can be a deterritorialising and disorienting experience, which again highlights the central part it has to play in the situated epistemology of the embodied subject. According to Roth, such a process can allow one to “experience, in and through [the] body, the phenomenon of otherness” (2013: par.7).

When I resumed data collection and immersed myself again in Portuguese, I transcribed the rest of the interviews in Portuguese and found the process far smoother. The English transcripts were far more divorced from the original recording than the Portuguese. With the Portuguese transcripts, my participants’ voices are clearer: when I read them I can hear the women

saying the phrases, their tone, see their facial expressions, and at times remember what clothes they were wearing and their general body language. That is much harder to do with the English transcripts, which have a lot more description in them trying to convey these aspects (Piller 2002). I decided then to analyse from the Portuguese texts and then translate the quotes needed for the thesis later.

The final transcribing stage (the last 20 interviews) took place in Scotland, while I was re-adjusting to the U.K. and speaking English. My progress was always slower when I started off each day, as I adjusted back to the Portuguese. While transcribing I was also doing some basic analysis that involved writing descriptions or extra details around certain statements. During this stage, I found it easier to write quick initial ideas in Portuguese, and then take a break from transcribing to write longer explanations later in English. This strategy allowed me to keep the initial dialogue with the data/speaker, and keep track of how my thinking about the data developed in both Portuguese and English. The aim here was to foreground each stage and type of translation/re-formulation that the 'data' goes through.

This process demonstrates how there are clear ethical, methodological, epistemological and ontological consequences in choosing particular approaches to translation in qualitative research. The early 'domestication' of research into written English meant that the ties between language and identity/culture were cut to the disadvantage of the non-English speakers. When the baseline becomes mainstream English too soon it terminates the possibility of dialogue with the data. The decision to delay translation into

English for as long as possible was therefore based on both a practical and political recognition of the ontological importance for people of their language and the implications of colluding, through early translation, with the invisibility of some languages and their users (Temple and Young, 2004: 174). I then drew upon translation theory and methods when making the final switch to English for quotes in the thesis, as I will detail in the following section.

3.5 Translation Techniques

Theorists who address issues of language, such as Derrida (1994), have long recognised the importance of language in constructing as well as describing the world. This perspective views the relationship between subjective experience and language as a two-way process, where language is used to both express meaning as well as influence how meaning is constructed (Voloshinov 1986). As Wolff-Michael (2013) explains, with this approach a statement is understood as a moment of a social relation that is irreducible to the individual (author/reader/speaker/listener) or a text (2013: par.4). The language we speak is as a result a multiplicity, both allowing and requiring translations into itself. Difficulties can therefore occur with any attempt at interpretation or representation of meaning, even when the same language is used.

The issues involved can become clearer when diverse cultural contexts are involved and interlingual translation is necessary. There are differing theories in the field of linguistics on how much experience and language affect each other, and disagreements on how far one can understand the

social reality of another individual with a different language (Chapmann 2006). While translation theory is therefore a contested field, the practice itself is generally considered to be a creative activity rather than a rendering of an original (Hervey, Higgins et al. 2000). This perspective has implications for my research, as it assumes that the very act of translation is a creative process of interpretation. As such, the choices one makes when translating have conceptual, methodological and ethical significance that should be considered carefully.

Fundamental concepts of translation studies - such as interpretation as process and as product, cultural transposition, and the nature and importance of compensation in translation – all deal with the themes of power, visibility and otherness in various ways (Venuti 1998). These concepts informed my approach to language issues in diverse ways throughout the different stages of the research process, but they were particularly relevant when translating quotes to insert into the thesis. Hervey et al. (2000) provide a summary of the salient features of a text that should be considered when translating. Some are not relevant in this case, but several are, including: cultural, formal, semantic and varietal (2000: 5). In the next subsection, I will provide a detailed example of how I used concepts from translation studies to address epistemological/ontological and ethical issues when translating from Portuguese.

3.5.1 Non-Equivalence: *Jogada, furada*

When talking about problems with contraception, a participant said that, ‘it was thrown away (*jogada*) because it was just another ‘*furada*’. *Jogar* can be

used to mean throw or play with a ball; *jogar fora* (throw out) is used in phrases like 'throwing out rubbish'; the latter immediately springs to mind as the closest meaning for this example, i.e. semantically, this is closest to the literal meaning. *Jogada (fora)* (thrown (out)) was also always used by my participants to describe children who were abandoned because their mother had too many and could not or did not care for them. This was often described as happening in the *favelas*, and sometimes specified as thrown in the rubbish or on the street. *Jogada* was also used on occasion to describe the residents of the *favelas/comunidades*, particularly when talking about the lack of services such as health or transport. So there are further meanings associated with *jogada*, the thing thrown out is often worthless, rubbish, not worth any time or effort, i.e. semantically, the attitudinal meaning is negative, conveying disgust of and disparaging to the referent.

Describing the pill as another '*furada*' reinforces the negative connotations, as it usually means 'a plan that has gone wrong'. This emphasises another aspect of the referent, instead of a particular technical object being thrown out because it failed its purpose or was broken. A more expansive meaning could be inferred, i.e. a life-style plan - a whole process involving planning/working something out, trying to implement it and it not working – was thrown out. This gives us the idea of the motivation, the attitude, and the work that went into attempting it, was all in vain. This phrase adds to both the semantic negative attitudinal meaning and the varietal tonal register: one of disgust, throwing out, giving up on something worthless. The participant's actual tone of voice also clearly conveyed disgust and frustration, along with her body language, as she waved her hand as if brushing something aside and then folded her arms forcefully or

dramatically. To reinforce the attitudinal meaning, I noted aspects of a participant's body language, both during and directly after interviews. These notes influenced both my analysis and translation, and have also been included in the following quotes when they particularly illuminate the meaning of participants' accounts.

Furthermore, the fact that it was 'another' *furada*, ties it into the rest of her narrative(s), to the fact that she had struggles in other areas of her life, particularly with social and economic disadvantage and public services, e.g. difficulties with transport, education and, in particular, difficulties with the health system. The allusive meaning therefore ties the intimate daily struggle she had with contraceptives to the wider societal problems, particularly faced by the residents of *favelas*. In this case, however, the failure itself was also thrown out. Giving up on something that was not working for so long, that was causing her hassle, was also a form of taking control and clearly felt as both a relief and liberation.

The example of these terms shows the necessity of knowledge of the subject matter of the source, familiarity with the language and culture in general, and the advantage of knowledge of the translation process. For instance, in the above example, attitudinal meaning and tonal register influence the translation. Tonal register, for example, accounts for the things the speaker wishes to reveal, notably the effect they want their utterance to have on the listener, i.e. deliberately using 'polite' or 'strong' language (Hervey et al. 2000: 105). It is obviously important to try render a phrase with the corresponding degree of politeness in the target language. It is vital to have a

range of expressions capable of injecting various affective meanings into a literal message.

3.5.2 Source Text to Target Text

There are many decisions to be taken when translating, for example, 'cultural transposition' is a term in translation studies that covers 'the main types and degrees of departure from literal translation that may be resorted to in the process of transferring the contents of a ST [source text] from one culture into another' (Hervey et al 2000: 27). Choosing between these approaches, which either emphasise source-culture bias (e.g. exoticism and calque, or cultural borrowing) or target-culture bias (e.g. communicative translation or cultural transplantation), will also help me translate words/phrases such as *furada*.

One can also decide between a gist, exegetic translation or rephrasing, i.e.: one that separates the content from the circumstantial details or tonal subtleties; another that explains the phrase; or a halfway point between both that would use different terms from the source but adds or omits nothing from the message. In translation studies, the exegetic approach takes account of the inevitable part played by the 'translator's experiential baggage' (Hervey et al 2000: 9). For qualitative research, I therefore suggest an 'exegetic approach' to translation, where it can account for: the knowledge the researcher has gained from the cultural context, from information conveyed in the rest of the interview, from previous interviews, from the setting, and the encounter with the participant.

There is no clear dividing line between any of the three choices outlined, as the message content of the source 'can never be precisely reproduced in the TT [target text], because of the very fact that the two *forms of expression* are different' (Hervey et al. 2000: 11). However, ethically speaking, a consciously exegetic translation can be used to avoid the 'domestication' of translations as much as possible (Venuti 1998) when providing 'direct' quotations in this text, in order to avoid the erasure of the original speaker and language. I will do this by highlighting any lack of translation fit through atypical English grammatical forms, providing the original Portuguese concept (e.g. *Furada*), along with an explanation if necessary. This strategy should highlight that even 'direct quotes' are shaped by the researcher's voice, showing how translation or interpretation of data is both impossible but accomplished at the same time (for issues around translating humour, see Lackoff (1987).

3.6 Main Analysis Phases: Narratives and CAQDAS

The methods literature indicates many ways in which interview data can be analysed (Coffey, Holbrook et al. 1996). As demonstrated above, the construction and interpretation of data cannot be separated from the data collection process. Nevertheless, once data collection is not the focus, a further analysis phase is then required, one that is usually described as 'the' analysis process in qualitative research. For this research, this 'main' analysis took place over three phases, each of which prompted a development in my approach, as will be described in this section.

3.6.1 Initial Phase: Analysing in the Field

During the data collection phase, I wrote extensive notes after each interview. These incorporated my notes taken during the interviews (on body language and both participant and my emotional reactions), as well as a summary of the discussion as an interactive type of 'story' including direct quotes that I found particularly relevant at the time. These 'stories' were compiled into one large document, which acted as an overall view of the data and strong reminder of my immediate impressions of each interview and participant. This document was undoubtedly an invaluable stage of analysis that helped me to understand the data, and one that I returned to frequently throughout the following analysis phases.

As mentioned previously in section 3.3 on Transcription, the initial analysis phase in the field took place halfway through the data collection phase and involved a pilot test on the first 13 interviews. As described above, the process of translation illuminated how issues of language were shaping my 'construction' and analysis of the data at the time. After I had translated six of these interviews, I then coded the transcripts using grounded theory and Hyperreaseach software. While this approach provided some themes and insights, the process did not seem to suit the data. I had long lists of codes that were divorced from the narrative contexts from which they were derived. Similar to the problems with translating the transcripts into English, the break-up of the narratives at such an early stage of analysis again led to a reduction or loss of participants' voices. I decided to try an alternative form of analysis when I finished the data collection phase.

3.6.2 Second Phase: Exploring Narratives

The second phase of analysis started after data collection, when I returned to Scotland. While finishing the transcriptions I compiled further summaries of each interview, this time in the form of timelines focusing on reproductive events and contraceptive practices. During the interviews, participants' naturally jumped about in time; remembering previous events, correcting the sequence of events, confusing dates of births, spacing or ages of children, or working out when exactly they started a particular contraceptive technology in relation to their marriage or what year they were sterilised. Writing out these relevant events in chronological order and matching them to the individual's age and date at the time was a very helpful process.

These timeline 'stories' enabled me to grasp both the relevant socio-political and medical context, as well as the relationship between an individual's personal experiences related to contraceptive practices. For instance, this helped to highlight the difference between attitudes and policies around contraception during earlier periods compared to contemporary attitudes. It also clarified the relationship between a participant's experiences of reversible contraception, birth and decision to sterilisation.

During this analysis phase, I also returned to the literature on life stories and decided to attempt a narrative analysis of the transcripts. There are a variety of definitions of narrative in the social sciences, and while there are major differences among them, all work with contingent sequences (Riessman, 2008). For research in sociology, Riessman points out that:

personal narrative encompasses long sections of talk - extended accounts of lives in context that develop over the course of single or multiple research interviews [...] [an] evolving series of stories that are framed in and through interaction.

From this viewpoint, speakers take turns to create plots from disordered experience, giving reality “a unity that neither nature nor the past possesses so clearly (Cronon 1992: 1349).

Narratives function in many different ways, significantly for my epistemological approach, it has been argued that narratives construct identities. Yuval-Davis points out that: “identities are narratives, stories people tell themselves and others about who they are (and who they are not).” Identity is, however, fluid, “always producing itself through the combined processes of being and becoming, belonging and longing to belong” (Yuval-Davis 2006: 201, Kaptani and Yuval-Davis 2008). Narratives structure perceptual experience from this viewpoint, as they organise memory and “segment and purpose-build the very events of a life”(Bruner 1987: 15). Furthermore, to be understood, these private constructions of identity must mesh with a community of life stories, or “deep structures” about the nature of life itself in a particular culture. This perspective accords with the ontological and epistemological position I have outlined above, particularly regarding how language is embedded within social contexts, and reciprocally constructs, as well as conveys, meaning and identity.

Narrative analysis relies on extended accounts that are preserved and treated analytically as units. This approach therefore helped me to avoid the early

fragmentation of data into thematic categories as is customary in other forms of qualitative analysis, such as grounded theory. Elliot Mishler (1996) contrasts variable-centred approaches in social research that strip individuals of agency, with case-based approaches that can restore agency in research and theory. As such, case methods grant individuals “unity and coherence through time, respecting them as subjects with both histories and intentions” (Mishler 1996: 80. Quoted in Riessman 2008). This aspect of narrative analysis therefore suited my attempt to retain the participants’ voices as much as possible for ethical reasons.

Additionally, narrative analysis is comprised of a range of different methods for interpreting stories. Attention to sequences of action distinguishes this approach, as it focuses on how the speaker assembles events to communicate meaning (Radly and Chamberlain 2001). The aim here is to interrogate intention and language, examining how and why incidents are storied, not simply the content to which language refers. This involves paying attention to words and plot, but also taking account of “all aspects of the literary apparatus of a text, [including] ambiguity, irony, paradox, and “tone” contained within the words themselves (Charon 2006). The focus on language as an active construction of meaning, therefore, facilitates the approach to translation and language that I chose to use for both data collection and analysis. During this second phase of analysis, I thus analysed several interviews, testing out various approaches within the field of narrative analysis. This phase of analysis, however, ended after several months when I had to take an extended interruption of studies.

3.6.3 Third Phase: Thematic and Performative Narrative Analysis

After a long period of interruption of studies, I spent many months becoming reacquainted with my data and participants. During this process I listened to the audio recordings of each interview, reviewed all my ethnographic, interview and analysis notes. I immersed myself in the Portuguese language as much as possible, so that I was again thinking and analysing the transcripts in that language. During this phase, I reviewed the various approaches to narrative analysis and then used a mixture of different types for different stages of analysis and according to the kinds of narratives present.

3.6.3.1 Thematic Narrative Analysis

To begin the analysis process again, I printed off twenty transcripts and thematically coded the narratives within each by hand. While all narrative analysis is concerned with the themes within data, for thematic analysis the content is the main focus. Focusing on the “told” or reported events rather than aspects of “the telling” (Mishler 1995), was a relatively straightforward process that allowed me to get a sense of the information the narratives communicated. The unit of analysis in this approach was a focus on bounded segments of interview text about a topic that followed a relatively structured plot with a middle, beginning and end. This led to broad themes that can be seen in the following data chapters on family relationships, health system and contraception etc., as well as sub-themes such as work experiences and intimate relationships (see Appendix E). The clear difference between thematic narrative analysis and grounded theory is that researchers keep a story “intact” by theorising from the case rather than from the component

themes or categories across cases. This approach was therefore more suitable than my previous attempt at grounded theory.

At this point, I had a clear idea of the themes, but found the vast amount of variously coloured bits of paper too unwieldy for more focused analysis. I then switched to computer aided qualitative data analysis software (CAQDAS), HyperResearch, and went through the whole process again; refining the thematic codes and ensuring the coherence of each narrative was preserved as much as possible. While this type of software has been critiqued for fracturing participants' responses (Ritchie, Lewis et al. 2003: 229), I found it to work surprisingly well. A simple click on an individual narrative immediately returned to the initial context of the interview, enabling me to keep a focus on the original intention and attitude of the participant in question. In addition, reviewing the whole, paper transcripts alongside the software process, as well as both the timeline and 'interviews as stories' documents, was also useful for retaining a fuller sense of how each narrative related to an individual's full story.

The data that did not fit into a strict narrative structure were also coded and highlighted as a separate form of discourse. This process of thematic analysis highlighted very clearly the topics that participants focused upon, such as the extended, often multiple narratives on accessing healthcare and sterilisation, as opposed to the more limited accounts on understandings of health or the experience of the operation itself.

Once I had groups of narratives and other forms of discourse organised by theme, it allowed me to examine various types of accounts differently. The accounts on family relationships (Chapter 4) were more straightforward, sometimes taking the form of an argument or simply conveying information. The accounts of the health system (Chapter 5) contain arguments but also clear, extended narratives with sequences of events purposively assembled. Some of these narratives also contain further, performative aspects. The majority of accounts on accessing sterilisation (Chapter 7), in contrast, are extended narratives that are highly performative.²¹ While the main focus was therefore on thematic analysis during this phase, due to the variety of narrative forms present, I also attended to the performance aspects of the narrative accounts when it was relevant (see Appendix F).

3.6.3.2 *Performance Narrative Analysis*

Performance analysis is a broad and varied interpretive approach that makes selective use of elements of both thematic and structural narrative analysis methods and adds further dimensions (Reissman 2008: 105). While thematic analysis examines the content, structural analysis focuses on *how* narratives are organised, interrogating the “telling” rather than the “told” (Reissman 2008: 77). Performance analysis examines how talk among speakers is interactively produced and performed as narrative. This necessitates the inclusion of contexts such as the influence of the researcher, environment, and social circumstances on both the production and interpretation of narrative (Reissman 2008: 105).

²¹ This is probably due to various reasons such as: chronology of interview, framing of questions, topic, previously rehearsed stories, strong public narratives on topic, persuading and justifying etc.

Performance analysis draws on theoretical traditions that include symbolic interaction theory (Goffman 1969) and literary theory influenced by Bakhtin (1981). In this view, identities are situated and accomplished with an audience in mind. Furthermore, according to Bakhtin, every text includes many voices – hidden internal politics, historical discourses, and ambiguities – beyond the author’s voice (Reissman 2008: 107). This is particularly evident in accounts on the right to sterilisation in Chapter 8. As a given word is saturated with ideology and meanings from previous usage, language is therefore not simply a neutral means to convey meaning. The performance analysis method, therefore, suits my approach to language as reciprocally creating and enacting meaning. The methodological strategies outlined above assume and attempt to indicate how an interview or story is a coproduction of a complex choreography that is both situated within, and indicative of, a particular historical and discursive moment in time.

This method was particularly suitable for the narratives discussed in Chapter 7 on Accessing Sterilisation. For these accounts, participants act out a story, presenting past actions as though they are happening in the present. The performance is therefore both an act and an enactment. Interpretation of performance narratives is linked to features of the text such as how it is organised. In addition, the linguistic features of the performance genre must be examined, including: direct speech, asides to the listener, repetition to emphasise key points, expressive sounds, as well as alternating verb tenses (the latter of which often highlights the agency of the narrator) (Reissman 2008: 112-113) (see Appendix F).

This method was helpful for illustrating issues of positionality and power relations as experienced and expressed by participants across the various domains addressed in the following data chapters. I focus on participants' viewpoints, linking analysis of these accounts to the social and historical contexts, such as the health policies and status of the sterilisation law at the time. In this manner, this research contributes to the long-standing debates on agency and sterilisation in Brazil (see Chapters 1 and 2), while also attempting to avoid reducing these women's experiences to simple, binary framing of agency versus structure or oppression.

CHAPTER 4. SOCIAL MILIEU OF REPRODUCTION

4.1 Introduction

A complex interplay of race, class and gender dynamics shapes both how women perceive and experience contraceptive technologies in Brazil. This first data chapter introduces the social milieu of participants, providing an outline of their work and family lives. As noted in the Introduction Chapter, class (and therefore race) has a significant impact on women's health in general as well as their sterilisation experiences in Brazil. An outline of participants' work experiences is therefore necessary to fully understand both their experiences of the health system (described in the following Chapter 5), as well as the later discussions of sterilisation (in Chapter 7 and 8). In addition, later chapters will illustrate how notions of the family are crucial regarding both wider discourses as well as particularities of the law on sterilisation, thus deeply shaping women's experiences of the operation.²² It is therefore essential to have an understanding of participants' experiences of family life.

The chapter begins by detailing first the gendered and racial aspects of participants' daily lives, including work and family responsibilities. The second part outlines some understandings of the family and focuses in particular on women's conceptualisations of motherhood. The final part examines participants' accounts of the gendered aspects of intimate relationships.

²² For instance, as described above, if a person is married and wants to be sterilised, her partner's signed consent is required by law.

4.2 Un/Paid Work: Intersection of Gender, Class and Race

As stated in the previous chapter, two thirds of participants in this research were from low-income and poor socio-economic backgrounds. These women were employed in precarious, low-paid jobs, with the majority working as domestic labourers. Several women from more middle-class backgrounds had a variety of higher-waged jobs, while the rest were supported financially by their partners. The following two subsections will outline participants' perspectives on these occupations, illustrating how intersections of gender, race and class are experienced in their daily lives.

4.2.1 Paid Employment 'Outside' the Home

This subsection begins by outlining the accounts of women who worked in higher income occupations, and then focuses in more detail on the majority of accounts that describe low-income employment experiences. Andrea (68, *branca*) studied at university and worked in Human Resources for many years within three large companies. Regina (30, *morena*) used to work as a dance teacher. Two other participants (Amanda, 47, *branca* and Bruna, 57, *negra*) trained as secretaries. Amanda found work easily and said that she enjoyed her job working as a secretary in the hospital, whereas Bruna ended up working as seamstress and shop assistant, explaining with much anger that she never found secretarial work due to racism.

A number of participants actually worked in the hospital and clinics where they were receiving healthcare, or had family who worked there, for example, Leticia (40, *parda*) prepared drinks for patients and Daniela (42,

preta) worked as a cleaner. Renata (40, *negra*) worked in the beauty industry but came to this clinic her whole life because her mother worked here as a cleaner for years. This link between the clinics and participants' work seems to indicate the importance of social networks for both healthcare and employment. Although some of these positions are low-income, employment at these clinics generally seemed to be more stable and satisfactory than for the majority of participants.

Most participants of this research were employed in precarious and low-income positions. Many had multiple jobs throughout their lives, such as Leticia (40, *parda*), who worked in 'general services' (*serviços gerais*, meaning cleaning or domestic work) for years, then as a carer for elderly people, before her job in the hospital. Juliana (40, *parda*) describes having multiple jobs as being on an endless treadmill: "I was already a cleaner, a *doméstica*. Everyone who said 'do you want to earn money?' I did it." The majority of the low-income work described by the women was highly gendered and related to aspects of care, including childcare, cooking and the beauty industry. After working as a *doméstica*, Sara (47, *parda*) describes how was self-employed:

I made cakes, sweets, savoury snacks, things for parties, mm. And at the same time [...], I have also worked at the fair, for 23 years.

Do you like it?

Look, at the moment I'm looking to do other things, mhm. I'm already tired of the fair. Because now I'm tired, mm. It's a job that requires (costs) a lot from a person, your body (físical/'physical' strength), so I'm going to find something else to do.

Sara's account highlights how precarious and difficult work can have negative effects on someone both as a person and physically. Her struggle to perform this demanding labour was particularly urgent for her, as without her daily income she could not pay for food or her rent.

A few other participants worked in the beauty industry, doing manicures, depilation or haircuts. Women of colour are generally over-represented in this highly gendered industry. However, in contrast to the *doméstica* role discussed below, all who worked in these jobs said that they enjoyed it.

Juliana (40 *parda*) explains:

*I now am not doing anything, but I am a manicurist, depilator and hairdresser, this I did for practically my whole life. **Mhm** I prefer to treat more with aesthetics. I like [it ...]. **Why?** Because I think like this: the woman, in herself, already likes to be pretty, and it's an even better thing to make a woman look more pretty, to feel better about herself. It's interesting.*

Throughout the interviews, participants made reference to the social and personal benefits of 'looking good'. Beauty is significantly valued in a particular way in Brazil (Edmonds 2010); the value ascribed to beauty may contribute to the more positive accounts of working in the beauty industry given by participants.

The majority of my participants, however, were employed as domestic workers (*domésticas*) either "in the home of a family" or as a "daily" in different homes. All of my participants who were employed as *domésticas*

expressed dissatisfaction with the role. Sara (47, *parda*) started to work when she was 13 years old:

Caring for children, doing all the house things, for low money. It was very hard. That was the job of the doméstica in the North. It doesn't have much value (Não tem valor muito). Really? It doesn't, it doesn't, it is nothing! And I worked a lot, caring for the children, cleaning everything, tidying always (shakes head).

The tasks listed here comprise the traditionally gendered 'women's work' within the home and family. Black women form the majority of those employed in the domestic sphere, a role which is generally broader than that of a cleaner (*faxineira*), including tasks such as cleaning, cooking, laundry and childcare. Black women in the workforce in Brazil face the double discrimination of gender and race (Carneiro and Santos 1985). Research links this to the part black women played during the period of slavery and the transition from slave to 'free' labour in Brazil (Azevedo 1985).

In contrast to those who work in 'the home of a family,' others such as Georgiane (59, *negra*) and Laura (48 *preta*) worked as daily *domésticas*. This position is even more insecure, lacking the basic regulation of a registered *doméstica*. Laura becomes upset when she describes how she has worked at this job for 28 years:

No, but... eh, because it's a job that doesn't have value. It is not valued, it doesn't have significance or meaning, nor a good salary, ah, you know? Mhm. I work a lot, and get very little (visibly unhappy).

*I think there is a new law about it now, did you hear about that?
What do you think about it?*

Only I am a daily, ah. I don't work as a registered, I am just daily (diarista) so it doesn't help much, mm. I go to different houses every day. So it is more tiring than working in just the one home, you know? (getting more upset).

Mm, I understand, it's hard

It's very hard. Yes, even my mother still works even today. She is 69 years old. Really? / She works even today and she is a domestic worker like me, a daily doméstica. It's difficult.

Aside from not being socially valued or recognised by others, Laura also mentions how such work has no intrinsic meaning. This lack of meaning along with the fact that many women continue this work for many years, highlights how hard it is to do such 'worthless' work for so long.

Feminist movements in the 1980s and 1990s such as the group *Coletivo de Mulheres Negras do Estado de São Paulo* founded in 1984, sought to increase the recognition of black women's rights in Brazilian society and ameliorate some of the social inequality and discrimination that they face (Hahner 1990, Roland 1995). The struggle to have domestic employment recognised and given the same rights as other work led to some regulation attempts, including an increase in minimum salary when I was there in 2013. Nonetheless, the job is often still precarious, low-wage and perceived to be of low value. The lack of recognition for the typical family/home work performed by *domésticas* (generally poor, black women) in my participants' accounts is clear and accords with the literature on the topic in Brazil, (Bruschini 1985).

However, despite how hard such work is, three participants also described it as a means to freedom and independence. Juliana (40 *parda*), for example, was happy to leave a very full and chaotic family home:

*My grandmother raised all of us, my mother hardly every stopped by the house **Mhm**. My father lived nearby, he was an alcoholic. At 15 years then I left to have a life (parti pra vida) [...] to be on my own and independent.*

Previous research has shown how paid work can provide women with autonomy and mobility, as well as the opportunity to expand one's social networks (Diniz, De Mello e Souza et al. 2004 [1998]).

The occupations of the women who worked outside the home, whether in higher-income or low-income employment, are all traditionally gendered roles. These roles encompass the emotional, relationship and physical work involved in: human resources of large companies; secretary work, teaching; caring for children, elderly or sick people; the beauty industry; preparing and serving food, and domestic work in other people's homes. Those women working in higher-paid roles generally spoke of this work positively. Of the lower-paid jobs, women working in the beauty industry also talked about enjoying these occupations. Participants who worked as domestic workers or self-employed food caterers spoke negatively about these roles. The analysis illustrates how the majority of participants struggled with precarious work and experienced it as demanding, underpaid and undervalued.

4.2.2 Unpaid Work in the Home

In contrast to the majority of participants, less than a quarter of the women were not employed outside of the home, staying at home instead to do housework and childcare. When asked “what do you do?” most of these women described this as ‘working’ at home. Vasti (36 *branca*), for instance replied: “I work at home (*em casa*). It is the profession of the home (*profissão do lar*).” Paloma’s (59 *negra*) description demonstrates how the work of the *doméstica* crosses both home and paid work: “I am a *doméstica*, I work at home.” She adds that she worked outside of the home before: “Just one time, years ago I worked as a *doméstica* in a home/house (*casa*), for three months.”

This framing of unpaid labour in the home as ‘work’ may be partly due to the influence of the feminist movements in Brazil, which attempted to highlight both *doméstica* workers’ rights and women’s unpaid work in the home as valuable despite its low social status. These movements formed part of the wider move to democracy from the 1970s, linking women’s rights to an emphasis on citizenship and the value of citizens (Diniz, De Mello e Souza et al. 2004 [1998]).

More recently, the 2003 *Bolsa Família* social welfare programme also recognised the importance of domestic and child/family-care work (Senna 2007). This programme was introduced by President Lula as part of his wider ‘Zero Hunger’ programme. The *Bolsa Família* involves direct cash transfers for poor families with children, on the condition that they attend school and are vaccinated. Money is given preferentially to a female head of household, through so-called *Citizen Cards* which are mailed to the family.

This programme reduced poverty dramatically in Brazil by 27.7% during Lula's first term. By February 2011, 26% of the Brazilian population were covered by programme, and it was the largest of its kind in the world.

In contrast to those who described housework in clear work terms, the remaining participants explained it in more personal or existential terms, describing themselves as either 'being at home' (*estou em casa*) or 'of the home' (*sou do lar*). These descriptions highlight how domestic work is a part of their identity, rather than an activity that they do. The blurring of home and work lives for (poor, black) women, and how much or little value is assigned to them, is therefore evident in the language used by participants to describe both paid and unpaid domestic work.

Most of the participants who did not work outside the home were generally satisfied with their situation. Isabela (67 *branca*) was very proud of the fact that her husband always worked so she would not have to leave the home, and could concentrate all of her energy on her *own* family. Some participants mentioned their desire to study that was interrupted by having to care for their children, such as Sofia (22 *negra*), but the majority were eager to have families and happy to not have paid employment outside of that.

Many participants, however, described how difficult it is to work in the home. Georgiane's (59 *negra*) almost breathless description of a typical day in her life echoes many of the elements in other participants' accounts of home 'work':

*I work! I organise my home, have a shower. I go to my church, **Ah yes?** I am Evangelical. I go to my church, I return, make lunch, tidy/sort anything for my family, **Mhm**. I and my son, my granddaughter, my grandson, the two are in visual communication. He is in second grade. She is a model and does theatre. And that's how it goes! **I see**. My daughter is also doing a course in security, she is studying and working. This week, our week was horrible! **Oh!** Today I already went, she went to school, soon there will be another communication (taps mobile), 7am was the first! My daughter goes to security study [...] She studies then she goes to Spanish and afterwards English class... then she returns home, runs to have shower again, prepare food and straight after returns to work. I care for the grandchildren, the children, pick them up, take them here and there, food, there is nobody else **Mhm**. Only at one in the early morning, she then works at the telephone for a taxi company. Then after there is nothing and stops, she arrives home at 5 o' clock of the morning. And already it all starts again at 9:30 in the morning. And so that's it! Monday to Sunday, every day **Uí!** On Saturday I wash my hair. And then when she has theatre I go to the theatre too, to watch. Everybody has a short pause there, **Mhm**. And then everything starts all over again, another day, I am running after everyone, running each day, it's like that. The run for life!*

Georgiane's account conveys the demanding nature of family care under precarious conditions. Most participants described supporting other family members, whether adult children, grandchildren, elderly parents or even members of their extended family. Although family care and housework are described as demanding by participants, these women appear to be mostly satisfied in contrast to earlier research on women's work in the home in Brazil (Diniz, De Mello e Souza et al. 2004 [1998]).

The blurring of home and work lives for *domésticas* highlights how much women, particularly black women in Brazil, are responsible for care within the family. They are responsible for the same activities, either in their home

or outside of it. Participants also mentioned how common it is for some women to spend all of their lives working as *domésticas*. Juliana mentions how her grandmother never worked outside, she took care of all the grandchildren until she died at 75 years old, but her mother “always worked in the home of a family, her whole life was only to work in the home of a family.”

4.2.3 Summary

This section on participants’ paid and unpaid occupations highlights the extension or blurring of gender roles both within and outside the home. Accounts illustrate how these experiences are shaped by both race and class. Most of the women who identified as white were in higher-income employment outside the home, or happy to stay at home and be supported by their partners. The majority of women who identified as brown or black worked in lower-income jobs, leading them to experience daily life as precarious and extremely stressful. The younger women who were employed as domestic workers were actively trying to find alternative, more stable jobs.

Although the difficulty of domestic work and childcare in particular, was evident in participants’ accounts regarding the role of the mother within the family, and despite the lack of social recognition for women’s domestic work in the workplace, almost all participants emphasised how important such work is for the family in the home. The next section will therefore discuss the importance of the family in participants’ accounts.

4.3 Collective Family Ideals and Motherhood

This section provides an outline of the reproductive ideals and aims in participants' accounts of the family. Participants' accounts of the importance of family, collective notions of social networks and the ideal number of children will be explored. Men are also present in the idea of the family here, however, their role is more ambiguous and fluid, as will be discussed in the following subsection on parenthood. This brief outline of family ideals provides context for the focus in the next subsection on women's understandings of the role of motherhood, as well as the analysis in the following chapters.

4.3.1 Collective Notions of Family: "you alone are nothing"

All participants but one (Juliana) generally affirmed how important the family is in various ways throughout the interviews.²³ Participants frequently conveyed a collective ideal of the family by describing a good family as "united." Lara (27 *indigena*) was a mother of three children (a boy, girl and pregnant with a boy) and originally from the Northeast of Brazil. She describes her childhood as "great! It was good, family always united, grandmother, grandfather, father, mother, always united."

Collective ideals and family practices were frequently described by participants, such as informal care for grandchildren, elderly or sick family members. In the heading above, Rosa (28 *morena*) emphasises a phrase mentioned by several participants that highlights how fundamental the

²³ Although a couple described it through a negative framing, focusing on the significant negative effects that a "bad" family can have on you.

notion of family support is: “There has to be help from the family... it has to be participating in everything, right, helping you with everything. A person alone is nothing! The support of the family is always necessary.” Marcela (66 *morena*) highlights the importance of family support with regards to health in particular: “Without the family there is nothing, nothing exists.” The self is fully relational in these accounts, as the family is crucial for survival. Sofia (22 *negra*) focuses on how important it is to spend time together as a family:

Thank God my father and my mother had a house, they always had the help of my family. Every one of us together, if you're sick or not, my mother and my father always helped me... Spend the day together, I go to their place at night to rest.

Collective notions of the family comprise practices such as supporting one another when in need, but also involve ordinary, everyday activities such as spending time with each other, relaxing together, and visiting each other's homes (Morgan 2011). The importance of family networks becomes apparent in later chapters, particularly when attempting to solve problems such as issues accessing healthcare. Diniz and colleagues point out how, in Brazil, cultural social contacts operate as the means towards problem resolution and achievements (Diniz, De Mello e Souza et al. 2004 [1998]: 45). This also links to how the *jeitinho* can be seen to operate, as outlined in Chapters 1 and 2.

Another way that participants described collective notions of family was in their descriptions of reconstituted family networks. Practices of intergenerational childcare were also clear in participants' descriptions of their families, usually with grandmothers as the main care provider (see

Georgiane on her daily life above). Fathers were rarely mentioned as fulfilling this role. For most participants, this was seen as normal, as for example with Renata (40 *negra*):

Ah there wasn't anything to say about my childhood, it was normal. My mother worked. My grandmother cared for us, we all did bits. Nothing strange. Everybody together, we all stuck together.

A few other participants, however, talk about how their mothers left and described their childhoods with their grandparents as difficult, as for instance, Bruna (57 *negra*), whose mother started a family with a new partner:

How was it, I don't know... it was like everyone that passes through difficulty. I didn't have a mother, I only met my mother when I was 30 years old. At 30? I didn't know her, I didn't have... It was the same thing that other families have... difficulties Mhm. But thanks be to God, I lived in Porto Alegre, I had my grandmother, my grandfather, he died, my grandmother raised me, my father lived nearby.

In contrast to Bruna who was grateful for her family despite the difficulties, others described being happy to leave their families.

Finally, a further way that way that participants expressed the significance of family was through highlighting the importance of having children. Many participants expressed how strong their desire to have children was, and how much they enjoyed being pregnant. Paula (52 *morena*) had a difficult

time conceiving due to health problems and had three miscarriages. Here she describes her delight during her first full-term pregnancy:

*I really wanted to have children, it was my dream [...] I was careful [...] and so making plans, dreaming for the hour I would know the sex, I was talking with my family, as the way it was, dreaming how it would be to breastfeed, all of that you know? **It was a strong dream for you?** Yes, yes, very. **Why?** Ah I always dreamt of having children you know, I always dreamt of it, always wanted it, more than marriage! **Really?** Really! (laughs). I always wanted to have a child, I always wanted to take care (cuidar), I took care of the children of my mother, they weren't mine, and I didn't know how it would be like, the change of the body how it would feel, and when the baby (neném) moves (shakes - mexe), it moved for the first time, feeling "wow!", and I "ui!" you know that kind of thing? **Mhm** I liked the baby moving inside of me, making that little wave in the belly, right. So you feel your body changing all of the days, you know? **Mm** Ah, I don't know how to explain, it is an immense happiness (laughs)! So, all of the times that I lost [the babies], I was left frustrated, sad, frustrated, you know? **I see.** So when I achieved (consegui) the role (papel), to have my daughter in my hands... Wow! **Uí!** My children, my two children, it was the most precious thing, it is everything that I have that is most important and most sacred, you can ask anyone!*

Paula's performative narrative conveys the emotional investment involved in her dream to have children. She describes it as a life-long aim and details the shared excitement of the family when a pregnancy occurs. She also highlights the physical and embodied nature of pregnancy, communicating joy and wonder through asides and body-language. Pregnancy is described very positively here, and having a child is also valued extremely highly, as 'sacred.' Paula's account is illustrative of the majority of participants' attitudes to pregnancy and having children. Just two women talked more about the difficulty of motherhood and Sofia (22 *negra*) was the only one who talked openly about how she does not enjoy the role. Overall, these accounts

on the family illustrate the important role that it plays in participants' identities and in their everyday lives.

4.3.2 The Ideal Number of Children: *Um casal*

Having 'a pair' (*um casal*) of children, particularly a boy and a girl, is a very strong ideal or norm in Brazil (Edu 2015). All participants, apart from Juliana (40 *parda*) and Sofia (22 *negra*), believed that women should be sterilised after having at least two children. Indeed, around half of my participants had only two children. Only two of the women who had more than two children actually wanted to have that increased number. Most participants described their later pregnancies as unplanned but accepted, often the result of irregular use of contraception, and contributing to their decision to sterilise.

Participants talked about various reasons why two children is the best number for a family. Many highlighted the financial cost of having more than two children. Sara (47 *parda*) said that one is "hard" to rear, two is good, but "three is already heavy on the purse, and you have to do it all alone." Her comment also highlights how it is generally assumed that the woman will bear this responsibility, which will be discussed in the next section below.

Additionally, several participants draw on ideals of collectivism to explain why it is better to have two children. Sara (47 *parda*) says that she would recommend sterilisation to her daughter, but only after two children:

*Yes, but I always recommend after the second child. Not only one. At least two. With one you don't have anything. **Oh?** Yes, I think so. You can't leave them alone, nobody exists alone... When the mother goes, that sibling already has another sibling, **Ah**. When you rear the two with love, teaching them to take care of each other, so one hand stays in the other. And it has to start from young, when they are still very small, to stay together. **Mhm** One is not enough, at least two is enough.*

This highlights again the importance of family social networks. In addition, Maria (30 *parda*) also describes having one child as being a risk to collective ideals but for a different reason:

*Because just one isn't enough [...] Usually we have to do all these things for the child ____ It's too much for just one... So say to the husband, 'I want another child, I love it too much'. With one you might be left alone, and it is a risk. **It is?** Yes, I think so. The lone child becomes very selfish, self-centred, it doesn't learn how to be with others. You know?*

Having only one child is seen as risky, particularly in unstable social conditions. This may link back to the high infant mortality rates in previous generations, as described by Scheper-Hughes (1993). Having only one also seems to go against the collective ideal of the family that was often evident in participants' accounts. As Sara explains, having one puts the child in a vulnerable position, as they will not have the social network of family to rely upon. While Maria believes that the only child will lack the knowledge of how to interact with other people, typically a crucial skill for survival in challenging social conditions. Further, by being selfish, they will perhaps not prioritise other people or family members, and not conform to the ideals of collectivism. The wider social and moral significance of having more than

two children is taken up again in accounts of participants' decision to sterilise and the right to be sterilised in Chapter 8.

These accounts highlight ideals of collectivism and the central role of the family, which both forms part of ones' identity, and provides a practical support networks for surviving challenging conditions. In reality, many participants did not achieve their aim of having 'only two' children, and some also struggled with pregnancy, births and managing family relationships and difficulties. Complicating the ideal of having 'only two,' accounts of reconstituted families were also very common among participants. This aspect of the women's family life will be discussed below in relation to matrifocality and conjugal relationships. These notions of the family are also crucial regarding the law and limits on sterilisation and wider reproductive discourses.

4.4 Understandings of Parenthood: Maternal Love

This section highlights some of the understandings of motherhood evident in participants' accounts, particularly focusing on the central role that the mother plays in conceptualisations of the family. Research in Brazil on family structures under conditions of urban poverty reveal a clear tendency towards matrifocality (Scott 1996). Scott defines this as a "complex web of relations constructed around the domestic group in which, even with the presence of a man in the house, the woman's side of the group is favoured" (1996:287). Other studies emphasise that consanguine ties are more important than conjugal for both women and men, as with Fonseca's (2000) research in Porto Alegre and Dalsgaard's (2004) research in Recife. Matrifocal family networks,

with the mothers acting as key 'nodes,' were evident alongside fluid family structures in participants' accounts in this research.

4.4.1 Motherhood as a Natural Instinct

Participants' conceptualised motherhood in various ways, and most participants emphasised that within the family, the mother is a more important role than the father. Some participants talked about how, in general, women have more of a special instinct for parenthood than men. For instance, Paloma (59 *negra*) said: "it's just in us, in the head, in the heart." Similarly, Andrea (68 *branca*) mentions:

*For my husband it was important to have children. Now I don't know for the majority of men though, no [shakes head]... I think it is more important for women! **Why?** I don't know how to explain to you, but I think that she already was born with that desire, with some exceptions, she already was born with that, inside of her... as she is gaining, she is maturing, she will gain conscience that she was born to create a life (*gerar*). **I see.** Only that she doesn't do this alone... although nowadays you can do insemination, but I think the old method is better! (*laughs/laughs*) It is better, I think that it even more beautiful. **Mhm.** But I do think like this, that inside of the woman that desire to create life rises more than the man.*

In these accounts, participants describe women's wish to have children as a strong 'desire' to create life that most are born with. This maternal instinct is conveyed as 'natural,' but it is difficult to describe and is vaguely located *inside* the woman. Renata (40 *negra*) formulates it a little differently, mentioning both that women love more, but also that women want to become mothers because it is an important social role. Mothers are seen as

more loving, caring, and concerned with children. In contrast, Maria (30 *parda*) focuses more on the practices involved in motherhood:

It is more important for the woman to have children, not the man. Why? Ah because it us that cares (se cuida), the father doesn't have the same strong link like the mother... she has the pain and the passion, wakes up at dawn to breastfeed... [...] we worry more, and life gets better with it.

These ideas of motherhood as both 'natural' and as practice highlight the strongly gendered aspects of a particular kind of care/emotion, and the social value that is attached to it. Men do not care to the same extent and are not born with the desire to generate life as much. The mental and emotional labour involved in the role of the mother is emphasised, as women are described as 'thinking' and 'worrying' more about children. These notions of motherhood link to the considerable sociological theories on the topic (see Jamieson 1998: 43-48).

Only three participants talked about motherhood as not being the most important aspect of life. Amanda (47 *branca*), for instance, argues:

*Look, I don't know, I understand that everything is in our nature, and the wish of God. If I am born without this condition to be a mother, it is because I don't have to be a mother. I am a bit radical, people don't agree much with my opinion, but I think it is like this. **Mhm**. If I could not have children, I would not adopt, because I don't have to be a mother, you see? **Mm, why not?** [...] You don't have to be a mother, if you are not born that way... you see? (Laughs)*

Amanda draws on notions of 'nature' and fate or desire of God, to hypothetically reject the role of motherhood, which paradoxically accords more closely with those participants who describe the 'maternal instinct' as central to women's identity. The unusual prioritising of the biological role of reproduction here highlights how, for most other participants, the desire or instinct to have children is not reduced to their bodies, as they generally agreed that adoption or treatment is possible, if not uncomplicated.

Overall, these accounts demonstrate how motherhood is conceptualised as a 'natural' instinct, coming from or located 'within' the body or self, for the majority of participants. The analysis illustrates how this notion is elaborated in terms of particular types of mental and emotional practices or enactments, such as 'worry.' Furthermore, these descriptions of maternal love are highly gendered, as they are contrasted with notions of men's absence of this type of care.

4.4.2 Protective Mothers

Participants also expanded on the 'worry' aspect of motherhood to describe how a good mother is also protective. This protective characteristic of motherhood was generally described in two ways: in terms of reliable and fighting mothers, and in spatial terms contrasting the 'home and street.' Participants commonly described mothers as being the one person that you could definitely rely upon. Good mothers are often portrayed by participants as being totally dedicated to their children. Amanda (47 *branca*) says:

Because when things get close [looks behind shoulder], we run fast to mother. When bad things get close, it is to mother and sometimes father that we run, so we are the secure port. So that like even today I have my mother, and with some problems I go to her still, and she is still my secure port. So we have to be the secure port for them.

Other participants talked about what it means to be a good mother in quite fierce terms. Juliana (40 *parda*) says:

I know one, a woman who is a fantastic mother, she would kill and die for her daughters. She is a very good mother. I think it's wrong that she... but being this way, either being right or wrong, she is always in favour of her daughters. I think for me this is being a mother. Even though she beats them, very much, oh she fights... but she keeps them close and defends her daughters with teeth and nails. She is a fighter.

The lengths to which good mothers go to support their children are emphasised in a violent, forceful manner here, and is echoed by several other participants, such as Marcela (66 *morena*): "If she is really a mother, she will die for her children and the father doesn't even want to know. [...] I would shoot for my children."

Maternal love here is very protective and it means putting one's children before everything else. There is a strong element of sacrifice involved in these accounts, with the mother dedicating everything to the wellbeing of her children, no matter the cost. This sacrifice reflects certain aspects of the conceptualisation of motherhood in Mayblin's (2010) ethnography of a village in Northeast Brazil. Mayblin's work argues that a narrative of suffering is connected to motherhood, where the ideal sufferer is one who

renders suffering as a 'skill;' like a mother who endures hardship to feed and raise her children. However, the participants in this research describe this sacrifice in far more active or aggressive terms, where a mother 'fights' for her children. The violent language of the fighter conveys the struggle of motherhood quite viscerally. However, it also positions the women as extremely active, and appears to be a far more agentic position than that of a 'sufferer.' This 'fighter' discourse is also discussed in later chapters, particularly Chapter 8.

A further conceptualisation of protective maternal love was described by participants in terms of place, specifically the 'home' versus the 'street.' Leticia (40 *parda*) says of her mother: "she was one of those women that are always more attached with her children than the fathers... [...] I started to work from home. I was always close to her." This binary conceptualisation of the home and street in terms of maternal love is also found in Amanda's (47 *branca*) account on her childhood:

My mother didn't let us play in the street, no way! She kept us close. We played inside the house, inside the backyard [quintal], it was me and my sister. Then one or two friends would come [...] we played inside near her.

These findings are reminiscent of previous research on the relationship between the home and the street in Brazil. DaMatta's (1997) classic, anthropological study - *the Home and the Street* - was the first to elaborate these places conceptually as sociological categories and examine how they are perceived within Brazil. He argues that the 'street' is seen as the place of commerce, men and sex workers, whereas the 'home' is the place of the

family, wife and children. The distinction between home and street in this conceptualisation is linked with traditional gender roles. In these accounts, maternal love is therefore closely associated with the home (Dalsgaard 2004: 18).

Other participants added to this conceptualisation of maternal love as linked to the home and as something possessive. Thus, Leticia (40 *parda*) says:

There are mothers that love their children, right, and there are mothers that abandon them, leave them alone, out on the street. And there are mothers that love so much, that no matter what, it's never enough, like me. I am a mother that is jealous of my children, if I stay away, my heart is left torn in pieces, when I go out to work.

Maternal love in these accounts means keeping one's children close and safely inside the home, in contrast to the public and sometimes dangerous world outside. This view accords somewhat with the matrifocal concept of motherhood in Hecht's (1998) research. In Recife, being a street child does not mean literally sleeping on the pavement, but having no mother (ibid: 108). The emphasis Hecht found on taking responsibility is also clear in my participants' accounts, and will be discussed further in the following section. The discourse on maternal love and homeless street children will be discussed in further detail in Chapter 8.

The final part of this subsection briefly outlines participants' conceptualisations of fathers. Most participants in this section focused on how responsible and loving women are, with some either implying or briefly

stating that men are the opposite. Some participants, however, focused more on the role of men, characterising them in general as irresponsible and as less caring than women. Rosa (28 *morena*), for instance, draws upon notions of collectivism when she says that she does not understand men, because: “women want company” but men “don’t want responsibility [...] Nowadays they just want to make the child (*fazer filho*) and go away.” Paula (52 *morena*) also says:

If it was important for men to have children, they would take care of the children how the mothers care for them, Ah. Because... there are mothers that take (pega) their child and throw them out, it doesn't matter, they don't care (se liga – bind), there are many, Mhm. But there are many mothers also who, when they are abandoned by their companions, their husbands, she becomes the man and the woman, she is the one who provides for the house, and supports the child, she doesn't throw the children out. Mhm. And the man, he doesn't think twice about abandoning the woman/wife (mulher) and going away with another. Why? I don't know. I'm saying this because I have five brothers, and it's like that. Really? Yes, yes with each one. He stops, to have children, then he goes out, he falls in love, and then leaves (larga) the woman with the children and goes away. The mother doesn't leave the child, doesn't abandon it and go organising her own fortune (arrumar a própria sorte). There are some that do it, but not all, you know?

Despite mentioning that some women may indeed abandon their children, women are strongly portrayed as the more responsible parent who takes on both traditional gender roles in the absence of men. Men are characterised as fickle, not attached to their partner or children, and focused more on their own life goals. This individualism goes against the ideals of collectivism, mentioned in most participants’ narratives above. The language that Paula uses highlights the spatial aspect of this dis/connect between family members. Women who abandon don’t care, ‘*se liga*’ literally means ‘binds,’

while *'larga'* means leave, but literally means wide/long, highlighting the point made in participants' accounts above that a good parent keeps children close. Furthermore, the man falling in love and leaving is happening 'outside' of the home.

Rebhun's (2007) study provides insight into changing gender roles, kinship and identity formation in a city in Northeast Brazil. She found the idea that people who love each other, support one another socially, emotionally and economically, thus creating a relationship between love and 'interest.' In this thesis, these dynamics are also highly gendered, where men are usually portrayed in opposition to mothers, as unreliable parents. Maternal love appears to involve particular emotional and practical aspects, where taking care and responsibility are positioned as morally good. These findings contrast with Scheper-Hughes' (1993) earlier study, where she argued that for her participants, mothering was guided by a metaphysical stance of 'letting go' (Nations and Rebhun 1988).

4.4.3 Summary

The accounts in this section on protective mothers illustrate how the figure of the mother is central, and almost synonymous with the family. Women are generally portrayed as having a natural instinct for motherhood, and good mothers are depicted as protective. I argue that this protectiveness appears to take two main forms, where mothers are reliable and willing to fight for their children, or also keep them close and safe in the home. The bond between a mother and her children is portrayed as far stronger than the bond between a woman and man, or man and his children. Although some participants did

have close and loving fathers and partners, in general men are portrayed as unreliable or less caring fathers. This type of individualism is usually contrasted with the strong love of the ideal mother, or the ideal collective family.

4.5 Conjugal Relationship Histories: Love and Infidelity

This section provides an overview of participants' accounts of their romantic or conjugal relationships, including examples of fulfilling and committed relationships and the more common experience of complicated or multiple relationships. Both Fonseca and Dalsgaard found that although the composition of households in their fieldsites was constantly changing, the diverse categories of residence were nevertheless generally complementary (Fonseca 2000: 62, Dalsgaard 2004). Both authors suggest that rather than talking about a certain percentage of households being female-headed, it may be more appropriate to think of units of 'mother alone with children' as transitory phases in-between conjugal unions (Dalsgaard 2004: 83). This suggestion seems to fit the description of the majority of my participants' accounts, as most had lived with their children in previous conjugal relationships.

Furthermore, as mentioned above, many participants spoke about growing up in or having reconstituted/blended families. These are often characterised by multiple conjugal relationships, more often because the father has another family, but a few times because the women separated instead. For instance, Laura (48 *preta*), describes her childhood family thus:

*Ah with all of the problems that families have, you know? Parents separated, parents fighting. I think, I think even these things didn't influence me, thanks be to God, **Mm.** [...] I have [siblings]... one sister and two brothers. And from my father... I think all are six. That is to say, my two brothers and 4 more from my father. So all together is 6.*

4.5.1 Supportive Relationship: Worry and Love

Although most participants spoke about complicated, multiple or disappointing relationships, some participants did talk about having fulfilling, long-term, committed relationships. Andrea (68 *branca*) had her first sexual experience with a lover, but met her husband when they were both studying at university, and has been with him since then. Paloma (59 *negra*) has been with her husband her whole adult life, and he takes good care of her: "This is the first time my husband has come with me, I didn't know where to go, you see. We came here to the Women's Health Clinic, it was he who found it and booked it for me. He worries." After the interview, she brought me out to meet him.

Other participants talk about having positive relationships with supportive partners, but usually this is their second, third or fourth committed relationship. Elise (41 *negra*), who describes how difficult it was to have her first child alone at 17 years old, talks about her two marriages.

*I was married at... I was 20 years old. I met a guy, right? **Mhm.** And he, we lived together. He knew I had this daughter, and he cared for her as though he was her father, **mm.** I had two marriages. I had that one and then another one. That was good. **Another one?** I did. We separated after a while. I think it was good to be alone and then afterwards I had my second husband. [...] I was 30 years old [for the second]. So I lived with him (the first) for 10 years.*

[...] But it was good for me. I was single, already had a daughter... I had good luck to get married as a single mother.

Paula (52 *morena*) also talked in detail about her current positive relationship, comparing it with her previous negative experiences. Paula's companion took on the care of her children from her previous relationship and she describes how they have lived together happily for the past 21 years:

*I was very lucky, because my companion is a person that is really eh, extremely understanding, caring, friendly, so then things become much easier, **Mhm**. He worries, and my daughter worries, so then for me it is not so difficult. [...]*

It seems a good relationship?

*It is, truly. So he is like this, he worries, he is not like a lot of other men that don't think, **mm**. He talks and asks: "did you take the medicine? Is anything happening? Tell me. Do you have to do exams? I will accompany you." If he has some work, he does it a bit later so he can come with me, you see? So he is a very good friend for me, he is helping me, so things are easier.' **I see**. And then says, "let's go out a little, go for a walk, you are needing to get out a bit, let's go to the beach, go to Urca, the Red Beach" so you know, with him I feel more free, he is very caring and romantic! (laughs/laughs).*

In Paula's account of romantic love, we see how 'worrying,' 'thinking about' and 'talking to' someone are seen as care, in a similar manner to the love and care described in the section on mothers above. This is in contrast to her previous husband who was an alcoholic, did not care about children, and did not care about her health so much that he put her life at risk. These accounts on romantic love, that emphasise emotional and sexual intimacy, seems similar in certain respects to Rebhun's (1999) and Dalsgaard's (2004) research. However, their findings illustrated that understandings of romantic

love were clashing with previous notions of marriage as based on decency and co-operation. Instead, participants in the above accounts describe having happy relationships and supportive, loving partners.

Other participants expressed an element of ambivalence, despite being currently in a positive relationship at the time, perhaps as a result of the stereotype of the 'unreliable man' leaving their partners. Rosa (28 *morena*) has a good relationship with her husband who is supportive. However, she decided to sterilise even though he offered to get a vasectomy, because: "I am thinking... if one day I separate, even then I don't want to have more children, if I get married to another person I don't want to have more."

Edila (27 *negra*) also expressed this ambivalence, even though she had a happy, long-term relationship with her husband. Similar to participants in the section above, she talked about how men should be sterilised because they do not want the responsibility of childcare:

*They do it and afterwards say it is not theirs, or if it is theirs but they don't help the woman. Nowadays, thanks be to God, we women are very independent. We need men for practically nothing... **No?** No, I think not, no. We work, we maintain ourselves... .. Sometimes I joke with my husband, "if you want to leave, you can go, I work, I maintain my children, man [cara]!" **Mhm.** Thanks be to God I have my very good family, that helps me, my mother and my father, so I don't have to be imprisoned/tied down to a person because of [having] four children, **Mm.** No, everybody has the right to choose, "it was good while it lasted, it happened, it didn't go right" also, damn – everybody has their own side[way], everybody will get to live their own lives.*

Edila's narrative shows how consanguine ties are portrayed as more reliable than conjugal ones. Conjugal relationships are characterised as fleeting and should not get in the way of the individual's goals. This account perhaps illustrates some characteristics of confluent love, in contrast to the romantic love described by other women above (see Giddens 1992).

For the accounts on happy relationships, participants generally described aspects of a romantic love that involves emotional intimacy and support. However, as the following subsection shows, these notions of conjugal love appeared to be balanced alongside a parallel discourse on unreliable or unfaithful men.

4.5.2 Husband Infidelity: 'Wife at Home and on the Street'

Male infidelity appears to be far more expected in Brazil than female infidelity, as is evident in both popular culture and in research on the topic (Dalsgaard 2004, Rebhun 1999). Dalsgaard (2004), for example, describes male infidelity in relation to patriarchal understandings of masculinity that are unattainable in precarious or low-wage jobs (2004: 192). While none of the participants of this research explained male infidelity in this way, all agreed that it is common. Some participants' accounts of their relationship experiences more closely represented the idea that men are untrustworthy, but focused more on irresponsible sexual behaviour than lack of care for wives or children. Leticia and Juliana both simply say that "most men cheat" (*traição* – lit. betray). Laura (48 *preta*) also believes that men should get a vasectomy, and uses the common phrase from the title above to express why:

Because they have more of a sex life than women... 'wife in the home and wife on the street'... I think they should do it. [...] it is common. It is common, but it is not normal! (small laugh).

Her explanation, that it is common but not normal, captures some of the essence of participants' views on gendered relationships in Rio. Although male infidelity seems to happen fairly frequently, it is not always approved of or accepted.

Various ways of dealing with this experience of infidelity are portrayed in participants' accounts. Some participants divorced or separated from their husbands because they cheated. This was the case for Laura, who got divorced the year before from her abusive and cheating husband, and Leticia, who was divorced three years before. Leticia (40 *parda*) explains: "It really didn't work, nowadays most men cheat. He cheated on me, I didn't accept it, so I divorced."

In contrast to the women who left their husband due to infidelity, several participants remained in a non-sexual relationship or stayed living with their husbands who cheated. Bruna (57 *negra*) married her husband when she got pregnant at 19 years, and describes it as a good relationship overall:

*Except I had that one thing with him, but it always happens... I think every couple today has this little phase [cheating]. But I live with him even today. I just didn't have sex (relação) with him after it. **Not afterwards...** No, no. I was disillusioned. But also ___ we pass above it, because I also was a young woman, and I didn't think this typical pattern was cool. Others: "Ah no, you have to enjoy too (aproveitar), and I: "no, I am not like that!" (laughs). **No?** I*

never saw myself that way, I think this has nothing to do with it, I think you have to respect yourself. So that you don't go... because you suffered something, and are needing something... you throw yourself (se atirer – lit. 'shoot yourself') on the first person that you see, because you can also get another disillusion.'

Bruna refuses to have a relationship with another man because she is so certain that men are always unfaithful. Although most participants talked about the importance of enjoying sex (Chapters 6 and 8), she thinks it is too risky. This account also provides an example of how participants can talk about difficult topics more indirectly, as she never actually uses the words 'cheat' or 'sex.'

After Georgiane's (59 *negra*) description of her busy daily life (above), she continued on directly afterwards to talk about how she feels about conjugal relationships:

*I got married at 22 years [...]. My husband died four years ago, but there were eight years before that that we didn't have any [sex] anymore, I was angry and disgusted with him, **mh**m. And now I am... single! (laughs)*

Are you happy to be?

*I don't have space in my head for a husband, or fathers... The world is too cruel... **It is?** You always have fear of the dark. **Oh?** I always have fear of my shadow, you know? You can't trust anyone anymore. **No?** I don't want anyone else in my life. Only me, my children and my grandchildren!*

Lack of trust is particularly stressed in Georgiane's account, which seems again to refer to a widespread belief in unreliable men and male infidelity. However, these examples also show that participants can still continue a

relationship while maintaining distrust about a partner's sexual practices. This ambivalence and lack of trust regarding men's sexual fidelity is discussed in further detail in Chapter 6 which focusses on contraception.

4.6 Conclusion: Gendered Experiences of Family and Intimate Relationships

This chapter has introduced the participants of this research, providing an overview of their work and family lives. The accounts on work reveal that women's paid employment outside of the home generally followed traditional gender roles, including care, beauty and housework. Yet within these occupations, there were distinct divisions between those who identified as white and those who identified as brown or black. Women of colour generally had low-paid and precarious jobs, and talked about how they led to considerable stress. Women who worked in the home were generally happy to be able to care for their family; however, those living in more difficult circumstances also talked about how demanding it is to care for an extended family.

This chapter also illustrated how collective understandings of the family were emphasised by participants, particularly framing the family as necessary for one's survival. Furthermore, all participants described the ideal number of children as two. They talked about too many children as too costly to raise, but having only one as risky for both mother and child, and not conforming to the collective ideal of family.

The analysis demonstrates how motherhood is conceptualised as a 'natural instinct' for most participants, and involves a particular type of mental or emotional practice of, or stance on, 'worry.' A good mother is characterised as protective in various ways; as active 'fighters' and reliable, and usually contrasted with unreliable fathers. Moreover, maternal love is sometimes conceptualised spatially in terms of the 'home' and opposed to the more public 'street.'

Participants' positive accounts of conjugal relationships usually describe elements of romantic love, particularly emotional intimacy. However, these accounts were also sometimes discussed in terms of a wider discourse on male infidelity. Men were often characterised as untrustworthy regarding sexual relations, and participants' accounts illustrate the various ways that women deal with this practice. Overall, the gendered nature of women's work, family and intimate relationships is emphasised in this chapter. As will become clear in Chapters 6 and 8, participants' experiences of and perspectives on family and intimate relationships shape their understandings and practices in relation to contraception and sterilisation.

CHAPTER 5. HEALTH PRACTICES, HEALTH SYSTEM

5.1 Introduction

The previous chapter introduced the women involved in this research, outlining several significant aspects of their socio-economic positions and conceptions of the family. This chapter begins by examining participants' notions of health and then focuses in detail on their understandings of the public health system in Brazil - *Sistema Unica Saude* (SUS). The majority of women's accounts of health focused on ideas of wellbeing and health practices. These accounts build upon the descriptions of women's lives in Chapter 4, and often involve a further critique of inequality. These views of wellbeing will be raised again in relation to women's experiences of reversible contraception and their evaluations of their sterilisation, in Chapters 6 and 8.

The remainder of the chapter examines participants' understandings of the public health system. These accounts were usually extensive and focused upon the strategies participants use to navigate the complex and unevenly developed health system. This institutional setting is crucial to understand, as the wider medical setting and culture shapes access to healthcare and contraceptive technologies. All participants were critical of the health system overall, with around two thirds of the women talking in detail about negative personal experiences. Within the negative accounts, around half also critiqued healthcare professionals. The remaining third of participants discussed positive personal experiences of healthcare, despite their overall assessment of the system. The rest of the chapter is therefore divided into three sections. The first explores the main points that most critical accounts

of the system raised, i.e. the problems of inefficiency and lack of infrastructure. The second section focuses on negative experiences with healthcare professionals. The final section, in contrast, explores participants' accounts of positive experiences of healthcare.

This chapter illustrates how certain types of participants, particularly those in positions of multiple intersecting inequalities, experience systemic obstacles to healthcare. The Brazilian concept of the *jeitinho* as a problem-solving strategy and emergent practice is drawn upon to demonstrate how women navigate the institutional barriers that they face. It also demonstrates how participants' notions of wellbeing are situated within their everyday lives and relationships, and thus incorporate and go beyond both physical and emotional health.

5.2 Health Practices: Situated Wellbeing and Emotions

5.2.1 Wellbeing: Place and Negotiating Family Boundaries

When discussing health practices, just two participants focused solely on issues related to physical health, i.e. diet and exercise. The majority of participants extended their definition to include broader notions beyond physical health. Several participants talked about health practices in terms of an individual's 'lifestyle.' Sofia (22 *negra*) explains that a person is healthy because she "lives well, it's the choices she makes." Amanda (47 *branca*) also mentions that, "it's the lifestyle of the person, right. It's the options that the person takes in life." These participants emphasise individual agency and responsibility, where health is a fluid, ongoing process that is actively practiced or chosen throughout one's life. The necessity and freedom to make individual choices in life is an important issue that is raised later by

participants regarding reproductive rights, particularly the right to sterilisation.

Most participants' accounts of health focused on an expansive notion of health that emphasises the importance of emotional health. My analysis in this section therefore draws on the notion of wellbeing, as it is a concept that is usually defined as addressing the conditions of human flourishing (Sen 1993). Wellbeing is culturally responsive and includes functional and existential aspects of health. In addition, analyses of this concept often address issues of both structure and agency (Cronin de Chavez, Backett-Milburn et al. 2005). Participants' accounts of wellbeing generally focus on the types of activities that people can choose that lead to a healthy life. Camila (23 *morena*), for example, describes a healthy person thus:

*It is the person who takes care of themselves, [...] everyone has problems, mm. But for... for us to be healthy it is the emotional side that is important, it is happiness, go out and enjoy yourself, on the street, have a drink, relax [...] It is the head. Not that a person who drinks a lot will live longer than someone who doesn't drink or who goes to the gym. But I think that it is linked to the emotions *cara*, the happiness of the person.*

Camila initially mentions how individual responsibility, 'taking care,' is necessary for a healthy life; however, the majority of her discussion revolves around emotional or mental wellbeing, or 'the head' as many participants describe it. Most participants' accounts of health practices and wellbeing emphasise the importance of 'enjoying life,' often prioritising it over a narrow focus on the body or physical health. In all of these accounts, bar one, enjoying life consists of 'going out,' though participants differ in how they define and locate this activity. The spatial dimension of these accounts of

wellbeing will be examined here, as it points to the importance of the situated nature of health understandings and practices.

In focusing on place, I do not attempt to enter into a debate regarding causal links between health and geographic location (Macintyre, Ellaway et al. 2002, Diez Roux and Mair 2010). Instead, the analysis here examines how wellbeing is conceptualised in terms of place (see Popay, Williams et al. 1998). The sociologist Gieryn explains that while 'space' involves a geographic location, the concept of 'place' focuses on how these spaces are imbued with social meaning (Gieryn 2000). For instance, in Camila's account, (emotional) health is positively influenced by 'going out' and socialising in 'the street.' The role that the street plays here contrasts with that illustrated in the previous Chapter 4. When discussing the role of the mother and the context of the family, 'the street' is often depicted negatively as the opposite of 'the home.' This notion of the street is also raised later in Chapter 8 on sterilisation rights. Yet, in the context of an individual's emotional wellbeing, it is depicted as a means of relaxation, happiness and health.

Two further accounts of wellbeing include a wider range of activities than the previous example. Paula (52 *morena*), for instance, defines a healthy life as:

It is diet, exercise, and try to, well, go on walks, go to the cinema, to the theatre. Oh? Health is going to the cinema? Yes, the theatre, beach, the mountains, the lakes, these things, you know? Mhm. It doesn't cost a lot, right? Mm. To take, well, some weekend time to wander a bit, meet new people, this all helps, you know? It clears the head.

Emotional health is again conceptualised as 'going out,' or away from the home here. The focus, however, moves beyond 'the street' or community and encompasses the diverse range of the cultural and nature activities available within the wider city of Rio. Although Paula raises a concern with financial cost, here she argues that it is not a limitation. The activities that she mentions, nonetheless, are generally either located within the wealthier southern regions of the city, such as the beaches, or associated closely with them, and farther away from the favelas in the north. This concern with cost is an issue that is taken up further by participants below.

In the following account, Livia (37 *preta*) similarly describes the importance of going out into the city; however, she adds a critique that further illustrates the significance of community or place for health understandings:

*Healthy is a person who practices sport, and goes out and enjoys life, enjoys nature, you know? **Nature?** It's always good to get fresh air. We who live in favela we only breathe the smell of marijuana, **oh**, so there's no fresh air at all. Only when we go to a park... **mm**. Go to the beach and you still run the risk of getting the smell of marijuana. **Really?** [...] It's healthy to go out, go shopping and to the cinema too, to distract the mind. **Ah the mind.** That's it, distract the mind so you don't stay only thinking of problems.*

In this account, Livia explicitly describes her neighbourhood as unhealthy, highlighting another aspect of life in many *favelas* that often have to deal with drug issues. This point also implicitly raises the topic of the dangers associated with gang and police violence, which often revolves around drugs in the poorer neighbourhoods. Health understandings and practices are further shown to be deeply affected by, and embedded within, experiences of daily life conditions and place.

Before moving on to a more detailed examination of critiques of health practices and health inequality, I will provide a brief look at an account that contrasts with the majority of participants' perspectives on health practices and emotional wellbeing. Just two participants described very different strategies or activities compared to 'going out' and 'enjoying life' for emotional wellbeing. Marcela (66 *morena*) describes a healthy life as one that involves restraint: "You have to try [...] to avoid a lot of things, drinks, parties, it is better to stay at home, calm." The idea of staying at home as healthy is the opposite of the majority of participants' accounts, particularly Camila's focus on the street above. Marcela's characterisation of the street is somewhat similar to Livia's description of the *favela*, as it highlights how certain places outside of the home, along with associated activities, are not healthy. This portrayal of the street as unhealthy and risky is closer to that described in the previous chapter, where the home generally represents safety and family love.

This unusual perspective highlights how 'the home' is generally absent from the majority of participants' accounts of a healthy life. When discussing how they manage their individual health, most participants emphasise that it is important to physically and mentally remove oneself from the home. Perhaps the home as the site of family and household duties represents the heavily gendered responsibility that women bear regarding these obligations. Implementing or negotiating a boundary around these responsibilities appears to be particularly important for these participants' health and emotional wellbeing. This boundary work regarding family relationships and individual health is reminiscent of studies on boundaries and relationships within the sociology of family (McKie and Cunningham-Burley 2005).

In reality, most participants were not able to do all that they wanted for their own health, generally because of their stressful lives or family and work obligations. Most struggled to exercise, and while some tried to keep to a healthy diet, others gave up entirely. Around half of those who discussed health practices and wellbeing also qualified their accounts with a critique on living conditions and health inequalities. Most women here make the point that not everybody can look after their health in the same way, particularly those living in precarious conditions. Renata (40 *negra*) puts it succinctly: “To be healthy is because of the life’s opportunity. To work as much as possible, diet... everything! I never had access to all of this.” Health is just one other restricted or limited opportunity, along with the many other aspects of life that are limited to people living in poverty. Lara (27 *indigena*) highlights that this lack of access and opportunity is particularly characteristic of *favelas*: “Life is always harder for those who live in [*favela*] communities, including the health.” Similar to Livia above, Lara frames her account of health practices within a critique of wider inequality, particularly the deprivation associated with living in a *favela*. Health understandings and practices are thus embedded within wider life issues.

In contrast with the majority of accounts on health practices, Andrea (68, *branca*) had a very different, positive experience with a supportive health group. Andrea worked for many years as an H.R. manager and lives in a wealthy middle-class neighbourhood nearby the hospital. To highlight this contrast, an extended extract from her account is presented here, where she describes how she cares for her health:

*I listen to what the doctor says (laughs)! I try to eat well, nowadays I have a well-regulated diet, I do exercise for my age, **ah mm, what type?** I do stretches, I do dance, **oh really?** Ballroom dance, **mm cool!** Well yes... I have friends. I do memory workshop once a week, they are exercises for memory, with a speech therapist that attends a group of people for my age. I do this each week, once a week. **Where is it?** Here in the Shopping Centre X., near my house.*

Mm, cool. What type of organisation is it?

*It's not really an NGO no, it is an organisation of a psychologist, a speech therapist, who formed this group and called for volunteers, **Mhm.** There is a volunteer psychologist, a volunteer dance master, because it involves everything, music workshop, memory workshop, dance, stretches, these things, **mm I see.** So it is there in the shopping centre before it opens, between 8 and 10am [...]*

And it is free?

*Yes it is free. We just pay, what? Once a year a registration card, 10 reais, a t-shirt that we use, 10 reais, All just 10 reais, nothing more, **mhm.** The expense that we have, we are happy to pay. There is the birthday of the teacher and we join together for a present, **ah mm.** Sometimes, every month actually, we pay towards the travel of the teacher, so everyone gives 5 reais, you give what you can, and divide it for the teachers. [...] So I consider it as free, because if I had to pay for everything we do there? [shakes head] Wow!... **Ah mhm.** It's so good.*

Andrea's account diverges significantly from the majority of participants' experiences of health practices. It highlights the contrasting critiques on lack of facilities and access to healthcare support in poorer *favela* neighbourhoods. Andrea lives in a middle-class area next to a large shopping centre, which are often a focus for facilities and entertainment in the wealthier neighbourhoods. She receives support and holistic healthcare, focused on physical, mental, and emotional wellbeing, at quite a low cost for her area. However, even that low cost would be impossible to pay for other participants, who can barely pay for food. Furthermore, Andrea's two children are university-educated, wealthy and pay for childcare for their own children, thus leaving her some time to focus on her own health. This

contrasts with the situation of the majority of participants who are too busy with family or work obligations to care for their own health.

Accounts of health practices that focus on wellbeing demonstrate how understandings of health are embedded within everyday lived experiences. Participants move beyond a narrow focus on the biological to emphasise emotional health and quality of life, where they are particularly aiming to reduce worry and stress. For these women, reducing stress is usually accomplished by going out and away from the home. This perhaps indicates that the home as the domain of family and relationships, which was seen as so crucial in Chapter 4, is also a burden that needs to be managed or negotiated for individual women's health. Similar research also demonstrates how health and wellbeing intersect with women's structural and familial circumstances, influencing their perspectives and experiences of caring roles (Backett-Millburn, Airey et al. 2005).

In addition, health understandings are also situated within and experienced as part of the community and wider city. The geographical character and built environment of the city appears in these accounts on health in various ways, usually alongside critiques of inequality. These findings expand upon the research on place that demonstrates how it sustains difference and hierarchy in ways that exclude and segregate particular categories of people (Wilson 1997, Gieryn 2000: 474). Notions of wellbeing are thus 'emplaced' (Gieryn 2000), as place itself is an interpretive framework through which people understand notions of wellbeing, evaluate their lives and take political positions. The focus on an expansive notion of wellbeing, alongside critiques of health inequality, has implications for the perceptions of contraception and sterilisation as will be examined in the following chapters.

Moving on from the individual, family and community conceptualisations of health, the remainder of the chapter focuses on health at the institutional level.

5.3 Structural Issues of SUS: Lack of Investment in the System

As stated above, every participant was critical of the health system in general. Most critiques of the public health system focused on structural issues, mainly inefficiency and lack of investment and “infrastructure.” The following accounts highlight two main aspects of the health system that have had negative effects on participants. The first is focused on issues of access and primarily details difficulties with bureaucracy, while the second point covers the lack of facilities within the clinics. The analysis details the various ways that participants use *jeitinho* practices to gain access to healthcare. As described in Chapters 1 and 2, the *jeitinho* is a way of accomplishing something by bending or bypassing the rules, and usually requires the use of resources such as money, family or social networks.

5.3.1 Accessing Healthcare: Place and Bureaucracy

Almost every participant mentioned the difficulties involved in accessing care on the public health system, usually discussing the problems with bureaucracy around receiving appointments in particular. Before addressing this issue, however, I should briefly mention that several participants also talked about the role of place in accessing healthcare. The awareness of the link between place and health inequality is evident above in participants’ accounts of health understandings and practices. This link between place and health inequality is a topic that is raised again in several participants’ accounts on accessing healthcare. Knowledge about the lack of clinics and

difficulty accessing them was hard to avoid at the time in Rio, and it appears to be assumed knowledge for many of the accounts on accessing healthcare and contraceptive technologies. This issue will be briefly outlined here, before focusing on the more explicit themes on the structural issues of the health system.

Several participants describe the difficulty of reaching clinics for both routine and emergency healthcare, particularly those that live in more distant *favela* communities that are built on unstable land and have poor transport links. Eliane (51, *negra*), for example, has to walk for around forty-five minutes downhill from her home to reach a bus stop. In the following example she is annoyed that she was sent to a more distant hospital:

That hospital is not closer, to walk there, for me is 'to give the hand' [huge effort, pay]. You have to see, if you don't go by taxi... I carried my son on my back to [...], he had dengue. Wow! [...]. He is much taller than me, over 1m 30, wow [...]. Even to walk down to the bus stop, he couldn't do it.

The lack of clinics in her community and lack of access to this hospital makes it extremely difficult even to attend a clinic. This critique highlights how the public health system is not adequate for the needs of those dealing with precarious living conditions. The inaccessibility of health clinics was even more obvious during the dangerous rainy season, when doctors did not come to the clinic, or it was cancelled, because most of the patients were not be able to reach it.

It is clear that the lack of clinics, along with precarious living conditions, increase obstacles to accessing healthcare for the majority of participants. These accounts highlight how health is not equally available to all. They

provide an understanding of the broader struggle involved in accessing healthcare, and how the uneven development of the SUS in turn shapes wider health inequality. These accounts illustrate the point made by Szwarcwald, Bastos et al. (2000), regarding the role of place as an indicator for class and race-based health inequalities in Rio de Janeiro.

The main issue with accessing healthcare that was raised by most participants involves the difficulty of dealing with bureaucracy around appointments. These accounts can be divided into two, the first covering issues registering at a clinic or hospital, and the second on the struggle of getting appointments or actually being seen by a doctor. Bruna (57 *negra*) gave multiple and detailed examples of the types of difficulties patients can encounter when attempting to register at a public clinic or hospital. This is probably due to the fact that she had private healthcare for many years through her husband's job, and just recently had to switch to the SUS when he retired:

I think that I suffer a lot with this [the SUS]. [...] you have to go knocking on the door, asking for charity... We don't have a health plan [now], so we must run. But I also got a bit disillusioned with this thing of the 'recommendation' [referral - indicação], "go here and there." But to be able to get it, you need to get someone to give you this recommendation in a hospital, you must have a doctor friend to be able to get it. If you don't you are left rotting. Even when I arrived here I went to [...] to (doctor) I asked him if there was a way (jeito) for me to get it [...], but I didn't get a space. I was supposed to get it through the health centre, and getting there is another type of bureaucracy. So you end up getting disillusioned. Then I asked this colleague [...] He was a director here, and it was he who gave me this recommendation so that I could matriculate here.

This account highlights the importance of *jeitinho* strategies for accessing healthcare, particularly in this case, the necessity of having contacts in the

system, or 'doctor friends.' Bruna's example emphasises how difficult it can be without such contacts and the struggle involved in getting them.

However, the account also demonstrates how this deliberate *jeitinho* strategy was eventually successful. The lack of power of the patient in this situation is highlighted, along with the significance of the doctor-patient relationship. The doctor's role as gatekeeper is crucial; furthermore, the necessity of knowing how to find the right people, and how to ask, is emphasised. In highlighting the multiple obstacles' that Bruna faced, her narrative also underlines her skills and particularly her active persistence in overcoming these structural constraints.

Bruna continues on to describe how she also got a place for her husband at a different hospital. He was very ill after having three heart attacks and needed almost daily care at a hospital, but he was not being seen at the hospital assigned to him by the SUS. Bruna got him a place at a better hospital, because:

You get desperate and crazy with the chaos. I got it, with a lot of cost, with a colleague from the centre, because I am Umbandista too. She organised the hospital that is there in [...]. So she got the place with much cost. She [was] operated there because she was full of problems too [...]. This friend of mine arranged so that they would see him more rapidly.

The importance of *jeitinho* practices in gaining access to healthcare is again highlighted in this account. Bruna was sure that her husband would die without receiving the daily care that he needs. The cost was so great for them that they do not have money for regular meals or for bus tickets, so he now must walk around four hours to the hospital and four hours back, until he

can get a transport card. Despite the significant trouble, stress and cost, it is still an example of a successful *jeitinho* strategy.

In this example, the role of social networks also provides crucial support: in this case, Bruna's religious community alongside the pooled financial resources. This refers back to the importance of collective notions of family, where social networks and the ability to navigate them smoothly is often seen as essential for survival. The role of social networks, contacts, and religious faith will be discussed further in section 5.5 on positive experiences of the SUS.

As both of Bruna's narratives illustrate, *jeitinho* accounts are often focused on the struggle to exercise agency and attempts to overcome systemic power inequalities with personal resources. Social savviness skills, such as how to find the correct gate-keeper and how to ask in the correct manner are highlighted. In these accounts, financial resources are also necessary. This fits more closely with Levine's (1997) definition of the *jeitinho* as requiring a payoff instead of the exchange of favours (Levine 1997: 81). Contacts and social networks can provide access to healthcare when one cannot pay for private care, and can be necessary even for serious conditions such as heart failure (Diniz, De Mello e Souza et al. 2004 [1998]). The role for such social networks in accessing contraception and sterilisation will be addressed further in the following chapters.

The second bureaucracy issue, the one participants describe most frequently, is the difficulty getting appointments when you already are registered with a clinic, particularly for more routine healthcare. Two examples of this difficulty are described by Eliane (51 *negra*) in the following extracts. After

detailing how it took over a year for her mother to get tested for breast cancer and the severely negative consequences that had, Eliane is now struggling to get an ultrasound too:

*It depends on the consultations that you have to book, if the doctor will get up from his chair and go to where you need the appointment, right? If you pay [tax] and still don't get to book a consultation then you eventually just give up [desist], right? **Mm**. "I've heard it before," so you give up! **Mhm, I see**. I'm needing to get an ultrasound done since March [7 months ago] and I still didn't get it, "ah return next month, return next month" ... and it is not being booked.*

The delays and waiting times for appointments were frequently expressed by participants with the phrase that they often hear: "return next week/month." Eliane describes clearly how these kind of challenges can lead to patients losing heart and not 'fighting' for access to healthcare. Similar to the successful *jeitinho* practices above, Eliane describes how the only thing that could work in this situation is the direct assistance of a doctor, but it appears that she did not have a 'doctor friend' nor the financial resources employed by Bruna above.

Participants also talked about how, even when you do have an appointment marked, it still does not guarantee that you will be seen or receive treatment. Eliane goes on to describe how she has been trying to get treatment for a hernia that was diagnosed eleven years ago:

*.. So I pay for what? For a health system? (shakes head) You know? **Mhm** [...] So what can I say?! Mm, it's not fair! One time it gives you help, another no, it's a question of luck, you know? **Mm**. It's luck, it's luck. Unhappily, it's just luck.
Mm mm, I see... And the hernia, why did it delay so long for..?*

*Because here, the [surgery risk] 'more than ten' comes already... for risk that is 'more than six'?... (eyebrows raised, then shakes head), they never have space, never are making appointments (marcando)! Now then the doctor gave me a piece of paper for my [health] plan, in 'clinic X', to make an appointment for a medical plan for there, for general surgery. Then I arrive there on the marked Thursday, and ask for the doctor, and he's not even there and nobody even knows him! [Angry sigh] What word do you use for a doctor that works there, you know?! **Mm.** Ah no, I'm disillusioned! It's not 'the doctor,' it's the 'god of hell,' right?! **Ah, I see!** Eeee! It's you that needs to know! **Mhm mhm.** If you only have positive responses, what will you know? [shaking head]*

Eliane's account highlights the lack of treatment for patients who are not requiring immediate, emergency medical treatment. This depiction of the SUS emphasises a system that is under strain and incapable of attending to all those who need treatment, thereby creating another category of people who are less likely to receive healthcare.

In this case, Eliane provides a strong critique of authority and structural violence, as she cannot surmount the systematic obstacles blocking her access to healthcare. Luck is a damning critique in this context, as it is an indication of lack of control, unreliability and unfairness. Eliane also mentions the "bit of paper" she received, which is another phrase that came up frequently in participants' accounts of accessing medical care. This phrase generally appears in accounts on the health system when there is a failure of access or treatment. Drawing upon sociology of science and technology theory (Pinch and Bijker 1984, Law 1986, Latour 1988), the 'paper' in this context perhaps acts as a mediator and material evidence of interaction with the health system, indicating that a process of access or treatment has been arranged. In these accounts, the 'paper' therefore seems to act as a type of narrative device or marker, indicating that a promise or contract has been broken, and thus

highlighting the failure of the system. This issue will be addressed in more detail in the following section on Health Care Professionals (HCP).

These narratives from both Bruna and Eliane are highly performative, with direct speech, non-verbal communication and asides to the listener. These characteristics emphasise the emotional tone of the account, drawing the audience to re-live the experience, as it is simultaneously being enacted. The anger, frustration and disillusionment are thus conveyed more forcefully, reinforcing the speaker's perspective and point that the listener needs to know about these experiences.

The complexity and unreliability of the public health system is highlighted in these 'bureaucracy accounts'. They illustrate various ways that certain participants' attempts to access healthcare are systematically blocked, while others with resources may still gain access through the crucial *jeitinho* practices. These findings seem to support De Abreau's (1982) argument that the *jeitinho* is a "recourse to power," arising as a response to unbending bureaucracies. The ideal of health as a right and entitlement for all provides a stark contrast with the reality of most participants' experiences. Both participants' struggles with the SUS provoke quite strong emotional reactions, and their frustration and anger is clearly conveyed. The 'unfairness' of paying tax for healthcare but not receiving it, along with the implied wider political ramifications, is also pointed out by many of these participants. This wider, political critique will be discussed in detail in the following subsection on hospital facilities.

5.3.2 Quality of Healthcare: Lack of Facilities

The second significant point in participants' accounts about structural problems of the public health system focused on the lack of "infrastructure." These accounts covered issues such as the lack of clinics, lack of HCPs, and lack of basic necessities such as beds. Sofia (22 *negra*) mentions that they lack the basics for routine care appointments, "tests that you need, they don't have." Edila (27 *negra*) also mentions that when you get a test done, "you don't get it back for many months because there aren't enough proper laboratories." These references to lack of facilities accord with the wider literature on the public health system in Brazil, particularly the imbalance between private and public facilities (Béhague, Gonçalves et al. 2002). Juliana (40 *parda*) also makes this point, relating how she knows someone doing a hospital internship who says: "I buy gloves with my own money, sometimes I buy syringe, needles, gauze with my money, because the hospital does not have them."

As mentioned above, these accounts on the lack of infrastructure were usually accompanied by either subtle or obvious critiques of the wider political classes and system in Brazil. Paloma (59 *negra*), for instance, jokes about how bad the system is: "It is the government, **mm**, isn't it?! (laughs) **I see (laughs)**. It's those that are in charge! (laughs). They are to blame." There was widespread concern over political corruption in Brazil at the time of data collection. As mentioned in Chapter 1, the year 2013 proved to be a significant political turning point, and this is mainly evident in participants' accounts on the health system. From April to July 2013, Brazil experienced the largest public protests since the early nineties. These protests led to a widespread public debate on social services and political mismanagement and corruption. Participants' political critiques of the health system became

particularly explicit during and after the largest protests in June. The following two accounts illustrate these concerns along with the link to the issues of the health system.

Georgiane (59 *negra*) mentioned that she had some good experiences with the SUS, but she focuses on the negative experiences of the system, when she describes it here:

Ah, it is a pile of rubbish (porcaria) (Laugh, laugh)! It's a pile of rubbish. While they are doing the World Cup, the Carnaval, they are forgetting the health, ah mm. They should look more to health, and afterwards the others [...] I think the protests are right, but I don't agree with the vandalism, right, but I think they are correct! [...] They don't have the infrastructure. On the floor above here [points up] my husband was admitted, and was 'thrown aside' [abandoned - ficqou jogada] [...] 42 days sitting in a chair in front of a filthy bathroom, dirty, oh! I had to go to the shop to buy disinfectant, and I cleaned it and him... for 42 days, waiting for a space on the ward, wow. And after the 42 days he was operated on. And my husband... it was in 2009, mm. [...] And when the admission [enternado] finished, mm, he died... (shakes head), wow. He died because of bad care [attendimento]... mhm [...]
So the people, the protests, are right.

Georgiane's narrative explicitly attributes the blame for her husband's death on the inadequate state of the health system. Her account is framed by a critique of the political system that was widespread among the protestors at the time, particularly regarding the spending on the World Cup. She uses the phrase '*jogada*' to describe the lack of attention or care for her husband, which is a term that is usually used for when throwing rubbish away. This negative association emphasises a sense of disregard and abandonment, which is reminiscent of the 'home versus street' dichotomy that was raised in participants' accounts of motherhood and the street in Chapter 4.

Juliana (40 *parda*) made the same point in the following extract, but focuses more on the political aspects of the situation. She first clarifies that although she has no problems now that she is being treated at this hospital, she encountered many difficulties with the health system in other locations:

But if you really depend, need, public health posts... (shakes finger and head) nothing, forget it! You can die!... How many times you wait hours and hours in a queue waiting to be seen [attended - atendimento]? You will die and not be attended, you know? It's crap [droga]. They worry a lot about fantasy and try to put Brazil, "ah beautiful Rio de Janeiro," [very sarcastic] for the others that come from abroad. But for those that are within [Brazil], everyone gets screwed! That is the idea... I'm not going to be arrested, right? (Laughs) (laughs) [...]

I'm not going to put the blame on the doctors, but I put it on the lack of resources you find within a hospital. [...] So where does the money of the government go? The tax that you pay, for what? To put make-up on the pile of rubbish Rio de Janeiro, so that some people from abroad come, people that we don't know who they are, but that live well, because, we'll say it this way, everyone says that outside of Rio de Janeiro is the first world. [Our money] goes to a make-up for the people that come here to see. And if they feel sick [passou mal], how are they going to find a doctor? If they don't have money in the moment to pay for an emergency?

The chances of dying on the public health system seems to be a very real risk and fear for many participants, as illustrated by Georgiane's account above. Juliana's account provides a more explicit link between political corruption and health inequality. The context of large and visible spending on the international sports events, alongside inadequate funding or attention for public services such as the health system, is clearly critiqued in these accounts.

5.3.3 Summary

For around two thirds of participants, the health system is generally perceived as unreliable, risky and even potentially deadly. Having resources such as social savviness, contacts, wider social networks, and money can enable some people to draw upon *jeitinho* practices to bypass systematic barriers to accessing healthcare. An underfunded and strained health system ensures that certain groups of people are more likely to be neglected. This neglect can be enacted and reinforced at various or multiple levels for certain participants: from being able to reach a health post, to registering, to booking appointments, or lack of basic facilities.

All of the participants in this section who discuss criticisms of the health system at length identified as either black or brown, which is in accord with the general literature on health inequalities in Brazil (Leal, Gama et al. 2005). Healthcare in these accounts is therefore enacted along multiple, intersecting axes of difference, reinforcing wider and embodied class, race and gender inequalities. The contemporary political context for these accounts is crucial to bear in mind, as explicit and widespread critiques of the health system link to wider issues of inequality in Brazilian society.

5.4 Uncaring Healthcare Professionals: ‘They don’t even look at you’

Of those who focused on negative experiences of the SUS, around one third also talked about difficult experiences they had with healthcare professionals (HCPs). These accounts often include structural issues, but the focus on HCPs adds a further, interactional dimension. This section will discuss participants’ understandings of the relationship between structural issues of the health system and the perceived problematic HCP attitudes. The

relationship between HCPs and patients will be the primary focus later in the majority of participants' accounts of accessing sterilisation.

The perceived negative or unhelpful attitudes of doctors is the main issue for the majority of these participants. Many participants mentioned that doctors "just want the salary" (Renata, 40 *negra*) but the majority of HCP-related accounts focus on the lack of attention that doctors pay to patients. This inattention can be perceived and experienced differently at different levels. Regina (30 *morena*) talks about how distant doctors can be during a consultation:

You can't generalize, Mhm. But I think the doctors that really want to be doctors nowadays are very few. Because they think that they are doing an enormous charity by attending you well, you know? (very sarcastic) Mhm. The patients aren't differentiated, it's all very theoretical, "Ah I learned this or that," ... only in practice it is different. I think that it doesn't really connect with patients no. It's not all of them, right, but few of them have it [care]. [...] I used to use the word 'spirit doctor [ghost]': they face you, but you have a headache, a sore throat, and they say that you have a virus, you have a gastroenteritis. But everything is at a distance because, other people have already had it, or they read that these are the symptoms in a book, so it is already diagnosed without touching or looking at you, without doing an exam, with nothing, Mm mm. This is bad. 'You have a sore throat, take amoxilina' 'ah you have a pain, take amoxilina', you know? It's all like that, always.

Regina's description of patients as an 'undifferentiated' mass highlights the dehumanising effect of the distance that doctors assume, which also positions patients in a relatively powerless position, lacking control. Her perspective is similar to Freidson's (1970) argument about the inherent differences and aims that meet in the doctor-patient relationship. He explains that some conflict inevitably results, as the function of the doctor is to apply

general knowledge, while the patient aims to retain the particularity of their own case.

In this account, Regina is also critiquing biomedicine itself, as this distance is an effect of the way that doctors are trained and the way diagnoses are made. A dichotomy is set up between abstract books and the practical; the latter characterised as being physically present, conducting exams, and actively engaging or listening. She highlights this felt absence of HCPs by calling them 'spirit' or 'ghost' doctors, and links it to an over-emphasis on medication as a cure-all, instead of individualised care. Regina's account therefore points out that the systematic construction of biomedical knowledge can lead to a lack of attention to (certain types of) patients, and increase barriers to healthcare.

A second perspective on this distance is provided from an HCP perspective in the following extract. Anielle (27 *parda*), a nurse technician at the hospital, talks about the varying levels of attention that patients receive from the different types of HCPs. She describes her understanding of the differences between doctors and nurses, explaining it in terms of '*writing versus humans*:'

The doctors are just passing through and writing, writing, only writing. They don't stay here, they don't interact with, care for patients. Only [mimes looking at paper and writing]. It's just paper, it's not about humans... Nurses do a mix of both writing and actual care. But we, we technicians are the lowest. We are here, we do the practical, the human care, face-to-face. (fieldnotes, 12/5/13)

Anielle was both annoyed that doctors do not interact with patients and annoyed that she had to interact with them so much. She was planning to quit her job as she thought it was too physically demanding, involved too

much stressful interaction with patients, and was low paid. A lack of interaction between the three types of HCPs also appears to occur frequently, who can operate within the same space as though the other were hardly there (*observation notes, 12/5/13*).

Anielle's point adds to Regina's above, emphasising an opposition between humanised, face-to-face care and abstraction in the form of writing and paper. This account, however, also highlights how the systematic set-up and organisation of biomedical institutions functions in a manner that can reinforce potentially dehumanising dynamics or interactions, creating additional barriers to healthcare. It further demonstrates how this dynamic varies for different types of HCPs, and how this variation is clearly in the form of a traditionally gendered hierarchy. The higher social position is more traditionally masculine as it is more intellectual, valued and well-paid, while the lowest resembles traditionally female gendered care, involving practical, physical and emotional labour. This gendered hierarchy of care within the health system mirrors the wider gendered relationships of care that were discussed in Chapter 4.

Furthermore, Bruna's (57 *negra*) account links the structural issues outlined in the previous subsection with uncaring HCP attitudes. After describing the hassle of getting a place at a clinic or hospital for both her husband and herself (detailed above), Bruna relates how, once this is accomplished, they still had to face issues with both bureaucracy and HCPs:

*You arrive sometimes in certain places and the people don't give you attention. It's humiliating! [punches her knee]. It is humiliating to have to go through, *mhm*. You studied, you know well that this doesn't help [adianta], nobody respects you. It is lack of respect, lack of respect for a fellow human*

being, mm mm [...] They don't pay attention, they treat you as if you had AIDs. [...] Man, they made him go to take his details, and he filled out them out various times, mm. He cannot walk much because of the lack of air, as he has liquid in his lungs [...] And he arrives there and the people, even if they are sick, they don't have any education with you [behave politely], mhm. This is very humiliating, you have the desire to curse and send them all up the ass! Mm, yes I see. You go to that queue, walk, they don't give you the correct information, so much that he goes and goes and goes... He wakes early, 4am he goes there, he doesn't get the thing they say he needs, a signature that they give. So he arrives and doesn't have it, then they ask questions, so much that the result is that he has to go back again. That form that he filled out was not worth anything, they cancel it all! Oh! He has to go back and start from the beginning... [shakes head]. So, I mean to say, this is tiring, humiliating, this makes all your, well, hopes, all go to hell, mm mhm. It is so much sacrificing [involved] to finally arrive, mm and get something [treatment], but you have already died because it is so difficult.

Similar to the previous accounts, Bruna emphasises that this uncaring attitude leads to the dehumanisation of patients. The inattention, however, is portrayed in a more active manner, and is indicative of what she sees as a lack of a wider lack of respect for “people like” her. Just before talking about the health system, Bruna described the difficulties she and her husband faced as a result of racism. She was particularly frustrated about how much effort they put into their education, and the fact that they could never get a suitable job or equal pay compared to their white colleagues. Bruna spoke at length about racism, framing it as a lack of respect, and frequently linked her discussions about difficult life experiences back to racism through repetition of this phrase.

Rather than explaining HCP inattention as resulting from inherent, systemic issues with biomedicine and the health system, this narrative illustrates how the combination of a lack of attention or respect on the part of HCPs interacts with systemic issues around bureaucracy detailed in the previous section.

The extended description of the problems Bruna's husband faces with both disrespect and bureaucratic papers provides a concrete, detailed description of how the systemic issues alongside HCP inattention and racism can compound the barriers that (poor, black) people can face to access healthcare.

5.4.1 Summary

Accounts in this section detail how participants experience doctors as uncaring, disrespectful and even dehumanising. A dichotomy is set up between individualised, face-to-face attention, and distant doctors, embodied or enacted as 'writing on paper.' These accounts also link to experiences of lack of treatment, and thus form another, interactional level of barriers to healthcare. All participants who spoke of negative experiences with HCPs identified as black or brown. This links with the research on racism in healthcare in Brazil, particularly Leal et al.'s (2005) study on women's experiences of reproductive healthcare. All of the white participants (bar one) talked about positive experiences with HCPs, as will be discussed in the following section on good medical care.

These examples of uncaring HCP treatment constitute a further obstacle to accessing treatment, and often led to these patients giving up their 'fight' to access healthcare due to the disappointment and stress. The findings here contribute to the long history of sociological studies on doctor-patient relations (e.g. Bury 1997), particularly regarding relationship asymmetries (Have 1991, Maynard 1991) and how these can interact with wider structural dynamics (Frank, Corman et al. 2010). These dynamics are an important context to bear in mind when examining participants' accounts of sexual and reproductive healthcare experiences in the following chapters.

5.5 Good Medical Care

In contrast to the majority of participants, just 12 women said that they had experiences of good healthcare treatment. Over half of these were white participants (which includes all white participants except one). Most of these women talked positively about their own doctors or the two fieldsite clinics in particular; nevertheless, each of them also described the overall health system as lacking. This section examines how these women made sense of their experiences, and the gap between them and their general evaluation of the SUS. The analysis here focuses on two main points: expanding themes on social networks and adding a further theme on spiritual faith.

5.5.1. Religious Faith

Five of the 12 participants focused on their spiritual or religious faith when explaining their perspective on their positive personal experiences of the health system. Within these accounts, and similar to participants in the previous section, two participants focused on structural problems of the health system. Andrea (68 *branca*), who identifies as an evangelical, highlights the unevenly developed aspects of the SUS, as she describes how the healthcare she received when she lived in a different city was better:

But here, within their possibilities, I am very well attended. [...] Here the doctors are great, but they don't have much structure, because of a lack of investment.

Why? This is a mystery. Or it is [could be] an inquiry [interrogação]! [...] We know that there are the conditions for it to function better, but the human factor exists (raises eyebrows), that is there 'managing' it (rubs fingers together). I see, mm. And what were your experiences of the SUS like in general?

I think well, I consider myself that I have, I'm not going to say luck, I think God is there in all of the situations, because every time that I needed the public health system, I was attended, and attended well. Now I see that it is not like that in the majority of cases. I think I am an exception.

Andrea's account offers a similar perspective to the majority of participants in the previous section, as it focuses on structural issues of the health system, particularly the unevenly developed aspects. Similar to the majority of accounts above, she does not blame doctors, but does imply corruption of authorities. Her description of her personal experiences, however, contrast dramatically. Although she raises the possibility of conceptualising her positive experiences in terms of luck, she rejects this notion in favour of her spiritual faith. Andrea talked extensively about her belief in the importance of a spiritual life for one's health and for dealing with life in general.

Although she does not mention it, these positive experiences of the health system may have been influenced by Andrea's relatively privileged background, compared to the majority of participants. Andrea attended university and worked in H.R. for years. Her good education and network of contacts that she built up through her studies, employment and family, provided her with higher social capital (Duarte 2006), allowing her to potentially employ *jeitinho* strategies if necessary. These intersecting socio-economic and race categories are generally associated with increased healthy life expectancy, according with the literature on health inequality in general (Szwarcwald, Bastos et al. 2000).

Vasti (36 *branca*) also talks about her spiritual faith in relation to her experiences of the health system, but adds a further focus on luck and complaints. Vasti was different from most participants in this group, as she did not have such a privileged background. Still, she did have a close, supportive family, and a husband with a steady job and income. When discussing the health system, Vasti said:

Everyone complains about the health [system], we can really see it. But I, thanks be to God, where I went I always got what I wanted, I always had luck. I never arrived like, 'ah I went to that hospital to search this and I didn't get it.' I always had luck, even with my mother too [...] We were one year battling a lot, and that is how we went about it and we got attended. I don't have this grievance to be complaining 'Ah, it is like this.' It is precarious. We see the units [departments] falling, in a state of calamity, we see this with certainty. But I, in particular, I always had this luck to find marvellous doctors. So I say like this, at times when people complain, I think that the negativity also makes people not achieve the things, as you already start out complaining 'ah I won't get it, ah it won't go right.' I think like this [hands together in prayer, head down]: 'I don't know the doctor, but Lord I am in your hands. You will give me a good doctor that is going to take care of me.' By this way I always get the things.

Vasti had a difficult early childhood due to poverty, but much support from her parents and 11 siblings. Her husband is illiterate, but supportive and works in the same job in trade since she met him. She was employed as a domestic worker, and started school again from scratch in 2006. At the time of the interview she was both working and studying to be a nurse technician. She continually emphasised, throughout the interview, the need to persevere and fight through the difficulties of life.

Vasti's account is more ambiguous than the others in this group, as there are elements closer to the negative accounts of the health system above. It refers to the need to fight for treatment and acknowledges structural problems. However, her account shows that she makes sense of her positive experiences of healthcare by focusing on positivity. She explains the role of her faith when dealing with health system issues, and situates it within wider difficulties within her life. This narrative also appears to be in conversation with the wider socio-cultural discourses that critique the health system.

Comparing these positive accounts with the negative ones above, there is consistency across them as they still detail or imply critique of structural issues of the health system. These accounts are markedly different, however, in their position on personal experiences, as well as the structure and tone. They sometimes list positive experiences, providing evidence for their position, but they are mostly not detailed in any performative or narrative way.

These participants all refer to their spiritual faith when discussing their personal positive experiences, despite a general critical stance to healthcare provision. All participants are white and have generally relatively privileged backgrounds. Those participants who had fewer financial resources and education, still had stable and supportive consanguine family ties, as well as long-term, supportive conjugal partners with secure jobs. These less-privileged participants also lived near the hospital, and had many years of family ties with and personal experiences to it.

5.5.2 Social Networks

A further five participants talk about having positive experiences of the health system, but focus more on their social networks or successful *jeitinho* strategies in these accounts. Leni (68, *branca*) said that she “never had any bad experiences on the health system.” Leni had ‘marvellous’ parents and was very close to her ten siblings. Both her father and her husband worked in the national steel company, the second largest one in the country. Her husband was very supportive and “never allowed her to work outside of the home.” Her account demonstrates again the importance of social networks for accessing specialised care for her son’s brain tumour:

*In that time he was doing a small Catholic magazine in the Archduke's Diocese of Rio. And he had many friends of priests, nuns, you know? **Mm**. And there was a very Catholic lady there that helped the church, and her son was a doctor, and she really liked my son, and the rumour started to run where he worked, that he had a brain tumour, **mm** [...]. Then she said when she knew, she spoke like this: 'Fernando I'm going to take you to my son,' then she said, 'do you have the CT scans from the exams?' He said 'no it is with my mother,' and she said 'then I will send my driver to go to your house to collect them.' So he went and she took my son to her son, **mhm**. Do you know who her son was? **Who?** Doctor 'A' (famous surgeon) ! **No! Wow!** [...] So, Doctor 'A' examined him and said 'Fernando do you have a health plan?' He had a plan until 24 years, when he lost it due to the age he was doing his degree, so Doctor 'A' said, 'there's no problem I will admit you to 'X' [high quality, private hospital],' **wow**. He did! In 'X' he had a nurse that came from his father and stayed with him. So my son was admitted and stayed there for a month.*

The role of Leni's religious community as a support network and how it facilitates access to healthcare is clear in this account. Leni later attributes this 'luck' to her faith in God.

All of the participants so far in this section identified as white. Five other women of colour also talked about having good personal experiences of the health system. They each had the contacts or the "luck" to be attended at this hospital for most of their lives. Monica (34 *parda*) describes how difficult it is for others to access healthcare, and says:

I in particular don't have much to complain about no. [...] I think it is because my family we always lived nearby, and I had my youngest daughter here [...] and since then I always only come here, [...], so there is not much to say because I don't know much about other hospitals, but here yes it is very good, I like it. I like the service, I like the doctors. I already know various [doctors] and all of them are all very good.

This is a different perspective compared to the majority of participants. Monica always attended this good hospital, as she grew up nearby in a middle class neighbourhood. This account highlights the unusually positive qualities of the fieldsite hospital. Two further participants talked about having positive personal experiences of the health system: Marcela (66 *morena*) and Beatriz (54 *parda*). Both described how they were never very sick, used the health system for general care, but also could go to private clinics when they wanted to, as they had a paid health plan because of their husbands' jobs.

5.5.3 Summary

Positive accounts of personal experiences of the health system are generally contextualised within a wider critique of the SUS. Most of the participants who fall into this group were from relatively privileged backgrounds or had stable and supportive family networks and lived nearby the hospital. While this is not intended to be a representative sample, there appears to be a clear link between class, race and participants' experiences of the health system in these accounts. All of the white participants, except Regiane, describe positive personal experiences of the SUS. Furthermore, each of these women refer to their spiritual faith when explaining the gap between their general critique of the failures of the system, and their own experiences. Other participants talk about their close ties to the hospital in question, at times referring to its reputation of higher quality.

5.6 Conclusion

This chapter examined participants' understandings of health and their experiences of accessing healthcare on the public health system. The analysis illustrated how emotional aspects of health and wellbeing are considered

significant. These findings build upon those from the previous chapter, where participants described the difficulty and stress involved in assuming the responsibility of motherhood; particularly under precarious living conditions. In this chapter, participants' accounts on wellbeing generally incorporate health practices around reducing stress.

I also illustrate how wellbeing is conceptualised as both expansive and socially situated, going beyond notions of individual physical and emotional health. I argue that women's accounts of wellbeing are 'emplaced;' they are shaped by and understood in relation to various places such as the street, neighbourhood or beach. These accounts generally incorporate a critique of social inequalities and make the point that this extends to health. In Chapter 4, good mothers were described using emotional (such as worry and jealous), as well as spatial (home as opposed to street) terms. Conceptualising wellbeing as emplaced, women appear to be negotiating boundaries between family/home and their own wellbeing.

This chapter also explored women's understandings and experiences of the health system. The majority of accounts were critical of the health system. Healthcare is largely understood as a right for all, and most women were critical of the mismanagement of the system or an associated wider political corruption. These accounts illustrate how participants face barriers to healthcare at multiple levels of the system. The analysis shows how, in this context, women are generally positioned as actively pursuing healthcare. I draw on the concept of the *jeitinho* to illustrate the various ways that women negotiate these barriers, particularly focusing on practices that involve the

role of social networks, financial resources and social savviness. In addition, accounts critical of doctor-patient encounters focus on asymmetrical power relations. These are generally conceptualised as a lack of care and experienced as disregard or dehumanising. The analysis points out how these relationship dynamics interact with wider systemic barriers to accessing healthcare, thus reinforcing inequalities along race and socio-economic divides. These findings around health inequalities, systemic barriers to accessing healthcare, and the need to draw upon *jeitinho* practices to actively pursue one's own interests, provide the context for understanding participants' accounts in the following chapters. These themes are raised again in relation to participants' accounts of accessing contraception and sterilisation, as well as the right to sterilisation.

CHAPTER 6. SOCIAL AND PHYSICAL DIMENSIONS OF REVERSIBLE CONTRACEPTION

6.1 Introduction

Chapter 6 focuses on how the wider social and health contexts described in the previous two chapters can be seen to influence participants' perceptions of contraception. Although most participants talked about how their experiences of reversible contraception influenced their decision to sterilise, their accounts also reveal a wide variety of understandings and experiences of contraception. How participants learn about and access contraception is examined first. Various dimensions of their contraceptive use are then examined in detail, including the influence of intimate relationships, daily obligations and the physical effects of hormonal contraception. The analysis demonstrates how contraception is relational, social, and embedded within class, gender and race dynamics. In addition, the physical 'otherness' of both barrier and hormonal contraception is also emphasised.

6.2 Accessing Contraception

6.2.1 Learning from Life

Very few women said that they learned about contraception from their families. Indeed around half of participants said that they received no information on contraception from their families or schools, and instead learned from "life" and "on their own" initiative. Although it is not set within a bureaucratic context, working around the social norms to learn by yourself is similar to certain aspects of the '*jeitinho*' concept. In the previous chapter, these problem solving strategies involved the use of social networks and resources to by-pass institutional inefficiency in order to access the type

of care that women needed. In this case, however, participants were able to employ these practices to circumvent a wider social silence and lack of information on contraception. This section therefore extends the analysis of this concept, examining how it is portrayed in relation to accessing a specific health technology. Participants' accounts of learning about contraception highlight various characteristics of *jeitinho* practices, as will be outlined in the following paragraphs.

The first way that participants described learning about contraception 'from life' is through their wider social networks. Most of these participants laughed at the idea of learning about it in school or from family, even if they were close to their family. Marcela (66, *morena*) learned about contraception from friends and the street because her family were "close but closed," (*fechada*) as "that period was very reserved (*requintada*)." Renata's (40, *negra*) family were "united and all together," but she still describes the family silence regarding sexual relationships or contraception:

I learned from life! (laughs) Mhm (laughs). From life... I heard something here, another thing there... it was taboo, not easy... I don't remember now! And from friends also [...]

So you didn't use contraception at the beginning?

No, no at the beginning I didn't. I started to have lovers [namorar] at 13 or 14. And after I went along learning. Ah really? No I didn't use it. Like I said, nowadays people have more information, mm. 10 years ago there were many things that weren't taught at school. In the old days we didn't have this, (wags admonishing finger), 20 or 30 years ago, there wasn't a word about this in school. Mm. Not even the mother or father would talk about it: "silence!" (points finger threateningly)

Renata's account shows how difficult it can be to talk about the process of acquiring information on a taboo topic, as she describes it laughingly, but

quite vaguely and with lots of hesitations. She characterises this process as tricky and contrasts her family silence with the general change in social attitudes to sex and contraception nowadays. Marcela's phrase "close but closed" regarding her family seems to describe many of these participants' accounts where they generally had a supportive family, which was also characterised by silence regarding taboo topics such as contraception.

Contraception is actively sought out by these participants despite the keenly policed silence. The importance of wider social networks in accessing a taboo technology is clear. In these accounts the sources of the desired information are uncertain, and women must go through an extended process of searching out their goal, compiling information from various arenas. While these practices are reminiscent of *jeitinhos*, the process of accessing information and health technologies 'off-label' is a widespread practice that has been examined within the fields of sociology of knowledge and sociology of science and technology (Coveney, Gabe et al. 2011, Steward and Pickersgill 2019).

A second aspect of participants' accounts of accessing contraception in this manner highlights the importance of their own initiative. Andrea (68, *branca*) emphasises how she learned about contraception on her own initiative, having to actively search for the information via her own careful studies. She describes how she had a good, "united" family, but as the "60s were years of rebellion, I moved out even though I was unmarried, because I wanted to study and work (laughs)." Andrea then continues on to provide more detail:

I learned on my own, reading, listening, researching and searching, even banned books! [...] I didn't learn at home or school, but really just by myself

[...] Contraception I remember, talking and exchanging information, because as I said, in that era of my youth, during the dictatorship everything was starting... the sexual liberation, it was the era that invented contraception! I loved taking the pill, I felt free.

Sara (47, *parda*), describes a different kind of research about and access to contraceptive technologies. She explains how she learned “on her own” via a *jeitinho* or “little way” about contraception when she was 17 years old:

*Look, when I started [sex], I didn't use it, nothing. **Why?** Because I didn't have any guidance at all. **Mhm**. So because I worked in the home of a family, I was very curious about things, I saw the box/packet (cartela) of tablets there... **Mhm?** And I had heard in some place that they were contraceptives, and that's what they were. So I copied the name. And what did I do? When I started to go out with my boyfriend, I would take it two days before and after. **Ah, yes?** I hid it, so nobody would discover me. I would take it during the four days, then stop, **mm**. I stayed like that, taking it alternatively. I think that's the reason I did not get pregnant!*

Sara's account, while still vague at times (e.g. she does not mention sex directly, or where she got the pill exactly), does give us concrete details of how she went about bending the social norms and rules in order to acquire the pill and to avoid social censure. She highlights the creativity and ingenuity required to find a *jeitinho* or ‘little way’ in such “strict” circumstances.

Andrea and Sara both faced gendered inequality, with restriction on the activities of young, unmarried women within a conservative and patriarchal society. Their narratives, however, provide a stark example of how class and race can influence participants' access to contraception. Both participants, nevertheless, highlight their determination to access contraception and their

rejection of restrictive patriarchal norms. On the one hand, Andrea does so by emphasising her excitement during the era of “sexual revolution” and her reading of banned books. On the other hand, Sara does so by stressing her resourcefulness in accessing the pill, and cleverness in using it to have an illicit sexual relationship with the son of her wealthy employers.

Instead of focusing on social networks, these narratives emphasise the importance of the individual’s own initiative. The framing of the narratives are more active and individualistic than the previous accounts. Participants’ motivation, ingenuity and skills are highlighted in their individual quest to achieve their goal. Their own active agency is thus celebrated as overcoming unfair or unequal structural constraints.

The majority of participants in this section are poor and identify as black or brown, with low education levels and limited access to information and resources. The multiple forms of oppression seen in these accounts restrict these women’s access to contraception, leading them to draw upon strategies such as *jeitinho* practices to overcome these barriers. The differing ease of access to medical technology and knowledge according to class and race, links to participants’ experiences of the health system in general (Chapter 5), and the wider literature on health in Brazil (Sanabria 2010).

Finally, the third characteristic of participants’ accounts of learning about contraception “from life” emphasises the solitary aspect of these experiences. These accounts include health clinics within this framing as one resource that they used among others, although not the primary one. Laura (48, *preta*) says:

*I learned absolutely nothing. What I learned I learned on my own. School didn't not teach me at all. Not even my father or mother, no? **Hm.** No, in the past now. Nowadays they learn much more, even I learn now. Ah, back then I learned from friends (female), from life. I learned by myself. After I got married. **Mhm?** When I was married I had to go to the doctor so that he could give me contraception to use while married.*

Although Laura emphasises the solitary aspect of her search for contraception, the importance of marriage is emphasised in her narrative. Furthermore, the inclusion of the doctor in this section as part of participants' learning 'by themselves and from life,' demonstrates that the division between these two categories is quite artificial on one level. The focus of this research, however, is on the participants' understandings of contraception, emphasising how they position themselves in relation to contraceptive technology. Separating these sections therefore is rooted in how participants describe their access strategies, and is useful for analysis as it highlights what the women choose to emphasise when relating their experiences. The broad divisions between *jeitinho*, clinic and family show the kind of significance some participants give to the medical establishment (as in the next section), or not, as in these examples above.

6.2.2. Learning from the Clinic: Reproductive Trajectories

The accounts in this subsection blur with the 'learning from life' narratives as the overlap above shows, but here the women focused on the clinic as their primary source of information, rather than their own social networks or research. Although the clinic is described as the source of information, it is framed by all participants, except one, as being within the context of their married lives. The participants in this section can be divided evenly into two groups: those who learned about contraception at the clinic after their first

pregnancies (planned or unplanned); and, those who learned about contraception at the clinic before their first pregnancies.

6.2.2.1 After First Pregnancy

Participants here mentioned the silence related to sex and contraception, but this is not highlighted to the same degree compared to the participants in the previous subsection. Most of these participants described their pregnancies as wanted or planned, with only two women displaying regret. For the majority of these women therefore, both accessing contraception and the role of the clinic take a secondary place in these narratives compared to their experiences of pregnancy and birth. Their accounts of learning about contraception are therefore more passive, and described as less of a struggle, compared to the *jeitinho* accounts above.

Vasti (36, *branca*) described how her parents were supportive but “didn’t talk much,” so when she became pregnant at 16 with her first child, she did not understand how it had happened, nor how the baby would be born: “the parents were very closed people, so they never spoke on the topic, never spoke about it. How would I learn? With whom?” She learned about pregnancy, birth and contraception from the clinic when she was pregnant, and started the pill after the birth when she was 17. Vasti here mentions the role that the family silence played in her ignorance, but as she was delighted about the birth of her child, it is not portrayed as a significant aspect of her perception or experience of contraception. The role of the clinic remains in the background but is positive by implication in comparison to the general social silence on the topic.

Two other participants also learned about contraception after becoming pregnant for the first time, but in contrast, they portrayed two different types of regret about their lack of knowledge. Camilla (23, *morena*), explains that her difficult childhood with an abusive step-father led to her lack of information about pregnancy and contraception. She had an unwanted pregnancy at 13 years old, and learned about the pill after she aborted it. She describes how contraception was still not of much concern to her then, as she still did not understand fully or care how it worked until she was older. Camilla's account goes against the broader trends of increasing information and access to contraception at a younger age in contemporary Brazil.

Mônica (34, *morena*) relates how she did not know anything about periods or sex when she was younger as her mother "didn't talk much about such things." She describes with a mild sense of regret how she became pregnant at 18 because she "didn't know about the pill, but would have delayed pregnancy until older if I had known." She started the pill after her first child and learned about contraception at the clinic lectures:

There it was that I started to know about illnesses, pregnancy, to prevent one thing and other... and I try until today to know more and more so that I can pass it to my daughters.

In contrast to the narratives addressed so far in this subsection, with Monica we see the clinic taking a more significant role, and the important part it played in educating participants about sex, reproduction and contraception when they are an 'unspeakable' topic in the family. This characterisation of the clinic is closer to that portrayed by participants in the following, second half of this section. In contrast to the other participants in this group, Mônica is actively searching and trying to learn more so that she can educate her

daughters on the topic herself. This portrayal of active searching and research is reminiscent of participants who used the *jeitinho* way to learn about contraception. Here it is contrasted by Mônica with her early experience of her 'reserved mother,' and presented as positive and empowering.

6.2.2.2 *Before First Pregnancy*

The other half of participants who described learning about contraception in a clinic, talked about how it happened before their first pregnancies. These accounts of contraception access are more active, with the clinic often portrayed positively, and as a means to autonomy and control over their reproductive and sexual lives. These women learned about contraception from the clinic when they got married, and so marriage is again raised as a 'legitimate' beginning of a woman's sex and reproductive life in these narratives. Participants described the clinic in some detail and enthusiastically, at times contrasting the knowledge provided there with the silence they experienced within the family.

Luana (31, *parda*) describes starting her sex life with her husband at 15 years old, and how she "learned everything about contraception from the clinic. It was great!" Regiane (44, *branca*) also describes how she did not learn about it from family or school "in those days." She started on the pill when she got married at 18, became pregnant while on the pill at 20, and started attending talks at the clinic when pregnant: "Our lectures taught everything, about contraception, the pill, the IUD, about the condom, everything! Yes, all of that is here. It is very good."

Ana Rita (57 *branca*), also contrasts the silence on the topic of sex and reproduction within her family, with the positive role that the clinic played in providing information when she was married, as “there I started to hear and read about it, and I loved it:”

*So I learned when I got married and I went to do... first I got pregnant and I took part in the family planning [... hesitation over term]. I did that during that whole period: I got married, passed some time having children and I learned many things, lectures, talks, reading, those things. **When was that?** I got married... my first daughter was at 28 years.*

And how old were you when you got married?

*I took the pill from, say, well, the early 20s... 22 to 28, then during this period I became pregnant with my daughter... but with the pills I learned many, many things, it was very good, and did a lot of good! **Oh yes?** Family planning?! It allows the person to learn a lot, it was good. For me it was great! I think it is a great thing for everyone.*

In contrast to participants who describe learning about contraception from ‘life’ and social networks, these accounts reveal how acquiring knowledge about ‘family planning’, reproductive and sexual health through the clinic is relatively straightforward, and portrayed as something very positive (Heilborn, Portella et al. 2009). The experience of the lectures, talks and reading materials provided by the clinic is in sharp contrast to the ‘here and there’ of the *jeitinho* practices, and is described as empowering and of benefit to all. Furthermore, these depictions of the medical establishment contrast greatly with the majority of those discussed in the previous chapter on the health system. In addition, this account provides an example of the evasive and vague language that participants sometimes used when talking about potentially taboo topics. Ana Rita avoids answering about the timing of her marriage, but later reveals that she was with her partner for a short while before she was married.

Finally, two participants described an overlap with the family and the clinic as their means of learning about contraception, although the clinic is still clearly the main source of information. Amanda (47, *branca*) describes the presence of both silence and talk about these taboo topics within her family, along with the clinic as a means of accessing contraception. When asked if she learned about the body from school or her family, she replies:

No not my mother... Also no, it was difficult for you to talk about anything related to the body in my era... it still is.

And about things such as sex life, contraception?

*Not even to think about it! When I was young, you say? Then ... "nothing of this! Prohibited topic!" (laughs) (**Laugh**) For my mother it was more difficult, for her **Mhm**. Even today she has more difficulty to talk about sex, all these things. In my childhood era who spoke to me was really my aunt. She explained to me about menstruation and sex **Mhm** [...] So you know, but my sex life only began after marriage really. I was married a virgin, but I started to use contraception 6 months before. **Really?** I went to the doctor, he passed me a pill 6 months before, because I didn't want to get pregnant soon after marriage. So I took the pill (anticoncepcional). And really my actual life only started when I got married, at 21 years, that I started my sex life. **Ah!** Nowadays it comes first! (laughs)*

Similarly, Sofia (22, *negra*) describes how the overlap that both her family and the clinic played in providing information about reproduction and contraception, despite the silence on the topics.

In contrast to the previous section, where participants described learning about and accessing contraception through informal networks and their own research, two different attitudes to contraception can be seen in this subsection on the clinic. In the first group, contraception and the role of the clinic form the backdrop to participants' focus on their desired pregnancies.

The clinic is the main source of information, but it is not described in detail by these participants. The other half of the participants, who started taking the pill before their first pregnancies, describe the clinic in positive terms as providing helpful and empowering information, and contrast it with the general silence on the topics within their families and school.

All but one (youngest, Sofia) of the participants framed these experiences as occurring within marriage or committed relationships. The second group in particular, who used the pill to delay pregnancy clearly emphasised the importance of marriage far more. This may relate to cultural primacy of maternity for respectable adult identity, as described in Chapter 4 on the importance of 'the mother.' Marriage is seen here as a respectable or legitimate way to have a sexual relationship that is not reproductive.

The influence of class and race can also be noted here as, with the exception of Andrea (68 *branca*), the remaining white participants who used contraception gained advice and access from the clinic. Each white participant talked about the silence around contraception and sex within their families and schools. However, their search for information about contraception was far easier than most participants, and their experience of learning about it through the clinic was positive and generally portrayed as empowering.

6.2.3 Learning from Family

In contrast to the silence around the topics of sex and contraception evident in the previous two sections, a small minority of participants did learn about such subjects from their families. Four women described how they learned about sex and contraception from their families. Julia (23, *negra*) is the only

participant that clearly said both her mother and her father talked to her about these issues. Rosa (28, *morena*), mentioned taking the pill and having her three children when discussing her mother's reproductive experiences:

My mother, my mother also had the same thing... the same rhythm.

She used the pill and had three caesareans?

*She did yes, the pill, three caesareans and during the third one she did the sterilisation... I did the same thing. And my aunt too. **Yes?** The same thing (laughs) (laughs) **Wow..** It's a family thing (laughs). I already knew about contraception, sterilisation when I was younger... I already knew, I had already had the conversations from my mother... and my aunt. **Really?** Mhm, she said to me, 'it's a good thing, be careful!'*

In this account Rosa describes how her mother and aunt passed on the knowledge about contraception and sterilisation, sharing their experiences and advising her on how to manage her sexual and reproductive health. Both contraception and sterilisation are portrayed as something normal, a part of (female) family life and knowledge. This lack of silence and the confidence about her knowledge may partially account for the fact that Rosa was the only participant who had no problem at all with contraception, unplanned births or accessing sterilisation.

In contrast to the previous sections on learning from life and from the clinic, these participants portrayed contraception as something normal and not a taboo. All four women had no difficulty understanding contraception, and accessing or using it if they wanted to. Rosa clearly describes the passing of knowledge between the female members of the family, from her mother and aunt to her children in the future. Learning about and accessing contraception is clearly variably experienced across the participants; for a

few this was an unproblematic process either at the clinic or in the family, while for others more difficult, requiring personal initiative.

6.2.4 Summary

Family silence around sex and contraception is emphasised by the majority of participants in this research. *Jeitinho* practices are the main way that these participants can access contraceptive knowledge and technologies. These accounts emphasise the importance of social networks as well as elements of shrewdness, opportunism and active individual initiative. Despite the lack of a specific bureaucratic context, these aspects of participants' accounts are similar to *jeitinho* strategies discussed in Chapter 5, as they are portrayed as a clever or pragmatic means to get what is needed despite lack of resources, or wider, difficult social norms (Barbosa 1992, Hess and DaMatta 1995). A clinic or pharmacy would likely be involved in actually obtaining contraception at some point in this way, but this was not emphasised by the majority of participants who talked about using these strategies.

The reproductive health clinic is the main source of information for the remaining participants. Participants' accounts of the role of the clinic in providing access to contraception falls into two groups, either as matter-of-fact and unremarkable, or portrayed as empowering and positive. The increasingly central role of the clinic as a source of information on sex and contraception seems to be similar to the process of medicalisation of reproduction in other countries, such as the U.S. and the U.K., where reproductive and sexual health moves from the domain of religion to that of the medical establishment (Graham 2003). Yet this move is not so straightforward, as the context of marriage still appears to be important, especially for those women taking the pill before they have had a child.

Participants of each race (and class) talked about encountering and overcoming gender and sexual inequalities in their search for access to contraception. However, of the white participants who used contraception, most had easier access to these technologies than those women who identified as black or brown.

6.3 Intimate Relationships: Trust and Pleasure

This section examines women's accounts of how their intimate relationships influenced their use of contraception. It therefore draws on the social context outlined in Chapter 4 to highlight the situational and relational nature of contraceptive use. Most participants talked about using contraception irregularly, at least at one point or period in their lives, and for various reasons. This section examines gender power dynamics and priorities within sexual relationships, and how this leads to either regular or irregular use of contraception. The section is divided into two: the first part introduces issues of trust around the condom, the second outlines gendered negotiation of contraceptive use and focuses on participants' sexual priorities. Participants' accounts highlight various strategies and priorities regarding the role of contraceptive technologies in their sexual relationships.

6.3.1 Partner Dis/Trust and the Condom

Much of the literature on contraception emphasises how avoiding use of the condom is often a sign of trust in a relationship, particularly women's trust in their male partner (Cabral 2011). For example, the condom is reportedly used less frequently later on in relationships (*ibid.*). As outlined in the Introduction, barrier methods of contraception became more widely used

and discussed in Brazil after the very successful HIV/AIDS programme in the late 1990s and early 2000s (Oliveira-Cruz, Kowalski et al. 2004). Recent research on sexual practices in Brazil has shown how men are now more concerned with the use of condoms than women, particularly with casual sexual partners (Brandão, Cabral et al. 2017). However, men who had sex with primary partners, or those who also had parallel relationships with someone trusted, were also less likely to use condoms. These findings are in accord with the general qualitative literature on contraception, where the idea of trust or confidence in a partner is equated with lack of protection in the sexual encounter (Cabral 2003).

As stated above, most participants in this research did not fully rely on the condom as a method of contraception. Contrasting with the general literature on barrier contraceptives, however, this lack of condom-use does not necessarily mean that these women fully trusted their sexual partners. This short subsection will provide a brief overview of the various approaches that participants took to the issue of trust and barrier contraceptives. A number of unusual perspectives on condom-use are outlined here, in order to highlight the contrast with the majority of accounts on the condom that are then examined in more detail.

Just three participants in this research talk about still using a condom despite parallel use of the pill or being sterilised, in order to protect themselves from sexually transmitted infections (STIs). These women all spoke about issues of trust and either said or implied that this trust was not continuous. Four participants emphasised how using the pill or even being sterilised is “not enough,” as the condom is needed for STIs. Rosa (28 *morena*, who was sterilised six months before) and Paula (52 *morena*, who was sterilised two

decades before) both had supportive partners (see Chapter 4) yet continued to use the condom “to protect” themselves. Rosa describes how:

*The boyfriends that I had always supported me in everything, sex life and contraception, everything, it was good **Mhm** [...] The pill is important, but also it is not sufficient you know? **Mm?** No, there are people that take the pill and ‘ah I’m taking the pill, I’m not going to use condom’.. it’s not enough. The pill, it ... how do you say... it secures you for some things, but not all, there are sexually transmitted diseases. You need to protect and prevent.*

Rosa’s account shows some of the language that is used around contraception. Phrases such as ‘secure’ and ‘protect’ yourself, to ‘take care of yourself’ and to ‘prevent,’ all focus on individual health and wellbeing, particularly the woman’s health in this case. Such accounts highlight the inherently risky nature of sex with a man, which seems to be particularly linked to the relationship context described in Chapter 4 where husband infidelity was frequently described as “common.”

In addition, Paula, despite the “extremely caring and romantic” relationship that she described above (Chapter 4), talks about how one still cannot generally trust men regarding sex. She implies this when discussing the purpose of the condom:

*It is not only so that you don’t become pregnant, the use of the condom is really for the woman’s own health, **mm**. Because the woman, she knows what she is doing and with whom she is going (andando)... and her partner? (Raises eyebrows questioningly) Her companion? (shakes head and finger warningly), **Ah**. Right? Isn’t it? **Mhm (nodding)**. We know about ourselves, now about them we don’t know! I am with my companion for 21 years, and I am always on alert, I never get careless (descuidada). Not because I don’t trust him, you see? But to protect myself. **Mhm, I see.**
You use the condom all the time?*

Yes, when this year, it happened that I had sex without condom, I came here to do the exam straight away, and I have the result here. It was fine in the end. It's not that I don't trust him, but I need to take care of myself, my own body.

In these accounts of condom use, Rosa and Paula give examples of what they see as responsible and irresponsible contraceptive practices. They highlight the risks involved and prioritise the protection of their own health and body. They imply a distrust of men regarding sexual practices, while also mentioning the “support” and “trust” that they do have in their partners. Trust is therefore a complex matter in these accounts. Paula, for example, appears to separate trust from taking care of the self, focusing instead on her own body, over which she has a measure of control and knowledge.

Unlike Rosa and Paula, most participants did not use the condom regularly, despite the general suspicion of the infidelity of men and the risk of STIs. Out of the 35 participants, Mônica (34 *parda*) was the only one who stated explicitly that she did not use the condom because she trusted her partner:

*We got married young and trust each other, so when we used it, it was more like a... an experiment. We didn't even comment on this... if I liked it or didn't, or him too, **mm**. It was like this, we managed to use it around five times.*

In contrast to these unusual accounts, the following and final narrative in this subsection conveys the majority of participants' perspectives on trust and condom-use. Edila (27 *negra*) previously talked about how she has a supportive relationship with her husband but still jokes with him about separating (Chapter 4). She describes a general distrust of men more explicitly than Rosa and Paula, although she still does not use the condom:

*I already used the condom with my husband, I already used it, already. But you know, I and he don't really like it. **No?** No. **Why?** I think it doesn't have grace. **No?** No, I don't like it. With my husband...No, it's not to say that with him too, he is free from disease, and also not because he doesn't have... we don't know what they do in the street; when they are working or when they go out. But even so, no I don't like it, but thanks be to God I have never had anything at all, thanks be to God.*

Even with the clearly stated suspicion of infidelity, Edila still prefers to risk STIs than use the condom as she prioritises sexual pleasure for both herself and her partner. Edila's description of the condom implies a particular understanding or aesthetic regarding the desired sexual encounter, where the contraceptive technology perhaps does not fit in, interrupting a graceful pleasurable practice.

6.3.2 Gendered Contraception and Sexual Satisfaction

As most of the women spoke about not using the condom, this subsection examines the reasons participants gave for this decision. These accounts are divided into two groups. The first, smaller group examines narratives focusing on the gendered nature of contraception responsibility. The second part details the perspective of the majority of women, who prioritised their own sexual pleasure over the risk of sexually transmitted infections.

The highly gendered nature of responsibility for contraception is frequently mentioned by participants. Men are described as not having to worry about the consequences of unprotected sex. Amanda (47, *branca*) laughingly makes the point that men: "don't think of the consequences... afterwards," while Vera (64, *branca*) adds that: "You know how men don't take care (*se segura* – secure oneself) about these things, they don't worry." Juliana (40 *parda*) also

thinks that men should get a vasectomy due to their irresponsible approach to sex:

*I know a guy that has 20 children, each one with a different woman, so if he had done this business [sterilisation] then he wouldn't have had them. Because the man in general doesn't worry much about that whole story: "Did you take the medicine [pill]? Let's use the condom? Have you been treated/checked (se trata)?" They don't worry themselves about this. **Why?** I don't know, I think that they are half animal, half dog. We already have to do the worrying... But we arrive in the moment and don't ask. And there are many women also that don't worry about this.*

In these accounts, Amanda, Vera and Juliana describe how men do not "think" or "worry" about contraception or the consequences of unprotected sex, with Juliana giving an example of one of the consequences. The general dynamic described by participants in Chapter 4 regarding gendered approaches to relationships and childcare - where women care and worry, while men are free not to – can also be seen to apply in this specific domain of contraceptive practice. 'Worry' is a burden, but also a morally responsible position that demonstrates care for one's children and family (in Chapter 4) and for one's own health and body (regarding contraception). However, despite this general cultural acceptance of the gendered dynamics of care, participants also describe knowing good fathers (Chapter 4). In addition, as Juliana mentions women's lack of care about contraception above, most participants also talk about women's "irresponsible reproduction" when discussing the right to sterilise (Chapter 8).

Juliana's account also introduces an example of responsible contraceptive practices, in the form of a hypothetical partner negotiation of contraception and sexual health. This is an illustration of the "worrying" that women have

to do, which she contrasts (again in her own colourful way) with the more irrational or uncivilised depiction of the man as a “dog.” She also mentions how women that do worry “don’t ask in the moment,” perhaps referring to gendered inequality in sexual relationships or their own dislike of the perceived “lack of grace” of contraceptive technologies or the topic of STIs (discussed below).

6.3.2.1 Gendered Negotiation of Barrier Contraceptive Technologies

The following examples continue to examine gendered accounts of contraception negotiation. The focus of these accounts, however, will be on how men are described as persuading women not to use the condom. Seven participants mentioned issues of negotiating contraception use. Maria (30 *parda*) did not like any type of contraception, particularly the condom, “[it] is horrible, painful. They [men] just say, ‘leave it to the side, love,’ ha!” Regina on the other hand, did not really mind the condom, but says that her husband refuses to use it: “then later (exaggerated gentle and persuasive voice) in the moment they say: ‘no, let it happen, love’ (laughs).” Regiane (44 *branca*) also described how the condom made no difference to her own pleasure. It was an issue however, because her partner did not like it and it was ineffective:

*Yes, I used the condom before. And I also became pregnant during that period. **And how was it?** It works and it doesn’t... **Mhm?** For me it makes no difference for sex. Those who don’t like it, generally, those who don’t like it are the partner, right... they say ‘ah love, just for today..’ (small laugh). So it was normal.*

Regiane's account highlights the ambiguous or conflicting nature of definitions of contraceptive use in saying that "it works, and it doesn't." This phrase emphasises a point made in previous research on contraception on the gap between scientific or clinician evaluations of a contraceptive technology and lay users' experiences (Luker 1975). Clinical definitions of a contraception, as technically preventing pregnancy or STIs, assume that the technology is successful if used in a particular way, and if it is unsuccessful it is due to the failure of the user. However, when the technology is viewed as forming part of a relational practice and embedded within social processes that produce meaning and enact identity, then the condom "doesn't work" (Brandão, Cabral et al. 2017, Marston, Renedo et al. 2018, Schwarz, Dumbaugh et al. 2019).

Moreover, it is noteworthy that Regiane evaluates this experience of the failure of the condom and the influence of her partner as "normal." This indicates a wider acceptance of a man's unenthusiastic perspective on this contraceptive technology. The above accounts show how important it is to participants to prioritise their partner's sexual pleasure over their concern about using contraception for the purposes of avoiding STIs or pregnancy. Furthermore, participants are also clearly amused by the interactions, particularly exaggerating their depiction of the men's requests. Amanda, Vera and Juliana's accounts of men's irresponsible approach to contraception and sex were also often amusing. This use of humour to talk about potentially difficult or ambiguous topics such as managing gendered expectations and responsibility for contraception, contrasts with that of Rosa, Paula and Edila in the section above, who express varying levels of distrust and prioritise their own sexual health.

In contrast, Marcela (66 *morena*) was the only participant who talked about this issue in a serious manner, highlighting how stressful it is to try to always use the condom when your partner does not like it:

He didn't like the condom, no, it didn't feel good [...] it's horrible. If you have your partner, only your partner, you're not going to use the condom, so it's terrible to have to worry. Terrible? It is, terrible the worries that you have to use the condom all the time. It doesn't feel good. So it's complicated.

This account highlights the participant's dissatisfaction with this particular contraceptive technology and the burden of this as a constant worry. While some participants' express annoyance at the gendered nature of contraceptive responsibility, most of those who talked about their partner's preference to avoid the condom did not express any irritation. This is highlighted by the contrast with Marcela's account, where she describes it as very stressful. However, even Marcela's narrative does not put blame on the partner, but rather the inconvenient nature of the design of this contraceptive technology.

Although the partner's preference is prioritised, it is accepted with a laugh for most. While the opinion of the partner is given as the reason for not using the condom, there are no retrospective complaints or accusations. There are also no attempts to assert a recuperative type of agency within the narrative (O'Dougherty 2008). This contrasts clearly with critical accounts of attempts to access healthcare in the previous chapter, where participants' wishes and needs were either actively denied or passively dismissed or ignored. This acceptance of a partners' preference regarding condom use appears to be more of a considered decision on behalf of the women to prioritise sexual pleasure and their intimate relationship.

There is no indication of ambiguous feelings over trust of their partner, as expressed by Paula above, for example. Yet most participants still viewed the gendered inequality and responsibility regarding contraception as a burden. Gender inequality is possibly at play in these situations, where women “don’t ask in the moment” despite having the “worry” and responsibility. Or perhaps these accounts simply reflect women’s rejection of the burden of the gendered responsibility for contraceptive use.

6.3.2.2 Women’s Sexual Pleasure

In contrast with the accounts so far that describe how men persuade women not to use the condom, the majority of participants instead emphasised that they did not use this method as they prioritised their own sexual pleasure and satisfaction. Negotiating or enacting trust may have been at play for some of these participants. However, unlike the accounts on trust above, when asked about condom use, they specifically chose to highlight this aspect of their experience as significant. The significance of sexual pleasure is also discussed later regarding participants’ assessments of their sterilisation. Of the women who talked about sexual satisfaction regarding the condom, Luana (31 *parda*) is the only participant who includes her partner in her account:

The doctor wanted me to use the diaphragm, but I didn't get used to it (disgusted face) and my husband didn't like it. Mhm. So we used the condom again, it was horrible. I got an allergy, burning, so we stopped.

This account highlights the social and relational aspect of both the diaphragm and the condom, by mentioning the doctor and husband’s opinion and use of the plural ‘we.’ Nevertheless, the participant’s own

negative reaction to the contraception is prioritised. In contrast to Luana's example, the remaining accounts in this section focused only on the participant's evaluation of the (male) condom. In these accounts, participants do not mention partners, and only talk about their own sexual satisfaction.

Participants' accounts that focused on sexual pleasure conceptualised the materiality of barrier methods of contraception, especially the male condom, and the corporeal body in particular ways. These accounts highlighted how unprotected sex was considered more 'natural' and condoms as 'unnatural'. For example, Lara (27, *indígena*) states that unprotected sex is: "more natural, it feels better," and Julia does not like the condom (23 *negra*): "Because it bothers, the condom gives discomfort (*incomoda*)". Several women mentioned that it gave them an irritation, as for instance Eliane (51 *negra*) mentions: "(Laughing) At first it gave me an irritation. A burning like an allergy."

These brief descriptions of the condom focus on participants' own pleasure or avoidance of irritation. The materiality of contraception and the body is highlighted and prioritised, as opposed to relational or social aspects. The condom's artificial nature causes discomfort and harm, disrupting the 'natural' or spontaneous feeling of the sexual encounter. The salient dimension of the 'natural' that participants therefore value appears to be feeling comfort and at ease physically (Cabral 2011).

Additionally, Leticia (40, *parda*) says that she does not use a condom regularly, even though she thinks "you should:"

The ideal is without anything, no medicine, no pill, not a thing. But you can't. I see... Because it's skin against skin (rubs fingers together), right (small laugh), it's natural, different from that plastic there causing friction Ah Yes? [...] it gives more pleasure.

The language used in Leticia's account highlights the physicality of the material body and the condom, describing different substances and sensations. A dichotomy is set up between contraception and the body, with one preventing or reducing pleasure, and the other providing sexual satisfaction. The absence of any type of "artificial" contraceptive technological intervention or interference is therefore valued as 'natural.' Juliana (40, *parda*) also focuses on the materiality of the body and the technology when discussing the condom:

*It's crap! [lit. it is a drug]. It's like sucking a candy with the paper on, but it has to be done, right? **Hm?** Sucking a candy with the paper! (laughs/laughs), **It is?** So I mean to say... Ah my God, how do I say this?! (laughs)... **It's ok!**... Because the human flesh (*carne*, lit. meat) has a temperature, it's hot. So then you put plastic on it, what does the plastic do? It hides that temperature, so that's what happens! **I see!** I tried to say it in a manner that wasn't so direct! (laughs)*

Feeling at ease physically and prioritising pleasure brings the corporeal body to the fore in these accounts. The immediacy of the sense of touch is the focus for both Leticia and Juliana, who mention skin and the heat of the flesh, contrasting it with the disruptive plastic of the condom. Participants are using a highly embodied narrative that separates the human (flesh) from the artificial (plastic), thus highlighting the 'otherness' of the condom as a contraceptive technology.

For Juliana, this is remembering her past, as she highlights how she now must use a condom because she has HIV. Juliana was the only participant who talked about having a serious STI, which was as a result of trusting a deceitful partner who cheated.²⁴ She was still very angry with him, mentioning how she “prayed for him to die” when he got very sick. Juliana’s account also demonstrates how difficult it can be to talk about something so intimate with a stranger, commenting reflexively on the interview context and the indirect talk that she uses to manage it. Humour is also evident again in most of these accounts, with only Julia appearing to be slightly frustrated about her experiences with the condom.

6.3.3 Summary

Several participants talked about using the condom regularly, generally prioritising their own sexual health and mentioning how men cannot be trusted regarding sex and contraception. For these participants, condom use was still risky, as Sara’s example demonstrates; however, sterilisation at least removes the worry of potential unplanned pregnancies associated with unprotected sex. Most women, conversely, described using the condom irregularly, which often led to unplanned pregnancies and ultimately to the decision to sterilise.

Most participants also described prioritising sexual pleasure over contraceptive use and STI risk. Accounts that focused on the partner’s pleasure show the relational nature of contraception and how this is perceived and managed by these women within a highly gendered relationship context. The majority of participants, nevertheless, focused on

²⁴ Only one other participant mentioned having an STI, which was HPV.

their own sexual satisfaction. These accounts valued the concept of ‘natural’ sex, a practice characterised by physical comfort and ease, and unmediated by any artificial, disruptive contraceptive technology. Understandings of sexual satisfaction will be raised again in Chapter 8.

6.4. Fluidity in Intimate Relationships and Daily Lives

Many participants talked about how both their intimate relationships and daily lives were marked by uncertainty, instability or stress (see Chapter 4). This section examines how this context can be seen to influence participants’ accounts of their use and perception of contraception.

6.4.1 Intimate Relationships and Sexual “Relapse”

Some participants talked about having unplanned pregnancies as a result of what they describe as an unexpected “relapse” in their sexual relationships. In the relationship context described in Chapter 4, where couple “difficulties,” infidelity and separation are “common,” the uncertainty or fluidity of intimate relationships in participants’ accounts can be seen to influence the inconsistent use of contraception. A “relapse” in this context involves the ‘unexpected’ resumption of sex after breaks in the relationship, without any method of fertility control. Brandão’s (2009) study also examines the sexual relationship “relapse” among youths in Brazil and discusses the unpredictability of sexual encounters while dating. This research, in contrast, focuses on adults in more long-term relationships. ‘Relapses’ affecting contraceptive use are described here by participants as occurring within various types of unstable but long-term relationships, two of which will be outlined below.

The first type of sexual “relapse” without contraceptive use described by participants occurred within supportive and committed relationships. The break in such relationships happened due to being physically and geographically separated, as for example when participants were travelling away for either health or work reasons. Marcela (66, *morena*) was away to have treatment for what she describes as her “early menopause:”

*I wanted only the two, a pair. I came to do the treatment, and then afterwards when I returned to Rio my husband stayed there, so then I came to stay at my mother's house here **mhm**. Then, when I returned, I said [to him] to give me time, but... (rolls eyes) ah! I became pregnant! (laughs). So then I had the boy, and operated (got sterilised, 'operei').*

Marcela's account here links to the previous section on negotiating contraception within intimate relationships, though in this case it appears that her desire for time without sex, in order to avoid using contraception, was not prioritised. Similar to the accounts of partner negotiation above, she is very amused while relating this narrative, perhaps using humour as a way to communicate about intimate details of gendered dynamics within their relationships. Marcela links this “relapse” and unplanned third pregnancy directly to her decision to sterilise.

A second type of participant “relapse” occurred after a separation that was the result of fighting or disturbance in the relationship. These accounts were still described with humour and the women explained that their relationships were positive overall. Lívia (37 *preta*) says:

I knew about the condom, but I didn't have much understanding you know. I knew about it but I lost myself in it, so then I had to take the pill [remédio/medicine] to prevent [pregnancy/prevenir]. And then there was one

time that I forgot... I was separated from him, then one of those relapses happened, with him... that's why my daughter arrived, these relapses that are fiery [hot - fogo]! (laughs)

Lívia talks, with humour, about how the fluid aspect of their relationships interrupted the routine of taking the pill, mentioning an element of lack of control in “losing” themselves and “falling” back into it unexpectedly.²⁵

Vasti's (36 *branca*) second and third pregnancies were also unplanned, the first because “the pill didn't work” and the second due to a “relapse” with her partner. She describes having a currently supportive and committed relationship with her husband, but that they used to fight in the past: “we fought a lot back then, so I didn't take pill. The situation was uncontrolled.” Then when her second child was nine months old, she describes how “I wasn't taking the pill then, I had thrown it out because it was another failure (*furada*) that didn't work.” She then laughingly describes how she was “not prepared” for the following, “very good” unplanned sexual encounter.

Finally, in contrast to the light-hearted accounts above, several participants described the ‘relapse’ as taking a far more negative form, explaining that it happened within a context of obstruction or abuse from their partners. Paula (52 *morena*), describes her previous partner as selfish and unhelpful rather than particularly violent:

My husband never understood that I was hypertensive (heart), and that I had to avoid the [sexual and reproductive] role, and I couldn't take the contraception pill. The rest was very complicated with him, so I had to do the role and he didn't understand. In truth I couldn't get pregnant again, and then I got pregnant (shakes head) it was a bad relapse.

²⁵ *recaída* could also be translated as ‘return’ or ‘fall’, and the root *cair* literally means to fall.

Daniela (42 *preta*) became very upset during the interview when she talked about her how her husband beat her, and how this “uncontrolled” situation led to an unplanned pregnancy. Laura (48 *preta*) also described how she had a bad time with her violent and abusive husband, so she was “on and off the pill,” while trying to separate from him:

My son was not planned... I don't really remember if I was still taking the pills then because my life at the time with my husband was very disturbed (conturbada), because of a cheating. so I... I don't remember... we separated. So when we returned, I don't remember, it was difficult..... then I had a relapse with him and got pregnant [upset, closed body language].

Intimate partner violence is widespread in Brazil (Zaleski, Pinsky et al. 2010, WHO 2012) with women of colour more likely to experience it than wealthier, white women (Goldstein 2003). ‘Femicide’ is discussed as a widespread problem in Brazil, as there are high rates of women who are murdered by their partners or ex-partners. As reversible contraception involves planning, stability and negotiation, it is perhaps unsurprising that it is affected when violence supplants negotiation by coercion within intimate relationships (Jamieson 1998: 152, Pallitto and O'Campo 2004). These experiences of Paula, Daniela and Laura demonstrate the more extreme end of the spectrum of participants’ accounts about gendered dynamics within intimate relationships affecting contraceptive use.

The accounts in this subsection on sexual ‘relapses’ demonstrate various understandings of relationships that differ from the literature on fidelity and contraception described above in Chapter 2, which focus on committed, stable relationships. Participants describe long-term conjugal relationships

that are yet marked by periods of absence due to geographical distance, or instability due to conflict or violence. This uncertainty leads to spontaneous, unplanned or coerced sexual encounters without the use of contraception, with each participant describing how they led to unplanned pregnancies and their decision to sterilise.

Gendered dynamics are evident within some accounts of the “relapse,” with participants’ partners described variously as supportive, or the source of conflict or abuse. Humour is again evident in the majority of these narratives and only absent from the accounts of violence. Within this context, participants assume or reject various levels of individual responsibility. Some imply that their partner was more responsible for the “relapse,” while others describe losing themselves in the “fiery” pleasure of sex. Two participants say that the pill itself works but that they did not use it “correctly,” while others rejected the pill as just one more “failure” (*furada*) among others that they experienced in their lives.

The inconvenient or ‘unnatural’ nature of contraception is highlighted by implication in these accounts, as it is a practice that requires planning, preparation and a certain level of stability or consistency that is not always a characteristic of participants’ relationships. This unsuitability of contraceptive technologies is reminiscent of the ‘unnatural’ and inconvenient descriptions of contraception in the section above. The narrow focus on the unacceptability of the (barrier method) technology itself regarding sexual practices is expanded in this section to include various types of contraceptive methods and situated within broader notions of the fluid dynamics of intimate relationships.

Most of these participants turned to sterilisation after these experiences with reversible contraception, as it provides a solution that guarantees certainty and control over their reproduction. The certainty of a permanent end to the worries of dealing with unsuitable contraceptive methods combined with fluid or “out of control” relationships was usually very appealing and a great relief for these participants.

6.4.2 Daily Life Obligations: Worry and Forgetting

Participants’ accounts of their daily lives and relationships outlined in Chapter 4 often highlighted the precarious nature of their work and living conditions, along with the stressful obligations involved in assuming responsibility for care of children and relatives. Similar to accounts above of the fluidity/inconsistency of intimate relationships affecting women’s contraceptive use, the instability and stress of day-to-day life can also be seen to affect some participants’ experiences of contraception. Moving beyond both sexual practices and the dynamics of sexual relationships, these accounts focus on the unsuitability of contraception within the wider domain of their everyday lives.

Almost all of the participants who talked about forgetting the contraceptive pill due to daily life obligations portrayed the pill as stressful and annoying. Edila (27 *negra*) had one planned pregnancy, a second “accepted” unplanned pregnancy, and two further unwanted pregnancies:

Ah no, I don't like the pill... No, it's not issue of me not liking it, but that you (a gente) really forget (esquece mesmo). If I am anxious, agitated to go out, late for work, some thing, then you (a gente) go and go, and don't even want to know about the pill or anything. Then it is afterwards when you (a gente) are there that you remember “ah, I forgot to take it,” but then it's

already late, you are already there drinking, you are already with your friends, you are already working, so that you end up forgetting.

Edila was very frustrated about her struggle to take the pill consistently when her life was stressful and was determined to be sterilised to be free of the “constant worry and forgetting” of the pill. Other participants highlighted how having the daily obligation to take the pill is taxing. Marcela (66 *morena*) mentions her daughter as an example, because she says “my phase is over thank god!”:

*She is just waiting to have another child so that she can do the sterilisation. [...] To be stuck avoiding [pregnancy] your whole life with pill and condom is horrible! So having another child means she will be able to do it [be sterilised]. **Why is it horrible?** Because you have that obligation to be taking that pill, every day, every day, every day! And the same even with the condom, every day you have to be using it, you see? **I see.** The discomfort, you know? The worry (uneasiness).*

The emotional strain and worry caused by the necessity of taking the pill or even using the condom is foregrounded in Marcela’s account. Here it is the pill that interferes with feeling at ease in life, by causing such stress and “discomfort.” Taking full responsibility, constantly, for contraception is clearly an unwanted burden, and one that can be avoided by being sterilised. Women, such as Marcela’s daughter who already has two children, are willing to have more than their ideal number of children in order to be sterilised, so that they are free of this stressful obligation.

Finally, at the time of interview, Sofia (22 *negra*) was pregnant with her unplanned and very much unwanted second child. She was very aware of her contraception options, had experienced negative physical side effects from the pill, but was happy with the injection until life interfered and she forgot:

Then as I was taking the injection I delayed it by two days, that time [no caso]. Because I got it, I bought it in the pharmacy, the doctor passed me the receipt... I worked in the pharmacy then... and I went to the [health] post so they could apply it. Only that it was a Saturday that day, I forgot, so Saturday and Sunday passed, and I took the injection on Monday. Mhm. It didn't make a difference/help anything anyway, so that I got pregnant again. So this was a thing that was not planned. I didn't want it, but it happened.

Sofia thought the injection was more reliable than the pill, as she did not have to remember to take it every day. She was determined never to have another child after the traumatic birth of her first son, so she was very angry about the circumstances that led to the pregnancy, particularly her inability to access the clinic on the correct day. The consistency and predictability that is required for contraception, even for the injection, is again not always feasible within uncertain or precarious living conditions.

The unpredictability of daily life for these women, who are dealing with precarious living conditions, interferes with the stability and planning that is required for contraception. These participants highlight how inconvenient and difficult it is to take contraception regularly, thus downplaying their own responsibility and assigning more blame to the nature or design of contraceptive technology.

6.4.3 Summary

Following on from section 6.3 which illustrated participants' perceptions of contraceptive technologies as inconvenient, unsuitable or undesirable, this section has explored the unsuitability of reversible contraception in two further dimensions of women's lives: the dynamics of fluid, intimate relationships and the instability of the daily lives.

The accounts of sexual 'relapses' illustrate diverse understandings of relationships that differ from the literature on fidelity and contraception explored in Chapter 2, which focused on stable relationships. Participants here talk about long-term relationships that are interrupted by episodes of absence because of geographical distance, or instability due to conflict. This uncertainty leads to unplanned sexual encounters without the use of contraception and to unplanned pregnancies. Participants assume or reject various levels of individual responsibility, some saying that the pill itself works but that they didn't use it 'properly,' while others rejected the pill as just one more 'failure' (*furada*).

The fluid and spontaneous nature of intimate relationships are highlighted in these examples, where participants describe enjoying the unplanned resumption of a sexual relationship. These accounts emphasise how the assumed conditions under which both hormonal and barrier contraceptive technologies are considered successful, do not take into account the reality of these women's sexual practices. The inconvenient or 'unnatural' nature of contraception is highlighted by implication in these accounts, as it is a practice that requires planning and a certain level of stability or consistency that is not always a characteristic of participants' relationships.

The uncertainty and volatility of daily life for participants also interferes with contraception use and highlights the necessity for planning and consistency for various types of contraception. In these accounts, contraception is described as something disruptive and causing worry and discomfort. Participants' who talked about the stress of life or the stress of constantly using contraception portrayed it as an unwanted burden.

Contraception is one more responsibility that they must assume, as part of the unequal gendered and sexual relationships described above, but also due to the nature of the contraceptive technologies themselves.

The stress, worry and discomfort evident in these accounts on reversible contraception are in stark contrast to the majority of participants' understandings of health and wellbeing (see Chapter 5). In this context, contraception is seen as interrupting the previously elaborated concept of an expansive notion of health as including physical, emotional and mental ease. From this perspective, reversible contraceptive technology is seen as inadequate, unrealistic and causing a negative effect on women's health and wellbeing. This link between contraceptive use and ill-health is discussed more clearly in the following section on the side effects of hormonal contraception.

6.5 Physical Effects of Hormonal Contraception: *Mal Estar* & Stress

The chapter so far has highlighted the social and relational aspects of contraception in participants' accounts. In contrast, this section focuses on the corporeal, bodily aspects of contraceptive experiences. Narrowing the focus from wider institutional and interactional levels, contraceptive technology is examined here as a highly individual and embodied practice. The majority of participants who took the pill said that they experienced negative physical side effects. This section will focus on how participants talked about feeling '*mal estar*' or unwell because of the pill. Participants' narratives on the physical side effects of the pill can be seen in relation to the

notions of wellbeing (Chapter 5). These narratives also link explicitly to participants' decision to sterilise.

Only three participants who used the pill did not report having any physical problems with it. Laura (48 *preta*) mentions, for instance: "I don't remember any effects, nothing bad, the doctor gave me one that was very weak [...] It was good. The medicine didn't do any harm to me at all." Andrea (68 *branca*) remarks that the pill caused her body to change as she got "fatter," but she "liked it and felt more free," explaining with a laugh that "it was the sixties!" Amanda (47 *branca*) also replied along the same lines:

The medication that I took I never felt anything different no, thank God. It never gave me any type of effect, not headache, not nausea, nothing of this. I never felt anything... It was really, very good! (Laughs)

In contrast, most participants had negative physical side effects from hormonal contraception, generally describing how they felt unwell and out of sorts, as a type of malaise and often used the phrase '*mal estar*.' The term '*mal estar*', literally means 'bad being', and is the opposite of '*bem estar*' or wellbeing. The importance of wellbeing was discussed in Chapter 5, but Vera (64, *branca*) provides a reminder, explaining that "'well' (*bem*) is something good, and "being" (*estar*) is the way a person *is* in that moment." These terms encompass a more expansive notion of health and 'being' than mere physical fitness, often including nebulous aspects such as comfort, wellness and happiness. This section, in contrast, examines the various ways that participants characterise the '*mal estar*' caused by the contraceptive pill.

The majority of participants that had physical problems with the pill described feeling sick, and most also had difficulty describing the sensation.

Leni (68 *branca*) describes changing her plan to space her children, because she refused to take the pill when it made her ill. When asked about her experiences, she replied hesitantly:

Look...well...(shrugs, uncertain)..

Was it ok? Or not good?

No, in the beginning I had these... (makes disgusted face, shakes body, waves hand up and down and points at stomach)

Side effects?

*Yes, it made effects, bad, you know, it wasn't good. Even so bad that I wanted my child to arrive more quickly. I was unwell (*mal estar*) and so I didn't want to stay on it and waiting much time for my child to come. So I let my son come soon... as soon as I got married...*

Leni's uncertainty when talking about physical illness and sensations is marked in this account, particularly as she communicates more using gestures and body language to convey feeling physically unwell. When asked about what type of effects she experienced, she then clarified:

*It was bad, eventually I [we, a gente] was getting sick when taking it, that is why I hurried even more to get the 'tie' (*ligadura*) too, you know, because... I already had two children, so why would I keep taking the pill? ***Mhm. It didn't suit me at all. Mhm.*** So I talked with my doctor, and I said, 'Doctor, seeing as you [*polite, o senhor*] already have to do the perineum, then do the tie (*ligadura, sterilisation*) for me,' so then he did. ***And...*** And then I never had to take the pill again!*

Leni states explicitly in this account that the pill was making her so unwell that it motivated her to obtain a sterilisation alongside a previously planned operation on her perineum. She uses the distancing and generalizing "we" (*a gente*) in relation to the negative physical effects, emphasising its unpleasantness and the difficulty talking about it. Leni's narrative highlights both the difficulty of experiencing and talking about physical sensations or

states such as '*mal estar*,' perhaps describing a kind of bodily alienation, and linking it directly to her desire, pursuit and 'achievement' of sterilisation.

Paloma (59 *negra*) also emphasises how she refused to take the pill regularly because it made her feel unwell:

I didn't use it at first, no, I got pregnant when I got pregnant [...] Only after I had two children I took it. Mhm. [...] But I only used it a small bit, not often. For just two years. And after that I tied (eu ligei).

Was it ok to use .../

*... To use the medicine? [pill] (shakes head and finger) No? No Why? Because it made me feel bad, unwell. My stomach was like this (makes a pained face and hold up tight fist) **Hm?** With nausea, when your stomach is like this (indicates getting bigger), full up. **Ah got it.** And when I was 32 years old I tied (eu ligei).. Because I really didn't want more of that, or more children (laughs)*

Paloma's description is similar to Leni's, as she emphasised how she resisted taking the pill, did not space out her pregnancies, and decided to be sterilised so that she could avoid taking it. Her narrative also demonstrates the difficulty describing the bodily experience of '*mal estar*' caused by the pill, as she uses gestures and body language to describe the physical sensations. These narratives seem to indicate the experience of *mal estar* caused by hormonal contraception is a type of bodily alienation, one that they evaded and overcame by becoming pregnant early and by being sterilised. Both participants, however, also mentioned that they were only sterilised after having their two children (the 'ideal number,' see Chapter 4).

In contrast to these accounts of *mal estar* where each participant was already sterilised, Luana (31, *parda*) was pregnant at the time with her third child, which was unplanned. She was far more frustrated when describing her

experiences of *mal estar* with the pill and talked about it more easily than Leni and Paloma above:

It's just that, every time I took the pill, I was unwell (mal estar), I felt bad... various things, it never agreed with me (eu nunca me dei papillo...), really? (looks and sounds unhappy) I was very unwell. I had pain, sickness, you know, I felt my breasts were very heavy, uncomfortable... it was annoying! I understand. And the doctor changed the brand, and I continued with the same symptoms. I had high pressure, stress, and I continued with those same symptoms! (very frustrated) Mhm, I see. It was too stressful, so I thought it was better to stop and continue on with the condom (preservativo). Then I became pregnant, there's no other way! (não tem jeito) [...] This is why I decided now to operate (sterilise, me opere) [...] I think 'that's enough!' So the 'tie' (ligadura) would be, um... good! (laughs)

Luana describes in more detail both physical and emotional aspects of her experience. She also uses body language to communicate by touching different parts of her body, including her head, stomach, thighs and breasts. Luana emphasises both the corporeal and emotional aspects of the bodily alienation caused by the pill and also links this experience directly with her decision to be sterilised.

Other participants focused more on how 'unnatural' the pill is, while also adding in a concern about gaining weight. Ana Rita (57, *branca*) mentions how she took the pill from 22 to 28 years old, but had negative side effects when she started it after the birth of her second child:

Afterwards [...] I had many problems with the pills. Really? Nauseas, getting very fat... my body (organismo) did not accept it well, the damage. Damage? I felt various symptoms, sick, unwell (mal estar)... so then the doctor wanted to change the types [...] but I wanted to tie (ligar).

Ana Rita's use of the word "organismo" emphasises the biological, physical matter of the body here. The body as object is vulnerable, and damaged by the pill. Sterilisation therefore provides a safer option to safeguard her physical wellbeing. Similarly to Ana Rita, Bruna (57, *negra*), had her sterilisation in Porto Alegre as soon as possible after the birth of her second child because she wanted to avoid the "worry" and "swelling" of the pill, which "complicates you, you take it and it causes strange reactions."

Both of these accounts further indicate the bodily alienation caused by the pill, with Ana Rita emphasising the materiality of the body by using biological terminology and Bruna emphasising the bodily disruption and oddness. The 'otherness' of hormonal contraception is highlighted here, as the body is portrayed as changing from a state of comfort, wholeness or 'naturalness,' to a more disturbed, unpredictable state; perhaps suggesting an experience of both bodily harm or lack of control.

Diverging from most of the women's accounts of contraceptive '*mal estar*,' a couple of participants framed their accounts as one of acceptance towards the negative side effects that they experienced. Leticia (40 *parda*) initially described her experience of the pill as "normal." When asked if she had any effects she described feeling "pain, uncomfortable breasts, nausea and even vomiting" because of it. She talks about how she also tried different types of contraception, but she again evaluates her experience as "normal," and that it was nothing too difficult for her. Similarly, Edila (27 *negra*) also had negative side effects from taking the pill, but stressed that she was not bothered by them:

No, I didn't have any side effects. For me it was calm (tranquilo)

Mhm, no headache, anything like that...

Oh, sometimes it gave me nausea, like that, a dizzy spell, getting sick of things, stress. It even seems like you are pregnant! But I take all of this in my stride, calmly, everything ok (calm, tranquilo).

Both Edila and Leticia describe similar negative side effects to others in this subsection, even adding more, such as feeling dizzy. Their interpretation of these symptoms, however, is different, as they frame their experiences as something “normal.” Their portrayal of “calm” acceptance diverges from the rest of the participants who emphasised their disorientation and attempts to avoid and eventually reject hormonal contraception.

Several participants’ narratives contain severe examples of physical side effects that are quite different, but are still ascribed to taking hormonal contraception. For instance, the pill is described as causing an early menopause and heart palpitations. Nevertheless, for both *mal estar* and these examples, the pill causes a type of bodily alienation, where the participant feels uncomfortable, and not at home in her body. This is usually portrayed as being out of control and causing too much stress, which leads to participants’ decision to sterilise.

6.5.1 Summary

In contrast with the influence of relationships on contraception, the pill affords more autonomy and control than the condom. Nonetheless, the body itself comes to the forefront here, as the pill acts directly on it, leading to negative corporeal experiences for most participants, and for some it is hard to fit into their daily lives. The condom, in comparison, does not impact so much on participants’ physical wellbeing and it provides protection against STIs, although it intrudes upon sexual pleasure and spontaneity.

For the participants who experienced *mal estar* due to the pill, the body is presented as something malleable; it can change from a state of 'natural' comfort, ease and happiness, to one of disorientation, disruption and stress. The form and boundaries of the body are also experienced as fluid, expanding with pain, swelling and heaviness. I argue that the physical 'otherness' of hormonal contraception is thus emphasised, which points to an experience of bodily alienation. Most of the participants who experienced this alienation described strategies of varying or selective resistance or evasion, with only a few women conveying an attitude of acceptance.

The importance of health and wellbeing for most of these participants was discussed previously, where for example feeling ill means that you cannot work to pay rent or take care of those dependent on you. The significance of taking care of your health and your emotions are also highlighted by many participants, including, for some, having a fulfilling sex life and intimate relationships. Within this context, taking the hormonal pill is generally portrayed as problematic, although sometimes it is seen as a pragmatic short-term solution. Dislike of the pill is common, causing much frustration and unhappiness for these participants, and leading to various strategies to avoid or limit the negative effects. Sterilisation, although more invasive in one sense, is presented as a rational and positive solution, one that causes less daily distress and continuous bodily alienation.

6.6 Conclusion

This chapter demonstrates how contraceptive technologies are socially situated and relational – where dynamics such as family silence, negotiations

of intimacy, abusive relationships and experiences in reproductive health clinics all shape participants' understanding and experiences of contraception. The analysis further illustrates how contraceptive practices are thus embedded within class, race and gendered dynamics. As such, participants' understandings and experiences of contraception vary widely. Women's understandings of reversible contraception are explored across multiple settings and dimensions in their lives, such as institutional, relational, and individually embodied.

For most women in this research, contraception was a taboo topic and difficult to access, which leads to participants positioning themselves as more or less active in their search for sexual and reproductive autonomy. These experiences were broadly shaped by race and class differences, as women who identified as white usually had more positive experiences or easier ways of accessing contraception. These inequalities link to similar accounts in Chapter 5 that detail the increased difficulty that women of colour had when attempting to access healthcare in general.

As a lived practice that forms part of participants' daily lives, contraception involves active negotiation and enactment of dis/trust within intimate relationships, while the context of unstable or fluid relationships highlights the inherent necessity for stability and predictability required to use reversible contraception effectively. The materiality and physicality of both barrier and hormonal contraception was discussed by participants. The artificial 'otherness' of the condom is highlighted for participants who prioritise pleasure in their sexual relationships, and the alienating 'otherness' of hormonal contraception is evident for participants who experienced negative physical effects from the pill. The use of vague or distancing

language, along with humour, appears to provide a means of emotionally managing and communicating about difficult or intimate topics.

These findings expand research on contraception that explores the competing perceptions of the meanings of contraception and unwanted pregnancy or STI risk (Luker 1975). This research shows that medical institutions assume that the most significant 'cost' of (hetero)sex is 'unplanned pregnancy, while also minimising the costs of these technologies and stigmatising those women who refuse to bear these costs as "irrational" (Luker 1975: 140, Shoveller and Johnson 2006). Similarly, the accounts in this chapter illustrate how, when contraception is situated within the lived context of its use, its non-use is entirely understandable.

Sterilisation is generally presented in these accounts as a means to overcome unreliable or inconsistent reversible contraception, particularly within a context of unstable relationships and unpredictable life circumstances. As will become clearer in Chapter 8, sterilisation provides control over, and a certain end to reproductive capacities, reducing participants' stress and freeing them to enjoy sexual relationships and deal with daily life challenges.

CHAPTER 7. 'ACHIEVING' STERILISATION: LEGAL AMBIGUITY AND THE *JEITINHO*

7.1 Introduction

Following on from the examination of participants' experiences of reversible contraception in the previous chapter, this chapter examines the actual process of accessing and being sterilised in Rio de Janeiro. This discussion links to Chapter 5, as it details what it is like to be sterilised in a health system consisting of inclusive policies and ideals, but unequal access and power. Aside from the issues that participants faced accessing healthcare in general, this chapter explores how women can access a legally ambiguous operation and what effects the legalisation of sterilisation has had. The analysis illustrates how systemic barriers to healthcare force women to mobilise various resources in order to regulate their fertility. This, as I will show, is often accomplished via *jeitinho* practices that allow women to bypass the law. It also demonstrates how the legalisation of sterilisation codified certain discourses around the operation, as well as introducing additional obstacles to access for certain groups of women.

The majority of participants described the process of accessing sterilisation as difficult or complicated. Issues outlined in Chapter 5 (such as systemic barriers to healthcare, health inequalities and the role of the *jeitinho*) play a crucial role in shaping the following sterilisation accounts. In contrast with Chapter 5, sterilisation accounts focused more on doctor-patient dynamics and negotiations rather than structural issues. This could be partly due to the fact that structural problems of the health system were usually addressed beforehand during the interview, and many participants also appeared to

assume knowledge of this context. Moreover, many participants were also sterilised before the SUS was established in 1990.²⁶ It may also indicate, however, the particular significance of the role of the doctor as gate-keeper with regards to sterilisation.

Of the 35 participants, 26 were sterilised at the time of the interview, at dates ranging from as long ago as 46 years and one as recently as a 6 months previously. The remaining respondents were planning to be sterilised and at various stages in the process. Of the 26 participants who were already sterilised, 19 women had the operation before the law changed in 1996, and seven were sterilised after the law. The law aimed to both open access to the operation to more women and to regulate its use, thereby changing the means of accessing it. This significant legal change affects the context within which these participants accessed sterilisation, so the experiences of these two groups will be examined separately.

This chapter is divided into three parts: examining participants who were sterilised before the operation was legalised, those sterilised after the law, and those who were planning to sterilise at the time of the interviews. These groupings facilitate a comparison of the varying, complex legal and policy contexts of participants' accounts, and their effects on women's experiences of sterilisation.

²⁶ Before SUS was created only people who paid for private care or who contributed Social Security could receive healthcare (see Chapter 1).

7.2 Sterilisation Before Legalisation: Navigating conditions of illegality

As described in Chapter 1, sterilisation was illegal in Brazil before 1997. The operation, however, was widespread as women accessed it when doctors covertly combined it with caesareans. Nineteen participants of this research were sterilised under these conditions, before the law changed. Just under half of these women described the process fairly positively, with the remainder talking about difficult experiences. As detailed in Chapter 5 (and Chapter 6), the *jeitinho* is a crucial means of accessing healthcare for many women. The resources of the *jeitinho*, including financial, contacts and a good relationship with a healthcare professional (HCP), are particularly important for accessing sterilisation before it was legalised.

7.2.1 Positive Accounts: Negotiating Doctor-Patient Relations

Participants who described their experience of accessing sterilisation positively generally paid for the operation and were supported by their partners. All of these participants, except one, were sterilised “at the time of birth,” as was typical before the law changed. The passing of time seems to have shaped some women’s memories of their sterilisation, particularly those who were happy with the process. Participants such as Isabela (67 *branca*) who was sterilised in 1977, Marcela (66 *morena*) sterilised in 1981, and Eliane (51 *negra*) sterilised in 1995, did not go into much detail on the topic, explaining that it was a long time ago. Marcela, however, referenced the illegal nature of the operation, explaining that although the process was “fine,” she had to pay for it because it was “a bit difficult to get it at the time.” This vague kind of allusion is the only way that participants indicated the illegal nature of the operation when discussing their own experiences of being sterilised.

Amanda (47 *branca*), sterilised in 1992, describes her experience of the process of sterilisation positively. Her account sums up the typical issues raised in participants' accounts of sterilisation as:

Good, calm... I did the pre-natal, all correct, it was the same doctor that operated [for previous birth]. So it was calm, everything went well, thanks be to God. I didn't have any inflammation, infection, nothing like that, I didn't have post-partum depression, thanks be to god.

Amanda highlights some negative outcomes that she did not suffer, pointing out both the potential physical and emotional risks involved (mixing birth/caesarean/sterilisation as one operation). Sterilisation is not separated from the process of birth, as will be seen for most of the accounts of access in this chapter. The avoidance of suffering is an issue that is taken up in more detail by participants who were sterilised after the law (below) and happy with their experience of the process. The importance of the role of the doctor in facilitating access to sterilisation is a major issue for the other women who talked about having positive (and negative) experiences of the process, and will be addressed in the following examples.

Most participants who had positive experiences of the sterilisation process focus on the initial means of accessing the operation, particularly their discussions with their doctor. Paula (52 *morena*), sterilised in 1991, had problems with high blood pressure and had caesarean deliveries for both her children. She explains that her experience was good because her decision to sterilise was "conscientious," and made after discussions with both her husband and doctor:

the doctor got me and talked with me about it, [...] 'so that you don't run the risk of becoming pregnant again, so that you don't run any health risk, the correct thing to do is sterilisation. You already have two children; do you want to sterilise?'

In Paula's narrative, the doctor actively seeks her out to discuss sterilisation and is also the only one whose speech is reported directly. Paula positions the doctor as the one with the knowledge about the correct circumstances for sterilisation, and who can advise her to have the operation. This contrasts with the majority of accounts on sterilisation, as most participants describe their active attempts to persuade their doctors that they need it. Paula's close relationship with her doctor may have contributed to this trust in medical authority in her account. Similar to those who had positive experiences of healthcare in general, the ability to mobilise social networks - in this case a trustworthy and reliable doctor - enables access to sterilisation. This account is also in line with the medical recommendations of the time where sterilisation was recommended for women who would be at risk if they became pregnant. In addition, sterilisation is described as an ethically correct choice, which links with the wider moral discourse on the right to sterilisation (Chapter 8).

In contrast, Andrea (68 *branca*), who was sterilised in 1982, informs the doctor of her decision quite firmly in her narrative, "my decision was well thought out, I talked with my husband, and I said to the doctor, 'look here (points finger), do the tie already as I am not going to want any more [children]!'" Andrea portrays a very different interaction with her doctor, where she assumes a position of authority, almost ordering her doctor to sterilise her. The doctor's voice is absent from the whole narrative and he clearly agreed to her demands. Andrea's confidence in her knowledge and

opinion may be linked to the fact that she came from a wealthier background and attended university. Andrea also previously described having only good personal experiences of the health system. When describing her positive experience of sterilisation, this interaction is the focus for Andrea, which again highlights how important it is to have a smooth negotiation with a doctor.

The following participant, Leni (68 *branca*), also previously talked about having positive experiences of the health system (Chapter 5). In contrast to Paula and Andrea's accounts above, she describes yet another position taken when discussing sterilisation with her doctor. She is the only participant with a positive experience of sterilisation who had the operation performed separately from the birth of her baby. Leni was sterilised a year after the birth of her second child in 1977 or 1978, along with a procedure to fix a botched operation on her perineum from a difficult birth. She says:

*He had pity on me, because I came from far with my son in my arms, carrying with that big belly every month to do the pre-natal [...] And also I was poor/humble [humilde], I lived in a simple house [...] so that is why... **mhm**. Then when my son was one year old he said "so now Mrs Leni ..." then I thought I was pregnant... "Ah Our Lady it's the third one! Virgin Maria, I didn't want it!" Then he said, "we'll do the exam here to see if you (Senhora) really are pregnant," so he collected the exam and everything, but I wasn't pregnant! **Ah!** So then I said "Ah doctor, so take advantage now that I'm not pregnant, thanks be to God! So you (Sir) take advantage and do it... do the perineum and the tie together." And so he did, **mhm** [...]. The health plan paid for the perineum and he did the tie along with it for free. It went well.*

In contrast to Andrea, Leni describes how her very lack of resources contributed to her ability to persuade her well-known, and sympathetic, doctor to sterilise her for free. She describes a very polite interaction with her

doctor, emphasising the fear that her pregnancy scare caused her and expressing it through quite religious terminology. Differing from the measured and accepting tone of Paula's narrative, or the firm determination of Andrea's, the emotional content of Leni's narrative is distinctive. The display of emotion is in itself persuasive, and is portrayed here as being a successful way to negotiate access to sterilisation. The enactment of emotional displays in these accounts thus appear to illustrate the *jeitinho* practices around social-savviness or the 'sweet-talking' skills as Barbosa (1992) describes.

The performative nature of these narratives highlights the importance of the emotional tone of participants' interactions with their doctors. My analysis here draws upon theories of language and communication, where emotional display is another, non-verbal, means of communication (see Chapter 3) (Wittgenstein 1972, Hallowell 2006). Furthermore, the emotional display in these accounts relates to wider research on how emotion is mobilised as a persuasive device within debates on reproductive rights, such as that by Hopkins et al. (2005). Their study illustrates how, when emotions are constructed as being "immediate and authentic," they can be harder to reject or contest (2005: 395). This point will be raised again in further examples of doctor negotiations below. The need to actively demonstrate a strong desire for sterilisation is common to both Andrea and Leni's accounts, despite the different positions of power or authority that they portray.

The good sterilisation process involves support from the partner and doctor. These narratives contrast with the accounts that focused on doctor-patient interactions in Chapter 5, where most participants described negative experiences and talked about how distant the doctors were. Positive

negotiations with a doctor, where a woman's opinion is heard and valued, again provides access and helps navigation of a complex system.

Furthermore, combining the operation with a caesarean delivery also makes the experience easier for these participants. Leni was the only participant who was not sterilised 'at the time of birth'; nevertheless, she was still sterilised along with another operation on her perineum, again reducing cost, complications and inconvenience.

As sterilisation was unregulated at this time and often difficult to access, the power of medical professionals in this regard was key. Doctors were often the gatekeepers who decided, according to their own personal beliefs and judgments, whether a woman would be sterilised or not. These examples describe three different attitudes and power dynamics between the participants and their doctors. Paula describes how her doctor persuaded her to be sterilised, while the other two participants describe persuading their doctors to do it. Andrea and Paula, however, take very different positions of authority in their narratives, although both succeed in their goal of being sterilised. As demonstrated in Chapter 5 on accessing healthcare in general, class and race also play a part in how women can negotiate access to sterilisation.

Despite a system that creates systemic barriers to healthcare for certain types of women, as well as a legally restrictive and ambiguous policy context, all of these women successfully accessed sterilisation. They each had the ability to mobilise various resources and employ skills of persuasion, thus enacting *jeitinho* practices to achieve their goals. The *jeitinho* accounts in Chapters 5 and 6 generally focus on using social networks and finding the correct information and contacts to gain their healthcare goals. These accounts, in

contrast, describe in more detail the actual encounter with the key gate-keeper. They illustrate various types of skills and strategies that participants use to negotiate access to their goal of sterilisation. These skills appear similar to the notion of *simpatia* that Duarte's (2006) study links to the ability to employ *jeitinho* practices.

Race again appears to be a factor in accessing contraceptive technology. Most of the white participants describe having positive sterilisation experiences, as can be noted in this section; each quote discussed here in more detail is from a white participant, apart from Paula. This is in accord with the general findings on the health system discussed in Chapter 5. Most of the white participants described having positive experiences of the health system in general, which diverges from the majority of participants. These women successfully navigated varying positions of power and levels of resources, taking more or less active positions in relation to their doctors.

7.2.2 Negative Accounts: Interactional and Institutional Barriers

In contrast to the relatively positive depictions of the process of sterilisation before the law changed, slightly more participants described encountering some type of difficulty during the process.²⁷ These participants talked about their experiences in more detail, describing how their sterilisation experience did not go as they had planned for various reasons. The accounts here focus on the women's negotiations with partners, doctors, and the difficulties of the health system and operation. Participants' perspectives on the

²⁷ The majority of the remaining accounts on sterilisation access in this chapter are also negative, as there are only two positive accounts from after the operation was legalised.

complicated experiences that they had with the sterilisation process ranged from proud or happy to very angry and sad.

Several participants had to overcome the disapproval of their partners in order to be sterilised. Paloma (59 *negra*) was sterilised in 1967 when she was almost 33, and was happy with the process despite the disapproval of her husband:

He didn't want it... I mean to say, he didn't want to pay for it, or for me to actually do it. But it was my desire, so I had to find it and I had to pay for it. It wasn't easy, but it went well.

Paloma's husband always supported her financially, apart from the 3 months that she worked as a *doméstica* outside of the home. She described how this was a difficult time for her, as having a job outside the home meant she had to take on additional work as well as enforce a significant change in the routine and daily life of her family. The traditional gendered work division, where her husband retained control of financial power and she was responsible for unpaid labour in the home, made it much harder for her to access sterilisation. Paloma, nevertheless, was determined to sterilise because she was devastated after having too many miscarriages (see Chapter 8). Therefore, despite these obstacles, she emphasised the strength of her personal desire for the operation, along with her own sense of responsibility and active agency. Her description of how she actually achieved it through the complicated health system is discussed further below.

The influence an intimate relationship can have on women's access to and experience of sterilisation is also evident in Georgiane's (59 *negra*) account.

She was sterilised after her third child in 1985 and describes it as a difficult process because of her husband's opposition:

I went to do the sterilisation and he didn't know that I had managed to get it done! Ah, what did he think?

Ah he wasn't happy about it no, right, mm, but I had it done by then. [...] I didn't say it to him before... I knew what he would think... let's say, that it's not good to do what I did. Mhm. So it was difficult, but I achieved it!

Georgiane deals with her partner's opposition in a different manner from Paloma, employing deception to bypass the need to negotiate with him or to obtain his consent. Her exercise of active agency is the focus and her narrative ends on a triumphant note. This is similar to participants' accounts of accessing reversible contraception drawing upon *jeitinho* practices. Both clever resourcefulness and independent determination are described as necessary to seek out and achieve sterilisation. In Chapter 6, participants usually describe overcoming family silence, lack of information and access issues, whereas here these participants are overcoming active opposition rather than silence or lack of information, in addition to access issues. Similar to Andrea and Leni's accounts above, there is a need to display assertive agency regarding contraceptive and reproductive choices for partners as well as for medical professionals.

Negotiating gendered intimate relationships forms part of the process these women must engage with, or overcome, when accessing contraception (Chapter 6). This is also the case for sterilisation, as the operation was often framed as relevant to the partner at the time. As previously mentioned, a general policy at the time required written consent from the partner before the operation could be performed (De Bessa 2006). This was later codified in

the law when sterilisation was legalised (see Chapter 1). Nonetheless, despite the problems they experienced, participants frame the process of accessing sterilisation as a personal challenge that they successfully overcame. They appear to be proud of the active role that they took in obtaining their sterilisation. For these women the decision to sterilise and the process of accessing it seems to be shaped by elements of resistance to patriarchal gender relations evident in their intimate relationships (Lopez 1997, De Bessa 2006). This account of active agency, as a struggle to achieve something despite opposition, is reminiscent of the 'fighter' discourse that is apparent in some participants' account on accessing healthcare and also on motherhood.

Other participants describe the sterilisation process more negatively. Doctors here are generally portrayed as interfering with the women's desires in different ways. Vera (64 *branca*), for example, was angry over the role played by her doctor in her sterilisation. She describes it as a "crisis," because she had to have the operation for a second time in 1982:

*So I found the doctor, the one that I had before in 'X' for the second baby, he guaranteed me that he had tied me. Ah, tied for the second... He gave me the paper of tubes tied (shakes papers in her hand)... Eee! (shoves papers away angrily and shakes head) **Oh!** [...] believing that I was sterilised, I went there [had sex], and it went wrong [entrei pelo cano]! (shakes head angrily) **Wow!** Mm!*

He didn't do it? Or it didn't work?

He tricked me! He didn't tie (shakes finger). He said that he had done the tie, he gave me the papers and everything, but he didn't tie! If he had I wouldn't have become pregnant, right?

There is an extremely low chance of sterilisation not working with the earlier 'knot' method, in comparison with the more frequently used 'cut' (EngenderHealth 2002). However, as discussed previously, there was also

evidence of sterilisations performed without the consent or knowledge of women, as well as reports of doctors lying about performing it (Dalsgaard 2004).

Similar to those who had positive experiences of sterilisation (above) and who managed to access healthcare despite structural problems (Chapter 5), Vera employed a type of *jeitinho* strategy when finding a familiar doctor who had worked with her before. This account, however, shows that despite the resourcefulness of the participant, she is still powerless in comparison to the doctor. Instead of the distant inattention or disrespect that most participants describe in accounts regarding HCPs in Chapter 5, the doctor interferes here in the form of straightforward obstruction. Three decades later, her anger about this experience remains palpable. The role of the sterilisation papers that she got in this account is comparable to the role that papers play in several accounts on the health system in Chapter 5. The official papers represents the bureaucracy of the health system and the role of the doctors within it. The sterilisation papers are concrete proof that the operation was performed; they are supposed to provide an official or certified guarantee, which further emphasises how Vera's trust was betrayed. Vera is one of the few white participants to have a negative experience of sterilisation. Her second attempt, however, was successful.

In contrast to the experience described by the participant above, in this second example, Beatriz (54 *parda*) describes a different type of interference by her doctor and takes a more passive position towards it. She mentions how she was "just" 25 years old when she was sterilised for her fourth child in 1985:

As I got pregnant very easily, so my doctor thought it better to do the sterilisation. So it was her.....

Mm? ... It was she who decided?

Well, she actually decided for the third child, but I didn't want it, because it was a boy. I always had the desire to have a daughter. So then for the fourth child she said "either way, if it's a boy or a girl, I'm going to do it," she was really going to do it, you know? So much so that she didn't charge me... it was private, but she didn't charge me. Ah no? No, because she said if she didn't, there were going to be many children. So she thought, well, the right thing was to do the sterilisation.

Beatriz is one of the few participants who does not describe actively seeking out sterilisation by means such as the *jeitinho*. Her sterilisation account instead highlights her lack of power and control, as she takes on a relatively passive role in this narrative and the influence and power of the doctor is highlighted. Even though the participant was able to insist on having a fourth child, her own opinion is not present in the account, which focuses on the doctors' voice. She does not narrate, for example, her insistence on having a fourth child or challenging the doctor as other participants often do. There is an element of reluctant but pragmatic acceptance instead, and she later talks about how she was very unhappy directly after the sterilisation.²⁸

Comparing Paula's account above with Beatriz' is useful, as both narrate how their doctors suggested that they sterilise. Paula describes how she made her own conscientious decision, contrasting with Beatriz' doctor who removed that choice by saying she would sterilise her no matter what. Respect for the woman's autonomy and decision-making capability appears to make a difference in how participants perceive these experiences. This links with negative accounts of inattentive doctors in Chapter 5. In this case,

²⁸ Although later on she comes to accept and feels glad about the operation.

however, the doctor actively disregards the woman's opinion. Furthermore, instead of deliberately deceiving her, as in Vera's case above, the doctor mobilises medical authority to go against Beatriz' wishes. She is portrayed as doing this ostensibly for the interest of the children and society, and even the woman herself. Beatriz believes that she is perceived as being 'too fertile,' and having "too many" children at a young age. The doctor takes on the 'responsibility' to make the morally "correct" decision to sterilise her, and has the power to do so. This links with the discourse of irresponsible reproduction discussed in Chapter 8. Research by authors such as de Bessa (2006) and Kanaaneh (2002) shows how ideas 'excessive' fertility are associated with poor, black women, and linked to concerns about a lack of social 'progress' or modernisation.

The third example provides yet another type of doctor interference, and is described by Sara (47 *parda*), who was sterilised in 1995 when she was 29:

Look, I prepared myself for everything to do the laqueadura for the third. I booked a caesarean on the 13 of March. But I was thinking down below is very heavy, I don't think I can stand another month. I told him, 'I won't last another month!' But he said, 'there will be time'. On the 8th she was born by normal birth (shakes head)... So I came to him, he said 'have another child and come back next year to do the sterilisation.' I said to him, 'No! I'm prepared now, I want to tie!' So two months later I went back to get a caesarean. They opened my stomach and did the laqueadura.

Sara does not actually need a caesarean in order to be sterilised, however her use of the term demonstrates how closely linked these two operations are, and how sterilisation as part of the birthing process has become so normalized for these participants. Despite the fact that Sara also draws upon *jeitinho* practices to organise her sterilisation, she was unable to have a

postpartum operation. Although this is also due to the fact that she had a premature birth, her narrative highlights how the doctor is to blame for this failure; the doctor is described as dismissing or ignoring the Sara's knowledge and warning. Unlike Beatriz and Vera's accounts, the doctor does not take direct action against her wishes, the interference here takes the form of a failure to listen and act. The power of the doctor as gatekeeper is again clear, and Sara's lack of control is highlighted.

After the birth, the doctor again raises another obstacle, advising her to "have one more to be tied." This phrase and idea has been widely documented in the literature on sterilisation in Brazil (Dalsgaard 2004). It appears to come from the context where sterilisation was frequently performed along with caesareans, acknowledging the difficulty of accessing the operation separately from birth. Many women describe their doctors, partners or family members using it to persuade them either to have more children, or console them if they did not 'achieve' sterilisation when they wanted it (see Marcela's narrative of her daughter's experiences, Chapter 6). In contrast to Beatriz's more passive stance above, Sara describes how she challenged the doctor's position, taking a firm stance and pushing for the sterilisation despite the difficulty of getting it separately from a birth. Sara's description of the actual operation will be discussed shortly below.

Compared to the positive accounts of sterilisation access above, the influence and role of the doctor is more negative in these narratives. The participants describe taking different positions in relation to their doctors, in a similar manner to the accounts in the previous subsection. Overall, however, these accounts demonstrate the various ways that doctors can maintain and exercise their power over women's reproductive decisions and life choices.

These findings relate to wider research on doctor-patient power dynamics in the context of reproductive health and decision-making (see Sheldon 1997, Lupton 2003).

Aside from negotiating partner and doctor interference, participants who had difficult experiences of being sterilised before the law also talked about further aspects of the process, including the health system and the operation itself. Paloma (59 negra), who decided to be sterilised despite her husband's opposition (above), describes how complicated it was to access the operation at the time:

*It went well. The suffering was there to the side, but I couldn't have any more miscarriages, so... I did it with a doctor in Campo Grande. I had to do it there in Campo Grande, it was very hard to get it at the time, so I had to leave Rio for it, as I knew people there. **Mhm.***

Did you pay?

I had to pay, I paid by kilo. Really? Yes, up to 60 kilos was one price. After 66 kilos you paid... It was... I think.. in that time it was 1R for each kilo. It was like that because of the anaesthetic. I paid the right one, because at that time I weighed, I think I weighed 57 kilo. So it was cheaper that way. If a person was fatter they had to pay more for the anaesthetic. Oh! Really? It was like that! (laughs)

Paloma describes in detail how the operation was generally accessed through *jeitinho* practices when it was illegal, as described in Chapters 5 and 6, particularly using one's contacts and social networks. For Paloma it involved a long journey to a city in Matto Grosso do Sul, a state in the Mid-Western region of Brazil. Paloma's description also highlights how her weight was important in accessing the operation. The material body as object is therefore present in this narrative, where the weight/type of your body influences the process of getting sterilisation.

Several participants also talk about how difficult their experiences of the actual operation were. As mentioned above, and in contrast to the more common sterilisation 'at birth,' Sara (47 *parda*) was sterilised separately after the early birth of her daughter:

*It was horrible. Really horrible, oh, really? Why? Because I paid, and I thought it was a clinic. It was there in Niteroi...Mhm I went to the place, it all looked well (bonito), then we went behind the building, to a hospital in there. They said sorry for doing the intervention, and... it was just a big wardrobe! (gestures: small space). **Mhm.** So then, the doctor arrived at night, and it was like this: to do 6 women at once. You know? **Mm** Most had a baby... In my case, by then, I already had the second to be tied, **Mhm.** And he did his work. He did it on one, he was doing the birth of one, while another was in the other room already open and empty (*esviada*). I was already being prepared, and there was another already there waiting. All at the same time (shakes head) **Ah..** [...] They didn't have the structure in the hospital, if anything had happened... You know?*

The illegal nature of the sterilisation is highlighted in Sara's description of her experience of sterilisation, particularly by the 'backstreet' type characterisation of lack of safe facilities, hidden behind and contrasted with the normal clinic. She is in the same, risky position as women who are terminating pregnancies. The lack of power and control is emphasised again, as the women's bodies are depicted as objects, vulnerable and opened-up. Instead of personalised care, they are treated as though they are in a factory. This description highlights how being sterilised 'at the time of birth' is safer, as it happens like a routine caesarean birth in a hospital with regular attendance, care and facilities.

In summary, participants' who described negative experiences of sterilisation often mention other people and the law as interfering with their ability to

access the operation. Opposition from intimate partners caused varying levels of obstruction and difficulty for participants, but all described how they managed to overcome this challenge through personal determination and resourcefulness. More participants described experiencing unwanted interference from their doctors, generally highlighting their own lack of control. The doctors were shown as having the power to enforce their own decisions about the participants' lives and bodies. Participants also described employing *jeitinho* practices in order to navigate the difficult health system and ambiguous rules. Those who described negative experiences of the operation itself again highlighted their lack of power and control, particularly over their own bodies. Before the law changed, sterilisation 'at the time of birth' can be seen to be safer than having it performed separately, as it generally takes place with more normal hospital facilities and a regular medical team. Ultimately, accounts of accessing sterilisation before the law describe a complex choreography of both personal agency and limits to autonomy. While this process culminated in sterilisation for all of these women, in comparison to the positive accounts of the operation above, it occurred in far from ideal circumstances.

7.2.3 Summary

The ambiguous legal status of sterilisation, alongside the provisions in the Brazilian Medical Code enabling doctors to perform the operation in certain circumstances, clearly shaped the conditions that participants faced when attempting to access the operation. All of those who had positive experiences of sterilisation before the law had supportive partners and doctors and were sterilised at the time of birth (except Leni, who was still sterilised along with another operation). The willingness of doctors, alongside women's resourcefulness and resources, enable them to by-pass the law. Other

participants talk about experiencing varying and multiple obstacles, including: partner opposition, lack of finances or contacts, uncooperative doctors or lack of healthcare facilities or safe procedures.

However, whether participants describe their experiences as positive or negative, and despite significant variation in effort and ease, each of these women managed to access sterilisation successfully before it was legalised. Furthermore, the majority of these accounts position women as actively pursuing sterilisation, similar to the negative accounts of the health system (Chapter 5) and the *jeitinho* accounts of accessing reversible contraception (Chapter 6).

Cussins' concept of 'ontological choreography' (see Chapter 2) is useful for conceptualising the relationship between agency and objectification in these accounts. In this research, a participant objectifies her fertility "so that she passes through a number of places which promise to bring about desired changes in her identity" (Cussins 1996: 600). Accounts on accessing sterilisation demonstrate how women can manifest agency and enact their subjectivity through their objectification. The process of accessing sterilisation generally required a high personal investment from these women - financially, emotionally and in terms of their long-range desires for their lives (Cussins 1996, 576).

For those who had positive experiences of this process, their active pursuit of, or 'fight for,' their goal entailed objectification. However, they encountered no significant barriers or incompatibility with the process, so there was no rupture between the long-range self and the entities deployed in objectifying the participant (Cussins 1996, 599). In contrast, the women

who described negative accounts of accessing sterilisation also underwent objectification, but their accounts demonstrate when objectification is antithetical to personhood, as they did experience a rupture at one or more stages in the process (e.g. doctors, bureaucracy or facilities of the health system). The interplay between agency, objectification and limits to autonomy will be addressed further in the following subsections.

These accounts of accessing sterilisation are in accord with the literature in Brazil, as they describe paying, using contacts with doctors, and consciously manipulating official medical recommendations to obtain the operation.

Jeitinho practices are therefore crucial in the majority of participants' sterilisation accounts. Furthermore, these narratives indicate how doctors use their own criteria and judgements on who should be sterilised and when. In addition, the difference between the positive and negative accounts appears to extend wider social inequalities, as most of the women who identified as white are within the former group. This further confirms the research demonstrating the disparity in health between white and black populations, as well as the racism experienced by women of colour within the health system in Brazil (Leal, Gama et al. 2005).

7.3 Sterilisation After Legalisation: Continuing Illegality and the Caesarean

The 1996 legalisation of sterilisation aimed to open access to the operation on the public health system in 1997. Adults who were older than 25, or had at least two children would qualify for the operation, if they had fulfilled three main requirements: written consent of their spouse; attended a family planning course; and waited the required period between asking for the

operation and having it. In 1999, postpartum operations were banned in order to prevent unregulated sterilisations occurring alongside caesareans (see Chapter 1). This section of Chapter 7 will illustrate how the law change was in fact not as significant as one might expect. For example, the issue of postpartum sterilisation is clearly still a major focus for the majority of participants who were sterilised after the law. In addition, participants' accounts of the SUS in Chapter 5 are particularly important to bear in mind for the following accounts, as the context of the health system can also be seen to directly affect women' experiences of sterilisation.

7.3.1 Positive Accounts: Continuing *Jeitinho* Practices

In contrast to the roughly even split between positive and negative experiences that participants described having before the law changed, just two of the seven participants talked about having positive experiences of sterilisation after the law changed. Both participants were sterilised postpartum, often mentioning the "suffering" on the public health system that they wanted to avoid. Regiane (44 *branca*) describes why she paid one month's full salary to be sterilised in 1997 along with the birth of her third child:

So I took advantage [aproveitei – enjoy] of this [birthing] problem and tied myself, you know? Mm. I took advantage to have one thing along with another [...] As I am already going to do caesarean, I'm going to open up the stomach, so I'm going to really operate then, right? Mhm. Do the cut too, right?

Regiane uses the phrase 'take advantage,' similar to several participants who were sterilised before the law, such as Leni (above) who was sterilised in the late 1970s. The ability to 'take advantage' of the situation seems to follow the

logic of the *jeitinho* in the accounts in this research (Levine 1997). This narrative also focuses on the body itself, as the aim here is to avoid the suffering inherently involved in surgeries. The body as vulnerable object is emphasised, as it is “opened,” “tied” and “cut.” This positive account also highlights the particular technological objectification that women pursue with a post-partum sterilisation, alongside the fact that it is clearly desired and evaluated positively (Cussins 1996).

The only other participant who described having positive experiences of sterilisation after the law, Rosa (28 *morena*), also had a postpartum operation, despite the fact that she did not have a history of multiple caesareans. Rosa was sterilised six months before the time of the interview. When asked if she paid, she started to say that she did but then whispers:

‘I paid for the surger..., no (lowers voice and leans in), I actually did the surgery here in [...]. Mhm. I __ (too quiet) Sorry? I didn’t pay Mm [...] All of my births were here. Because they ah, only, ah ah, only do the sterilisation if you have already have had caesareans. The normal [vaginal birth] you can only do it [sterilisation] 6 months after the birth. (Whispers quietly:) Who doesn’t want it at the time of birth? The mother is already suffering at the time of birth, so to have to return 6 months after to do a sterilisation? [shakes head] That’s very difficult, right? Mhm Too much suffering.’

Rosa’s manner is one of the most obvious indications from a participant of the illicit nature of their operation. As mentioned previously, Rosa was one of the very few women of colour who described having positive experiences of the health system. As outlined in Chapter 5, her long-term contact with this higher-quality hospital led to her positive evaluation of the SUS, as well as facilitating her access to postpartum sterilisation. Despite the illegality of the procedure, her ability to draw upon *jeitinho* practices allowed her to

access her preferred means of sterilizing, particularly employing social networks and persuasion so that a familiar doctor bypassed the law for her. The main point Rosa makes is similar to Regiane's above, that having sterilisation at the time of birth is a way to avoid suffering. Both convey their dissatisfaction with the current system, as it adds unnecessary suffering and hassle in their perspective.

Rosa (28 *morena*) is the only participant sterilised after the law who attempts to describe the experience of the actual operation:

Ah it was all normal, it was so quick that I didn't even feel anything, nothing.. mhm? At the time of birth, he did the birth of my baby, at the same time he did the sterilisation, so shortly afterwards it was finished, all ready. Ah. It is such a quick thing, so that you don't even feel it, mm, you can't even explain it.

As with participants' attempts to describe embodied health issues in Chapter 6 on contraception, Rosa struggles to explain her experience of the sterilisation operation. The focus here, however, is on absence rather than discomfort. Because the operation is subsumed within the caesarean/birth event, it is not experienced as separate. The postpartum operation deliberately makes the sterilisation disappear in order to avoid further suffering and complications. This may be partly why most participants focused more on access issues rather than the actual operation itself. Rosa's description, nonetheless, is also reminiscent of participants' assessments of reversible contraception, as the good sterilisation operation is easy and no hassle, and the absence of sensation or pain is positive.

It is noteworthy that the only two participants who described positive experiences of the sterilisation process after the law changed both had postpartum operations, despite the fact that - legally - they did not qualify for them. This is similar to participants' positive experiences of sterilisation before the law changed, where all of them were performed along with another operation. Regiane paid to have it performed privately, whereas Rosa was able to use her contacts at the hospital to have it performed freely there. As described in Chapter 5, Rosa attended that clinic her whole life, had all her births there, and her mother also worked there. *Jeitinho* practices that work to bypass official rules are therefore still evident despite the legalisation of sterilisation. In this case, however, these workarounds are being used to gain a particular form of the operation that is banned (Whooley 2010). This may indicate what Mello de Souza (1996) described in her research as a particular 'reproductive culture' where the link between the two operations has become normalised due to the routine and parallel use of Caesarean and sterilisation (De Bessa 2006: 225).

7.3.2 Negative Accounts: Sterilisation Policy and Regret

Like those who had negative experiences of sterilisation before the law changed, five of the seven participants sterilised after the law described having difficult experiences. Similar to Regiane and Rosa, Juliana (40 *parda*), who was sterilised in 2004, talked about how hard it is to have the operation separately after a birth. Juliana planned to be sterilised on the public health system after her third child, but "didn't succeed." She says:

I tried to tie for the fourth daughter, and the third also, I tried to tie, mm. But then for the third I had to do the normal [vaginal] child, for after having the normal child to then do another surgery to tie me... Shit! Mm. You are already admitted, are already there, and then you even return there

afterwards when you are already better? To do it all again? You won't go, Mhm. Even more so for someone who 'runs after,' who works! Ah, mhm. There aren't the conditions. So I didn't manage it. Mhm.

Juliana is in the same position as Regiane and Rosa above; however, she does not have the financial or social network resources that they can draw upon to access the operation. For Juliana, sterilisation is not simple to access; indeed, it was not possible to achieve it after her third birth. She points out the difficulty of having sterilisation separately from birth, particularly for people of lower economic classes. This links to the description of the working life and parenthood in Chapter 4. The law that bans postpartum sterilisation does not take into account the reality of some women's lives, where the instability or precarity of daily life interferes with their access of the operation. These points were previously highlighted by research on sterilisation in Brazil by Janowitz et al. (1982). They confirmed that "the difficulties of arranging for substitute child care and for transportation will always make an interval procedure a less satisfactory alternative to postpartum procedure" (Janowitz, Covington et al. 1982: 1983). This account is also reminiscent of some participants' descriptions of how daily life interferes with their use of reversible contraception (see Chapter 6).

Two other participants hoped to be sterilised postpartum, but the unpredictable nature of birth interfered with their plans. For instance, for Ana Rita (57 *branca*), who was sterilised in 2002, her plan did not work out as she had hoped. She wanted to be sterilised for her second baby, but he was born very sick:

I planned to have the sterilisation after the birth [...] only I made a plan and God determined another. Oh? [...] Everything happened contrary to what I

wanted, I had to stay... running with him to doctor, to hospital, so that's why the sterilisation happened a bit later. [...] Because my son was born with high risk, he was born sick so the doctors didn't do the sterilisation, Mm. I think they were even afraid that maybe the child might die... Ah, A child born with respiratory problems, lack of oxygen, a problematic child, right?

The role of the doctors is mentioned here, as it is they who decided not to sterilise her as she had planned. This decision seems to make sense to Ana Rita, perhaps considering the strong family ideal of having two children. This seems to imply that there was a risk that Ana Rita might regret being sterilised, which is an issue raised in more detail in accounts below. However, instead of focusing on the doctors, the illness of her son is highlighted, as the responsibility of parenthood is prioritised over the sterilisation. Sterilisation is again not separated from the reproductive process. These narratives indicate an element of acceptance that what happened was out of their control, thus contrasting with the negative accounts of sterilisation access before legalisation, which often involved explicit or implicit accusations of blame.

As is evident in Ana Rita's extract, doctors still play a significant role for some participants who were sterilised since the law changed. Letícia (40 *parda*), for instance, was sterilised for the second time in 2001 in a military hospital, because it did not work when she had it done for her third birth. In contrast to Vera above, she does not blame the doctor for this, but does focus on doctor interaction for her second sterilisation:

So when I got pregnant, I went there to have it, and I said to the doctor: "Cut, because I don't want to have more!" Then he cut, and said: "You don't have to return again, no," I said: "I don't want to return, no!"[...] What did you think about it?

Everyone, family, partner, thought that it was the right time, because it was already the fourth child. But the medical team also, well... they said "you are still very young..." [wags finger exaggerated] (then shakes head, rolls eyes)

How old were you then?

I don't remember, I'm not sure if I was 36 maybe [...] So then he said:

"there's no return, later you might want to have another child," I said

"You're crazy! I don't want to have more children!" (laughs) I liked the team (smiling, nodding).

The concern over sterilisation regret that was raised by the inquiry and one of the reasons that led to legalisation of the operation, is evident in Leticia's account. This is a new element of the sterilisation accounts, as regret is not mentioned in any of the negative accounts from before the law. Only one participant above, Beatriz, mentioned that she was not happy right after the operation, probably because she describes her doctor pushing her to sterilise. But none of the HCPs were worried about regret or mentioned it as a reason not to sterilise. Here Letícia describes how the medical staff were supportive but still warned her about the potential for regret and checked her commitment.

In this account, the doctors seem to be a potential obstacle, but they did not actually interfere with her desire to be sterilised. The participant exaggerates and portrays their attitude quite comically, perhaps using humour as way to convey the absurdity of the situation - questioning her commitment for her second sterilisation attempt and already with four children. The tone of this humorous narrative contrasts with the negative accounts of sterilisation access above and those on accessing healthcare in general. In contrast, Juliana (40 *parda*), who was not able to return for the operation after her third baby, tried to negotiate with her doctor to be sterilised for her fourth "at the time of birth" and failed:

Then I got pregnant with her, I did a caesarean, mm. With the caesarean open, with the stomach all open I then asked the doctor to rip out (/tie – arrancar) everything, mhm. I said: “rip it out! You can rip it out, you won't make a mistake no, rip out the uterus, rip out the ovaries, rip out the whole fucking lot.” He didn't want to tie. Why? Because I had to do a [family] planning [course] before, because I might regret it. Ah. I said: “Man, I already have four children, you [polite, senhor] think I'm going to regret not having more?! Being tied?!”

Juliana takes a typically (for her) strong stance in relation to the doctor in this narrative, while also using the polite form of address, and is very clear about her desire to be sterilised. Although the doctor's voice is not depicted at all, he still retains a position of power, raising the issue of regret again and refusing to sterilise her according to the law.

As this account shows, even having a history of multiple caesareans does not guarantee access to post-partum sterilisation for some women. In contrast with Regiane, Rosa and Letícia, in this case Juliana did not have the money or the connections to arrange to be sterilised at the time of birth. She described how she moves around a lot and does not like to live in the same place for too long, and also how she attended many different clinics and hospitals throughout her life. Juliana's sterilisation narrative was complex and lengthy, and taken all together it provides an idea of the difficulties women can face when accessing the operation:

So you tried... three times?! And I only succeeded on the fifth! And even then, at the time there open on the caesarean table, the doctor said, “ I think I'm not going to tie you...” Oh! I said “you're crazy, I already have five! How can I have more? For the love of God, enough! I'm going to put it all on your bill.” He, “ ah but you will regret it,” “I will not regret it no. Imagine

taking care of five little dolls? No, that's fine, I don't want more no." So then he tied.

Even though Juliana had attended the family planning course, had multiple caesareans and arranged for the sterilisation beforehand, she still had to negotiate with the doctor in the middle of the surgery. Both Letícia and Juliana must convince the doctors of their commitment to their decision, using quite strong language and displays of emotion. Both highlight what they perceive as the absurdity of the doctors' position in warning them about regret.

Despite the legal requirements that emphasise the need to avoid sterilisation regret, these participants present the doctors' questions as another type of obstacle that must be overcome in order to achieve sterilisation. Still, the need to demonstrate a strong desire for and certainty about sterilisation is similar to participants' accounts from before legalisation. This resemblance would seem to indicate that a concern with regret was already present before, and simply clarified and codified by the law. Furthermore, this discourse on sterilisation regret does not reflect actual rates of regret in Brazil. As mentioned in Chapter 1, previous research on sterilisation regret appeared to be somewhat contradictory at first, yet overall recent research indicates low levels of sterilisation regret (Potter, I.H.O. Perpetuo et al. 2003, Nicolau, Moraes et al. 2011).

Additionally, there are parallels between participants' talk about their negotiations with doctors before and after the law on sterilisation changed. Instead of assuming their right to sterilisation, participants still describe how they have to persuade the doctor to do the operation. Nevertheless, there

appears to be less direct interference and control after the legislation than before. Doctors are not depicted as tricking participants or forcing their decision before the operation. Still, doctors have more control if the birth is risky, or the participants want to be sterilised 'at the time of birth.' Rosa and Leticia's family doctors, at good-quality hospitals, agreed to sterilise them at birth, whereas the unfamiliar doctor on the public health system did not agree to sterilise Juliana. Participants who can pay have more power to bypass all the obstacles and 'suffering' faced by the poorer women when accessing sterilisation.

Finishing off the narrative of her experience of sterilisation, Juliana explicitly discusses the issue of class and access to sterilisation raised in the previous paragraph in further detail. Instead of focusing on the role of the doctor, Juliana describes the steps required by law for those accessing the operation on the public health system, particularly attending the family planning course:

So that's where I had [lit. did] my son, so then I did all of the Planning correctly, all 9 months, so when the caesarean day arrives I can tie. Because if not, my daughter, I was risking it to have another three children!

What do you have to do for the Planning?

*Nowadays, if you don't have money to tie privately, you have to do a planning [course], in every public hospital. **And it is...?** Planning is a joke! I'll tell you like this; it's a piece of paper that the doctor goes there every month to sign. This is Planning. I was also saying: "Damn!, what Planning is this that I have to face, to overcome?" **Mhm?** It's a piece of paper, with authorisation from your doctor, that says you've done your pre-natal, so that you can do the tie. I only got this because I was there with HIV, if not I would not have succeeded, even though I already had five children on my back [Responsible for/burden].*

So you got it for the fifth?

*Just the last one. I wanted to tie earlier, but I was young, **mm**. Nowadays they have this; if you are young, depending on the quantity of children that*

*you have, they don't tie you... on the Public. Private, if you have only one you go there and they tie you. But that way you have to have cash in the bag, **mm**. This, my daughter, the poor don't have.*

Juliana's account highlights how socio-economic factors clearly affect access to sterilisation. The law makes sterilisation harder to access for more vulnerable women or those who do not have the money. This depiction of the family planning course is very negative compared to that described by participants in Chapter 6. There the clinic contraception courses were viewed as very helpful and even empowering. In the context of accessing sterilisation, it is perceived as an unnecessary obstacle to achieving something they have usually already decided. Similar to the discourse on regret, this discourse and the resulting family planning course appear to highlight a lack of trust in women as decision-makers (Beynon-Jones 2009).

Finally, one other sterilisation account focuses on the participants' experience of aftercare and the inadequate conditions on the SUS. When asked if she had any positive or negative experiences of the SUS, Regina (30 *morena*), describes the 'suffering' she experienced when she was sterilised in 2011:

Yes I did have a bad one (lowers voice) [...] I left the hospital early because I was in in such a filthy state, that I would have gotten more ill from the hospital, than from staying at my home [...]

Oh, why without the official discharge?

*I operated, I did the surgery. I had to stay for at least 70 hours in the hospital, **mm** [...]. But the doctors were so horrible, I was feeling a lot of pain **Oh**, and I wasn't being medicated, it was so dirty, so I left, without being discharged **Mm**. I, well, I was left without attendance/care.*

Regina's description of the aftercare that she experienced after her sterilisation is similar to the negative accounts of the health system that focused on lack of facilities. These accounts emphasise that the individual was ignored, left in pain and in unclean or unacceptable conditions. This account highlights another stage in the process of sterilisation that can lead a woman to experience objectification negatively, despite her active pursuit of the operation.

Participants who describe negative experiences when being sterilised after the law talk about the unpredictability of reproductive events that interfere with their plans. Sterilisation is thus still understood or experienced as being closely linked to births. Other women talk about the interference of doctors and the persuasive strategies that they must use. Still other participants talk about how the law increases the obstacles that poorer women, in particular, must face. These sterilisation accounts demonstrate that illegality, as well as ambiguity and confusion over the law and policy, continued despite legalisation of the operation.

7.3.3 Summary

Since the legalisation of sterilisation, the operation is still difficult to access for most participants; the law has actually introduced new obstacles to the operation, particularly affecting more vulnerable groups of women. Sterilisation is still closely linked with the reproductive process and now there is more focus on whether the operation is postpartum or separate from the birth. The law appears to have formalised a discourse on regret, as there is no explicit reference to regret in the sterilisation accounts before the law. Negative accounts before legalisation usually involve more direct

interference from HCPs preventing women from being sterilised. After the law, negative accounts often include a focus on negotiations with a doctor who raises the possibility of regret as either a warning or an attempt to dissuade participants from being sterilised.

The characteristics of the good sterilisation process are similar to that before the law, consisting of a scheduled postpartum operation, doctor and partner support, and the ability to pay or use contacts to access it for free. Difficult sterilisation experiences involve obstacles to the operation, including unpredictable reproductive events, doctor interference and new legal restrictions such as the required contraception course. Most participants' sterilisation accounts still focus on their negotiations with doctors, however the negative accounts demonstrate less direct interference compared to before the law. HCPs still retain control, however, particularly in the cases of postpartum operations and if a birth is risky. Legalisation introduced some changes into the process of accessing sterilisation, but it is still complicated for most and the influence of socio-economic factors and resulting health-inequalities persist.

7.4 Planning to Sterilise: Ambiguity in Policy and Practice

At the time of these interviews, the law on sterilisation had not changed. However, although the signature of the partner was still required by law, several healthcare professionals told me that this was usually not enforced in practice. All but one of the nine participants who were planning to be sterilised at the time of the interview were, to various degrees, confused about how to access the operation. Each woman also talked about how difficult and frustrating the process was. Most had already wanted to be

sterilised or even tried to before, and postpartum operations were still a concern for the majority of women. Similar to the accounts of women who were already sterilised, these sterilisation narratives mostly include discussion of *jeitinho* strategies and issues such as misinformation, interference from doctors and problems with bureaucracy.

7.4.1. Ways to Access Sterilisation: SUS versus Private

Four of the nine women had either already organised their sterilisations or were fairly certain of how they would access it at the time of the interview. The first of these participants also talked about the role of her partner and health in her sterilisation account. Monica (34 *preta*) wanted to be sterilised fourteen years previously, but her husband wanted another child and would not sign the consent form. She argued with him about it in the intervening years, but could never get it:

Because my husband still wanted to have another child. And for me to operate myself, he had to sign (consent). So because he wasn't in agreement I didn't succeed in operating, mm. Now that fourteen years have passed he decided it is time to operate, mhm. He finally knows that children... 'one child created is work doubled,' isn't it?

The legalisation of sterilisation made it harder for Monica to access the operation, as it made the consent of the partner a requirement. This was often an informal practice from before the law was introduced, but it was possible to by-pass it more easily when it was not a legal requirement. The law therefore reinforced patriarchal gender relations by legally codifying a previously generalized practice. Although the spouse's signature is still required by law, perhaps Monica was unaware that it was unofficially not needed in practice, demonstrating a further example of the confusion and

misinformation around sterilisation access. Monica also stopped taking the pill the week before, because of a history of cancer in her family. She said that her doctor advised her to take this course of action and also reassured her that it would make it easier for her to access the operation. Her long-term family attendance at this good clinic appears to have influenced this easier access to sterilisation.

Similar to Monica, three other participants had already started to organise their sterilisation and were more certain than the rest that they can access the operation. Just one woman, Vasti was already prepared to do it on the public health system, and seemed to be the only participant who was clear on how to access the operation this way. The other two were planning to sterilise privately, and seemed more certain about how to do it that way than on the SUS. Vasti (36 *branca*) describes how she organised access to sterilisation on the SUS thus:

I wanted to free myself from this responsibility to be stuck taking (the pill), but I am very afraid, mm. I have even done all of the family planning at 'X', I even have the card. My doctor encouraged and helped me. It was complicated, but I did it all. As soon as I want to tie I go there and they will do give the procedure and do the process, mhm. But I am afraid to tie.

Vasti was the only participant who talked about how her religious beliefs and her mother's opinion in particular, influenced her attitude to sterilisation negatively. This dynamic is different from most other participants, whose female family members generally assist with the sterilisation process. Similar to Monica above, and to most other white participants, Vasti's good experiences of the SUS and contact with a helpful doctor facilitated her access to sterilisation.

Contrasting with Vasti, Camila (23 *morena*), was determined to sterilise and had saved and already booked to have her postpartum sterilisation privately. Similar to Regiane in section 7.3 above, she decided to pay for it privately so that she could avoid the 'suffering' of the SUS, as she had previous negative experiences on the health system. When asked if she was going to do a family planning course, she replied:

You have to do that when it is the government, you... you have to when... But I'm not sure about the SUS way, mm. I already went and spoke to the doctor that tied my daughter... that did the caesarean for my daughter, mhm. So with him I'm going to do four consultations with a psychologist, because it is two before and two after, after 45 days after the caesarean.

Camila does not have a history of multiple caesareans so she legally does not qualify for a post-partum sterilisation. She does, however, have the financial resources to pay for the operation. Her account therefore provides an example of a way to access sterilisation through a private health clinic. The concern with regret and possible psychological ramifications that was evident in the previous section is still present, but here it takes the form of counselling sessions instead of the need to attend a full family planning course.

The third participant who had already started to organise her sterilisation, Sofia (22 *negra*), had booked an appointment at a private clinic and seemed likely to access it this way, although she had not fully confirmed it yet. Sofia was pregnant with her second child, and had what she describes as a traumatic birth for her first child when she was 18 years old. She tried to sterilise two years later: "I researched online how to do it, got the money,

booked an appointment and all.” The doctor, however, persuaded her not to sterilise because she was “too young and may regret it” and suggested that she see a psychologist instead. At the time of the interview, she was determined to sterilise as she was not happy about her unplanned pregnancy. When asked about the family planning course, Sofia replies:

*I don't know because I am... I still need to see about this, **mhm**. I went with my aunt to her clinic last week and they booked me in for next week for a consultation to know about all the procedures, the cost, these things, **mm**. So I don't know, they must have them, probably, some talks and meetings and the like.*

***Ah so you want to do it privately? Not on the public system?** Preferably public, but I don't know if it is possible because I have not informed myself. Because what I was knowing until now, that you have to have three children to do it on the public system, or something like that. But I don't know, **mm**. Who passed me this information was not a doctor, it was a nurse who was talking to me forcefully. But I will see what they say at my aunt's clinic next week. I have to sterilise this time no matter what happens, I'm never going through that again.*

Sofia's account suggests she will be paying to access sterilisation privately. She did not know about the legal 'two child' requirement for the operation. It seems that she was perhaps deliberately misinformed or possibly received criticism from the nurse. To bypass the uncertainty and unreliability of the SUS, she was able to contact a suitable private clinic through her aunt. This again illustrates how social networks can still be used to provide access to sterilisation. Sofia also did not know about the requirement to do a family planning course on the SUS, a point that is discussed by the following participants below.

These four participants who are more organised or certain of their access to sterilisation were able to draw on different types of resources to access the

operation. These accounts are similar to earlier sterilisation narratives in that they draw on *jeitinho* practices to bypass rules or deal with confusion around accessing the operation. There still appears to be uncertainty about, and obstacles to, accessing the operation on the SUS. It appears as though the two participants with familiar doctors and good experiences of the SUS would probably achieve sterilisation on the public health system relatively easily. In contrast, the two younger women of colour, who both had difficult experiences of birth and the health system, were determined to pay for the operation privately so that they could be certain to achieve it.

7.4.2 Barriers to Accessing Sterilisation

Some of the confusion that Sofia demonstrated about the sterilisation law and policy is evident in more detail in the remaining participants' accounts. These narratives focus on negotiating with doctors, accessing the family planning course and dealing with bureaucracy issues. Two participants had made initial inquiries into accessing sterilisation, and both accounts focus on the influence of the doctor in accessing postpartum operations. Lara (27 *indígena*) made it clear that she did not have the resources to pay for sterilisation privately. When asked about how she will access the operation and about the the family planning course, Lara replied:

*No no I haven't done it, because I talked with the doctor there in the Family Clinic near where I live, and she said that because I had already done two caesareans she could give me a recommendation, **mhm**. [...] but she made it very clear that it depends on the obstetrician, if he will do it or not. **Why?** I don't know, I don't really understand! (laughs)*

How do you feel about this?

Ah I think it is a thing that if you want to do it it you have the right to do it! Because I am a mother, I already have two children and am now having a third. I don't understand why I cannot do it! This is what I said to her.

Do you want to do it at the time of birth?

Everyone has it like that, during the birth, mm. And as I was already thinking about doing a cesarean I would like to yes [...] So as it is already all open {points to stomach}, better to do it all together.

Lara's account provides an example of both the confusion around sterilisation but also a possible way to access it on SUS. Again, it is an understanding and familiar doctor who provides the recommendation, although it is not certain she will achieve it. With a history of multiple caesareans, Lara should legally qualify for a post-partum sterilisation on the SUS. The requirement to attend the family planning course is, nonetheless, the same. Lara's indignant point about a woman's right to sterilisation is linked to the discussion on reproductive rights in Chapter 8. Her reasoning is clearly focused on the family ideal described in Chapter 4, as well as the two-child restriction codified by the sterilisation law. Her point about having both operations together is also similar to narratives on postpartum sterilisation above.

Luana (31 *preta*) has also recently asked about being sterilised postpartum, but did not have the same support from her doctor:

The doctor that accompanies me said that we have to do it after the birth, because it is illegal, mm [...]. I'll have to see what is the best [...] I wanted to do it with the birth, but he told me that you have to be careful, it's a thing that, "ah you have to search for it on private," mhm. So I'll have to see.

Although Luana's doctor did not help her to access sterilisation directly, he advised her both how to access it and on the need to be careful about it. The fact that it is illegal was not stopping her, it was just another obstacle that she must overcome to access it. These accounts give examples of how to bypass the law, as well as the fact that the confusion and multiple ways of accessing

sterilisation still exists. Clearly, the banning of postpartum sterilisations has not changed the preference for and reproductive culture encouraging this way of sterilizing.

Two participants focus on the practical difficulty of accessing the family planning course required to sterilise. Julia (23 *negra*), wanted to sterilise after her first child but she did not have the money to do it privately. Now she is pregnant with her second child and wants to sterilise but is unsure how to do it. "I didn't know about this family planning. The doctor just told me about it now, that to do the tie you need to do the family planning. I'm not sure how I can do it, it's not easy." Aside from confusion or lack of information, another participant pointed out accessibility issues with the course. When asked about the family planning course, Livia (37 *preta*) said:

I'll have to see about this, now I am working I can only do it after I leave work, you know? Mm, I leave work at 4pm. If they have it on Saturdays for me that would be good. In that case I could do it until 2pm by day to compensate for the weekday that I cannot do. This would be good if they have it on Saturday for the mothers that work, so then you cannot miss, mm. If you keep missing too much then the boss (patrão) fires you, puts another in your place fast, ah mm. So there are no... they don't have the conditions (não tem condições).

I see. Do you have to do the course for it?

I don't know, the doctor didn't explain anything to me. I'll have to see. He will have to pass this information to me... the Family Clinic said that that you have to do it, but I'm not going to do pre-natal there, I'll do it here, mhm. If they have it there on Saturday and I'm doing it here but they send me there, I'll do it there. Here by the time I finish work they don't have it anymore, it's already practically finished, oh. I don't have a health plan you know? Ah yes. My health plan is this public hospital here, so you have to rely on luck. Luck? You have to count on luck, if not, you don't get it (consegue).

Livia's point reinforces the difficulty of doing the family planning course for working mothers. Her discussion links back to the point Juliana made about her inability to attend the course and the difficulty of life conditions for some mothers outlined in Chapter 4. This account also highlights the confusion, inadequacy and unreliability of the public health system discussed in Chapter 5.

The two final participants in this section both attempted to obtain a sterilisation before, but were unsuccessful. These accounts illustrate further confusion or misinformation, as well as HCP interference. Livia (37 *preta*), who discusses the difficulty of accessing the family planning course above in detail, wanted to sterilise after her first child but she did not have the money. She also tried to sterilise after her second child but "the doctor said that I would need to have at least one more though so I couldn't. Now that I have this one we will run after to try to tie." Livia ended up having three children instead of her initial plan, and accounted for this in terms of a lack of money, and confusion or misinformation about the rules regarding sterilisation. Edila (27 *negra*) also tried to sterilise before unsuccessfully. She focuses on HCP interference too, but adds a further concern with bureaucracy:

She [doctor] said for the third: "after three months I will be tying anyway there in the Family Clinic, where I do the pre-natal. [...] So you can do it, right, the sterilisation." But until today she didn't tie, nothing! It doesn't give satisfaction. It meant I had to do so much for this, even the family planning, the card registration of SUS, I did it all, but nothing!

For her, the fourth, because of this attempt to abort her she was born at seven months, Ah. So I couldn't go there to be tied, no? No. There they don't tie without children, it's only if you are pregnant.

This time I already did the planning, but it's still difficult, you know? Mm. It's good when the doctor helps. Imposes, "no, you go there, yes, do these exams, go to this place and then this." Mhm. It's like an IQ test for who get it [...] I'm going to try to see if I can achieve it. It's just luck!

Edila's account illustrates how both interference from a doctor as well as bureaucracy issues still compound barriers to accessing sterilisation, thus linking with general experiences of SUS as discussed in Chapter 5. There appears to be continuing confusion over the law, as she does not seem to know that it is possible to be sterilised separately from a birth. Edila's frustration with the bureaucratic hoops that she must confront highlights another similarity with Cussins' (1996) ontological choreography concept, as Cussins describes how objectification can take the form of the bureaucratization of a patient (1996: 596-97). In Edila's case her engagement with this process did not lead to her desired outcome, and so the objectification is experienced as in opposition to her agency.

7.4.3 Summary

Overall, the accounts of women who were planning to obtain a sterilisation at the time of the interviews illustrate how the issues created by the unrealistic or unsuitable law were still present. These barriers were also compounded by wider systemic issues within the health system. Most of these women were actively pursuing sterilisation or just starting the process. They were strategically assessing, researching and deciding how to engage with this process, and drawing on their resources to make the process easier. Participants were still using *jeitinho* practices when attempting to access sterilisation, including negotiating with doctors, paying privately, and using social networks. Similar to women's experiences before and after legalisation

of the operation, these experiences are still shaped by social difference and further reinforce health and wider inequalities.

7.5 Conclusion

This chapter illustrates the mixed effects of the legalisation and changing policies on sterilisation in Brazil. The comparison of women's experiences accessing the operation before and after it was legalised highlights the institutional barriers that can impede policy changes in practice, despite the significant social and healthcare movements in favour of increasing access to sterilisation. The effects of the historical, legal and procedural ambiguity are thus still evident today around sterilisation. It still causes much uncertainty and is difficult to access for most; and, it is still closely associated with the process of birth. The inefficiency of the health system can also obstruct access for participants, even those who are willing to follow the law. The corresponding *jeitinho* practices are then necessary for most women who want to access it. In this context, doctor–patient relationships are complex, uncertain and involve various ways of carefully negotiating power dynamics. Health inequalities are still present, as these experiences are generally shaped by class, race and gender.

The ambiguity, inefficiency, and this specific 'reproductive culture,' opens a flexible space for women and doctors to bend rules or act beyond the law, although this also leads to much uncertainty and often frustration for the women in particular. The analysis illustrates how women pursue objectification through the medical institution and sterilisation operation. Cussin's (1996) concept of ontological choreography facilitates the differentiation between objectification as allowing the creation or fulfilment

of an individual's self, and objectification that is experienced in opposition to a person's agency. These findings therefore avoid binary conceptualisations of agency, thus avoiding reductive approaches to the agency-structure debates on sterilisation in Brazil.

CHAPTER 8. STERILISATION DECISION AND DISCOURSES

8.1 Introduction

This chapter begins by examining the reasons participants gave for their decision to sterilise. In these accounts, sterilisation is depicted as a way of managing living conditions, family relationships and as a means to achieve personal goals. The second section explores how women draw on two different reproductive discourses when discussing the right to sterilisation. The first includes elements of a neo-Malthusian discourse on population control, but these accounts are tempered by emphasis on the structural violence of precarious living conditions. The second discourse focuses on the notion of reproductive rights, where participants' focus on an individual's right to choose. The analysis demonstrates how the discourse of the 'fighter' works within this context, and how these discourses can be mixed together to differentiate between self, other and society in general. Finally, women's evaluations of the results of their sterilisation are outlined. When sterilisation is discussed at this individual level, women emphasise that sterilisation increases their own wellbeing, particularly by reducing stress and increasing sexual pleasure.

8.2 Deciding to Sterilise: Difficulty of life 'Condições' and Birth Experiences

Participants often mentioned preliminary motivators that led them to the decision to sterilise, such as their negative experiences of contraception (Chapter 6). When asked directly why they decided to sterilise, however, 29 of the 35 participants talked about how they did not want more children

because of their lack of means, or life *'condições'* (conditions). The remaining six participants' accounts of their decision to sterilise due to difficult pregnancy experiences will also be discussed briefly below.

Most participants describe the difficulty and cost of raising children, especially for those surviving in precarious living conditions. When asked why they decided to sterilise, the majority of the younger participants, such as Luana (31 *parda*), Julia (23, *negra*) and Sofia (22, *negra*), all spoke about how unhappy they were with their lives and how they did not want more than two children. Sofia referred to how she tried to be sterilised after the birth of her first baby, and was unhappy when she became pregnant with her current, second baby. She was determined to sterilise because:

If I had done it at that time I still would not regret it, mm. As I said to you, I wanted to realize this dream, I wanted to study engineering, mhm. But then as I didn't manage to do it and began to be pregnant again, it's good to sterilise right, because now I think yes, it is the time to do it. I can study when this one is older in a few years...

Sofia was one of the few participants who talked openly about how unhappy she was that becoming a mother disrupted her life plans, which involved attending university and attaining a better standard of living. This negative perspective on motherhood was quite unusual, given the wider discourse on the importance of motherhood in Brazil (Chapter 4). Julia's account similarly focused on her own life goals, and she initially appeared frustrated by the question:

Because I don't have the conditions to have more children! you know? I only wanted the two, I don't want to have more children! Mm I see. You have enough? That's it! (sighs). I want to tie myself. I have the goal to go do the

course, to return to study, you know? *Mhm*.[...] so that I can have a more stable and better life.

For Julia, the sterilisation operation also provided the means to gain a personal dream and a better life. She did not talk about how her children made life more difficult, as Sofia did, but she emphasised her belief that limiting her births would enable her to improve her living conditions. These aspirational accounts view sterilisation as the surest way to achieve the social ideal of two children, whilst also enabling women to go beyond the traditional gendered roles of mother and the insecurity of life as a workplace *doméstica*. Sterilisation provides a means of attaining an element of control, creating stability and certainty in a life characterised by insecurity.

All of the participants who talked about using sterilisation as a means to study and improve their lives were relatively young and women of colour. This age difference may be due to the changing public discourse on women's reproductive rights, along with the increasing accessibility of the education system (Kirakosyan 2014, Becak and Cirino 2018). The notion that sterilisation provides more control and stability, particularly for women living in precarious conditions, was also raised in Dalsgaard's (2004) research on sterilisation in the Northeast of Brazil.

In contrast to these younger women, the majority of participants who talked about life conditions leading to their decision to sterilise focus more on the difficulty of life with many children. Sara (47, *parda*) describes her decision to sterilise thus:

'Because, "one, it is hard to raise (rear). Two, everything's fine. Now, three is already heavy on the purse!" You have to work, and you have to pull those children along, all alone.

Similar to accounts on parenthood in Chapter 4, the mother is again positioned as the only responsible parent, despite Sara's previous description of her caring, long-term partner. Several participants who focused on the ideal number of children as two also describe learning from previous generations about the cost of having too many children. For instance, Marcela (66 *morena*), who had three children, talks about deciding to sterilise because her 'dream' was always to have two:

*Because doesn't the woman have such a dream in her head, right?[...] **You think so?** I think so. The family of my husband are 10 siblings, **mhm**. My mother had eight, and has a brother that has eleven or twelve children. The family can happen like that, one after another, **mhm**. So he said, 'I don't want to have this no, I really don't have the conditions, my children can't be suffering no.'" So I only wanted to have two, just the pair, and finish.*

Marcela's reference to the previous generation's difficult reproductive experiences raises the historical context of high birth rates and high infant mortality, common in Brazil until contraception was introduced throughout the 1960s-1980s. Unusually, Marcela's explanation highlights her husband's desire to limit their family size, which is the opposite of most accounts that detail a partner's desire to have more children than the participant.

Diverging from participants who emphasised the financial cost or practicalities of parenting in their accounts of their decision to sterilise, others focused on the emotional aspects of childcare. Leticia (40 *parda*), who

wanted three children but had four, argues that emotional care is more important when parenting:

When did you decide to sterilise?

In my bedroom, right?! (winks and laughs) (laughs)

And why did you decide to sterilise?

*Look, how am I going to put a child in the world, a child that I don't have the conditions to rear? **Mm**. Nowadays it is very difficult right. If I had then the thought (understanding – pensamento) that I have today... I love my children, I adore them, my whole life is for my children... but I wouldn't have them, no, because the difficulty is very big, **mhm**. It's not like people think: "ah I have the conditions, I'm going to get a person to take care of them, I will give a present"... It's not that! Children don't live on presents, children live on affection and care, but today you have to work, **mm**. In the old days the mothers stayed at home more, nowadays mothers are all there working, travelling. There are some that go for five or six months without seeing their child. And the child misses them, she needs affection and dialogue, **mhm mm**. I talk a lot with my children. I give conversation, affection, I play. So I think that this is most important for the family.*

This extract assumes that basic financial stability exists, and focuses on parenting in terms of emotional care and communication. Leticia argues against what she perceives as a common idea that having the *condições* to have children means only having enough money. This perspective may be influenced by her family upbringing, as although she had 12 siblings and her mother stayed at home, her father worked in the military. This meant that they had a relatively stable life with good healthcare available for each family member. Declaring that you would not have your children over again is quite a dramatic rejection of motherhood in this pro-natalist context where the role is so significant. She does, however, make clear that she can fulfil what she believes are the correct parenting practices, but that sterilisation was an important means to maintaining this ability.

Lívia (37, *preta*), who was pregnant with her third child, also talks about both her precarious living conditions and the emotional aspects of parenthood when describing her decision to sterilise. In contrast to Letícia, however, she focuses on the emotional strain of parenthood on the mother, especially when describing her two and a half year old son:

I also don't want to have more children, no enough! Now this one (points to belly) is going to be three. I don't have the conditions no, I only live renting, I don't want more.' You have enough? I don't want more children no. Thiago is clinging to me, he's a little terrorist, you know? A what? A little terrorist! Oh! (laughs). He's impossible! Mhm. He doesn't let up! He hangs about my neck, he's fat and throws himself on us, and hurts us because he's so fat! Mm. Kids don't want to know, can't understand, but he is disturbed, the little terrorist. I don't have the patience anymore! [...] I hope this one [points to belly] is calm, the other is no game, I see. I don't have the conditions no, it's not for me, mhm. If you don't have patience, then you tie.

The conditions to have children for Lívia involve financial stability but also emotional suitability or patience. Lívia is the only participant who talks openly about how she does not enjoy or is not suited to motherhood without any kind of qualification (cf. Letícia, for example, who advanced the qualifications noted above). She talks about how she thinks her daughter is “rude, lazy and impatient,” and that her son is “annoying” and “attention-seeking.” This is a very unusual position in contrast to the majority of participants in this research and also the wider social expectations of motherhood. In this extract, sterilisation therefore becomes a solution for the emotional stress that parenting within unstable living conditions can cause.

These accounts demonstrate that most participants talked about how their living conditions influenced their decision to sterilise, particularly for those living in precarious circumstances. Participants discussed this issue in

several ways, focusing on different aspects of their experiences. Young, black women mostly spoke about aspirations to study as a means of personal fulfilment and attaining a better standard and stable life. Others talked about what they perceived as the problems of excessive reproduction and contrasted their reproductive practices with the previous generation's experiences or their own childhood experience of poverty. Some women also went into further detail about the difficulty of parenting in unstable living conditions, both practicalities and emotional.

Furthermore, a strong shared narrative can be seen in these accounts regarding the difficulty of constrained living conditions. This concept focuses on structural inequality in society, with women critiquing poverty and social insecurity. Within this discourse, sterilisation is positioned as means of managing the living conditions of the family, and allowing women to fulfil the role and manage the associated burden of motherhood. Sterilisation is a way to gain control of a life in conditions of uncertainty, or a means of preventing increased precarity, through control over one's own reproduction and body. These findings are similar Dalsgaard's research that emphasised a discourse on the responsible adjustment of fertility to a family's economy, which was also related to the necessity of funding children's schooling (Dalsgaard 2004: 17).

In contrast to those participants who focused on how their general experiences of living conditions influenced their decision to sterilise, several participants talked instead about their difficult personal experiences of reproduction. These contrasting accounts highlight how consistent the other narratives are. Four participants mentioned getting sterilised because they had difficult pregnancies or births. Paula (52 *morena*) had high blood

pressure and was told that being pregnant or giving birth would be putting her life at risk; Regiane (44 *branca*), was afraid after her first difficult birth; Ana Rita (57 *branca*) had a second difficult birth and her son had severe health problems; and Georgiane (59 *negra*) had a miscarriage and three difficult births, particularly her last one where she had to spend two months in pain in hospital, due to a severe haemorrhage, before she gave birth.

Paloma (59 *negra*) describes how she gave birth to three children and then was sterilised when she was 32 years old:

Because I didn't want any more, no [...] I got pregnant 5 times, but I only wanted a pair... Ah I see. The second daughter died, after that one died I felt very bad, I had lots of losses, but it was all normal (miscarriage)... I didn't want any more of that. [very sad]. And after that I tied, mm. I didn't want more children after my daughter died, and the others [starts to cry] I didn't want more of that feeling [points to stomach], mhm [...] If I had known that all that was going to happen like that, I wouldn't want to do it over again.

Paloma's account emphasises the suffering that can be involved in reproductive experiences, and the death of her child was clearly still a very upsetting topic. Sterilisation in this context provides relief and an end to the pain and loss involved in miscarriages.

8.2.1 Summary

A strong shared narrative of life conditions is evident in most participants' accounts. Within this context, sterilisation is a means to shape and achieve the life that they desire, for themselves and for their families. This enables them to fulfil the role of the responsible mother, as well as improve the lives of their children. Sterilisation is thus seen to reduce the stress associated with the difficulty of parenting. In contrast, several participants focus on their

difficult personal experiences of reproduction, including experiences of multiple miscarriages or abortions. For these women, sterilisation became a means to end the emotional distress and physical suffering associated with these events, and was a source of great relief.

8.3 The Right to Sterilisation: Discourses on Irr/Responsible Reproduction

Following on from the discussion of participants' decisions to sterilise, this section examines what women think about the operation more broadly. As access to sterilisation has been historically a complex and problematic issue for women in Brazil, here participants talk about who has the right to be sterilised, generally describing why they think access to the operation is important. Similar to women's accounts of the decision to sterilise above, these discussions shed new light on participants' discussions of the family in Chapter 4. The narratives in this section re-contextualize notions of motherhood and the family within the wider, competing discourses on reproduction in Brazil.

This section illustrates below how participants drew on two distinct reproductive health discourses regarding the right to sterilise, and details how they do this in different ways. The two reproductive health discourses are: the necessity of limiting irresponsible reproduction and the right of individual women to have control over their own reproduction. The first position reflects an older neo-Malthusian discourse that is linked to historical and cultural approaches to citizenship and reproductive health policy in Brazil (Fonseca Sobrinho 1993). The second position draws on the current dominant discourse on reproductive rights and gender equality. The

presence of two distinct discourses on reproduction within the one healthcare setting is similar in some respects to the findings of De Zordo's (2012) research on reproductive rights in Salvador. Her study also found the presence of both discourses based on earlier neo-Malthusian notions of population control, as well as reproductive rights for women. Still, there are clear differences in how the participants of this research frame these discussions, both within this sample and in comparison to De Zordo's findings, as will be outlined below.

8.3.1 Sterilisation as a Moral Duty: A Discourse on Irresponsible Reproduction

Neo-Malthusianism is a theory and movement that began in 1877 and was concerned with population growth. It advocates for population control programmes, particularly by the use of birth control methods such as contraception. It also identified the working class and particularly overcrowded, industrial slums as sites of moral degeneration, and is closely associated with eugenics (Petchesky 1995). When discussing the right to sterilise, half of the participants focus on what they describe as the irresponsible reproduction of poor women. These participants reflect on what they believe to be excessive reproduction, describing it as immoral and arguing that it should be curbed by the use of sterilisation, broadly reflecting a neo-Malthusian discourse on reproduction.

As described in Chapter 1, this concern with the size and characteristics of the population was evident in Brazil since the beginning of the Empire, throughout the republic and the more recent military dictatorship and democracy periods (Fonseca Sobrinho 1993). Elements of this older neo-Malthusian discourse on reproduction are evident in the following accounts

of the right to sterilise. This subsection examines three main issues in these accounts, namely the suffering of children and violence in society; “obligatory” sterilisation; and, accounts with a mixture of both neo-Malthusian and rights-based discourses. The majority of participants who drew on this discourse focused on how irresponsible reproduction led to the suffering of ‘abandoned’ children. As in Chapter 4, we see again the important role of the family and particularly the contrast between the mother and the street. The following two examples focus on this issue. When asked about the right to sterilise, Beatriz (54, *parda*) responded:

I think, seeing as the person didn't take the medicine (pill), they don't prevent and are always getting pregnant, I think it is preferable to do the tie.

[speaking more softly) There are many __ children in Brazil, in the world...

Sorry, many children?

*Abandoned. **Abandoned?** (nodding) Many children. The parents just keep having them, having them. It's good to have a child so that you can care for them. And the children, when I see children of seven or nine working, working at night, selling candy (*bala* - bullet)... Ah! (sadly shakes head), **mm**. Just the other day I saw a small boy working at 11 at night [...] selling candy. This hurts... [presses fist to heart]. So isn't it better that the parents sterilise, if you don't have the conditions to rear a child, to care for him... I think. Or prevent so that you don't have (children), right.*

She focuses on the role of the parents and the suffering that their ‘irresponsible’ behaviour causes. Sterilisation in this perspective provides a medical means to fix the social problems caused by poverty, particularly childhood poverty and underage work. The suffering of abandoned children on the street draws on the oppositional conceptualisation of the ‘mother versus street’ descriptions of the family in Chapter 4. This narrative is reminiscent of the older neo-Malthusian reproductive discourse, where family planning is seen as a moral duty. However, instead of focusing on the mother, Beatriz unusually uses non-gendered and collective terms, such as

'people' and 'parents.' She is sad when talking about this topic and she frequently whispers while discussing it, perhaps an indication of the shame or stigma/social censure associated with abandoning one's child. Beatriz' critique of irresponsible reproduction, however, is tempered by the acknowledgment of the lack of conditions that poor women must struggle with.

Beatriz' perspective is the mildest one. Most other participants who discuss the suffering of children talk about the irresponsible behaviour of the mother, as for example Bruna (57, *negra*):

*Look, because there are a lot of children thrown out [jogada], that cause pity, which causes pain, **mm**. Lots of things are done, well, from nothing, without responsibility. [...] so many children without mother, [...] stuck out in the world, thrown out (atirado – shoot), sick, suffering, mother suffering, mother crying.*

In contrast with Beatriz, Bruna makes the more common link that abandoned and suffering children are those without a mother, as opposed to a family. Motherhood is again positioned as an important role, as in Chapter 4, but from a negative perspective, where the failure to fulfil the role causes great suffering. The description of mothers as irresponsible diverges greatly from Chapter 4, where women were generally described as responsible parents in comparison with men. However, the overall framing of parenthood as a moral responsibility persists. For these participants, this perspective on careless mothers seems to be linked more closely to the discourse on the right to sterilise, as opposed to the more general discourse on the role of mothers and family. This difference may also be due to the fact that discussion of the

family in Chapter 4 generally revolved around the participants' own family or parenting practices, as opposed to society in general.

Bruna also uses stronger language such as 'thrown out,' (both terms with 'rubbish' and 'shot' connotations) and she explicitly describes the behaviour as irresponsible. She describes more plainly how the suffering of children causes pain in general for others and suffering for mothers, linking it to both families and wider societal/community levels. Sterilisation of women in this sense becomes more openly a solution for wider social ills and 'immoral' behaviour.

Other participants draw more clearly on aspects of a neo-Malthusian discourse, linking sterilisation directly to problems of violence in society. For example, Rosa (28, *morena*) talks about why she did not want more than three children:

Why sterilisation?

Just that's why, I didn't want more, mm? The world is not (ok) to have many children no [...], It's very difficult, life today [...] is very difficult. Mm...

Why is it so difficult?

Ah so much violence in the world. Ah yes. So.. the fewer children in the world, encountering violence, the better. Ah really? Ah I think so. It's a suffering! [...]. There are people (gente), people (pessoas) that keep having children, and having children, but don't have the capacity to really do the role of mother. So that is very difficult, mm. So, if everyone thought as I do, the world would not be the way it is, ah, with lots of violence, lots of children in the middle of the street, feeling bad/sick [passando mal], starving, using drugs, and the parents not even there, you know?

Rosa's account highlights a further aspect of the role of the mother, as crucial for society. The responsibilities of the mother and the consequences involved for those who fail in this role are emphasised, as their irresponsible

behaviour causes violence in the world. Drawing on the point above about the difference between the personal and wider social discourses on motherhood, Rosa explicitly makes the point that she is not in this category. This move illustrates a difference between the personal and wider social subject, as well as the importance of not being part of the irresponsible category. Rosa's account also demonstrates that there is no clear generational divide on this neo-Malthusian discourse. This discourse on sterilisation highlights the wider social context around the operation, particularly the risks and consequences involved in not being sterilised. However, although the account draws more openly on a neo-Malthusian discourse, Rosa also explicitly introduces it with a critique of the social conditions and difficulty involved in raising a family, thereby again assigning some portion of the blame to structural inequality and poverty.

Leticia (40, *parda*) also talks about the violence in society when asked about the right to sterilise:

It should be obligatory. Because I even cry when I see a child suffer [...] People that don't have conditions, two children maximum! That's already a good size.

You think it should be obligatory?

*I think so. Nowadays it's very difficult, because there is so much violence, right? **Mm.** The teenagers all there using drugs, drinking, all to be able to have brand runners. Sometimes they don't have family support, so father and mother separated... as I today am divorced... So it's not good to be [having children].*

This stronger position is more closely aligned with a neo-Malthusian reproductive rationale and eugenics discourse. Leticia adds further detail on role of the ideal family in society, as the lack of family here includes separation/divorce, a common relationship configuration described in Chapter 4, which also leads to 'immoral' and violent behaviour. However,

referring to lack of conditions and the lack of support again highlights the difficulty of surviving precarious living conditions (as well as the importance of family and social networks). Therefore, Leticia also points to the wider structural inequalities poor women face, so that it is not solely a matter of individual morals and blame. As Leticia mentioned briefly, other participants also focus more on the idea of encouraging or forcing a limit on the amount of children for poor women through sterilisation. The idea of 'obligatory' sterilisation was spoken of by most of these participants, and will therefore be discussed in detail for the remainder of this section.

Only two participants' accounts of obligatory sterilisation did not mention poverty directly, but instead focused on the family and mother-child relationships. Georgiane (59, *negra*) highlights how important it is to have family: "Many children don't have any family [...] it's no good at all as it is, so it's better to sterilise. The same as in Japan right, have a limit [...] you can only have two children." This account again draws on the concept of the family as described in Chapter 4, the ideal of two children and the danger of isolation or being without family. The majority of women who argued for obligatory sterilisations used Japan as an example, perhaps due to the historical migration of Japanese people to Brazil (Levine 1997). Vera (64, *branca*), also believes that sterilisation should be obligatory for "those mothers that don't have love for their children. They should give and enforce quotas of children, for those who are to blame, right?" These accounts are unusual as both Georiane and Vera do not refer directly to poverty or conditions, however, as the wider cultural discourse on abandoned children and poverty is so strong, it is probable that poor women are the subjects.

Three further examples of the accounts on obligatory sterilisation will be discussed here. Two of these accounts, from Regiane and Marcela, are remarkably similar in narrative form and content. Both start out with a critique of poverty and then argue for the necessity of obligatory sterilisation. They then refer to the fact that they do not fall into the category of irresponsible women, but were able to parent successfully. They finish by giving specific examples of the difficulty of parenting in poverty. Marcela (66, *morena*) talks about the difficulty of childcare when children are younger, and then concludes her narrative by saying: “Because of this there should be a law - two children and finish! It’s hard for everyone to even just get a job, right?!” Regiane (44, *branca*) ends her long narrative on sterilisation similarly:

*Many women throw them [children] out in the rubbish because they don’t have the conditions [...]. They should do it this way: third child, operate all women. **Third...** The third is enough, right? “One is not enough, two is few, three is too much!” (**Laughs**) Isn’t that the saying?! (laughs)[...] It costs too much. I at least achieved my part, but there are other families that don’t have the same luck, you know? **Mhm**. Over there [indicates favela] there is a hut, a baby boy on the breast, and she has no milk to give even, he is jealous already, it is bad.*

Regiane’s tone was initially joking but very sharp, highlighting both the fault of the mother’s as well as the government. Living next to someone who is struggling in this difficult situation, and framing it as ‘luck,’ highlights that there is no certainty and that there is the potential risk of it happening to anyone living in similar circumstances. The physicality of motherhood in conditions of poverty is emphasised, the implication being that she does not have enough food to produce milk, and also the resulting child’s jealousy that will lead to violence on the street later in life. This is a clear reference to the role of poverty and difficulty living conditions, including the failure of

the government to provide adequate sterilisation or social welfare. So although both Marcela and Regiane argue for strictly enforced sterilisation and the immorality of having many children “without the conditions,” they also both repeatedly mention the difficulty of surviving precarious living conditions and contextualise their narratives with a critique of the wider structural inequality within which the women live.

The final example from Eliane (51, *negra*), is one of the strongest positions on obligatory sterilisations, but it also includes elements of the reproductive rights discourse. The extended extract is included to demonstrate the extent to which most of these participants talked about the topic:

*Everyone has the right to sterilise, certainly, it is free will, you know? **Mm...** Because it is better than stuck avoiding in the street a load of boys that assault you, that say “o aunt, o aunt, aunt!? Give me a Real?”. “What is this one Real? Where is your mother? Go find your mother!” You know, I feel... I am incapable of treating one of them badly. I think that they are the victims... **mm**, because I never left (*largar*) one of my children on the street. I did a sterilisation so that I wouldn’t give birth in case another child came, and it is not possible to care for them and leave them abandoned on the street, or become disinterested in the child... Because this starts within the woman, it does. I think that a woman who is not interested in the child, she is interested in doing a sterilisation. **Mhm**. I think that all of these kind of women (getting angry), when they knock at the hospital (leans in) if I were a doctor, I would cut them [sterilise]! **really?** I would tie all of them! I swear it! (shakes finger) **Mhm**. I might be being a bit radical, but I think that it would be doing a good thing for these children, **mm**. I think no matter who has children, they should do it! [...]*

And when did you decide to sterilise?

*But I think that it is the right of each person, everyone knows the moment, everyone has to know their own moment. I in my moment went and made my decision and I did it, **mm**. I think that everyone should have their own choice, to see if they can (have children) or cannot...*

*I’ll tell you this one thing though... **Mhm?** These girls that go to the hospital, women that live on the street, knocking at the hospital (disgusted*

face), I would sterilise them all, I would! Really? To have a child just to leave it on the street?? (raises voice, frustration/indignation) Ah. To have (one) when you don't even have somewhere to stay?! She is going to be sacrificing the lives of children! (very angry) Mhm, mm. So I am a bit radical... (Lowers voice, sad) but I think that, for the love of the life of a human being (getting upset), of a small child, right, mm, that doesn't even have a choice or chance, right, mm, or love even, right (shaking head)... mhm mm, and the love of a child, is... (taps heart with fist, starts to cry), ah I don't know...

Eliane's account of the right to sterilise is quite an extreme position, one which she acknowledges is quite 'radical' and implying that it is not the norm. It illustrates why so many participants are in favour of forced sterilisation. Her narrative gives us an indication of the strong emotional response this topic can cause, as she displays intense anger and grief. She also circles back to the topic, demonstrating how important it is to her. This open display of emotion is quite different from the other women discussed here. The other participants are often angry and sad as well, however, it was more restrained, and conveyed and tempered by various means such as whispering (Beatriz), joking (Regiane) or body language (Rosa). Eliane's intense reaction to this topic may have been influenced by her earlier discussions about her struggles to care for her family in conditions of poverty and violence, as well as her difficulties accessing healthcare for both mental and physical illnesses and reproductive health.

Although Eliane is distressed by the street children and focuses a lot of anger and blame on the homeless women in her account, it also evokes a clear picture of what a precarious life 'without conditions,' can be like, both for the most vulnerable and also for those living alongside them. The crucial importance of a mother's love that is discussed in Chapter 4 and above, is used here to demonstrate the dehumanising horror of living in extreme

poverty, where a mother must 'sacrifice' her child instead of caring for it. This reference to poverty and inequality again reminds us of the structural violence that is frequently present in, or associated with, poor communities in Rio (Scheper-Hughes 1993, Dalsgaard 2004). Similar to the accounts above, this also tempers some of the blame that focused on the mothers in this account. Contrasting with her perspective when discussing sterilisation in the context of the collective, when asked about her individual experience with sterilisation Eliane switches from a neo-Malthusian to a 'rights' and autonomy perspective. These differences may be due to the fact that a neo-Malthusian discourse was associated with collective notions of the nation in Brazil, particularly focused on poor black women, for many years (Coutinho 1998). Whereas the reproductive rights discourse on reproduction is both more recent in Brazil and also focused conceptually on the individual and personal choice. This latter discourse will be discussed in further detail in the following section 8.3.2 below.

Finally, two following examples expand this point, further detailing how the older neo-Malthusian discourse appears alongside the more current discourse to varying extents. However, in contrast to Eliane above, both focus more on the rights of the individual overall. Linking back to the discussions of unplanned pregnancies in Chapter 6 on contraception, Luana (31, *parda*) points out that many women have "unwanted" pregnancies, and are therefore:

Practicing abortion and the like, mm. Women that have a child and don't want it, spend the whole time doing a lot of wrong things. And it is the right of... I think the person has to decide very well, so that they don't regret, right, mm, because at times there is no going back. I think that every person has to have the right to decide if they want it or not.'

Abortion is mostly illegal and far less socially acceptable than contraception or sterilisation in Brazil, and sterilisation is proposed here as a means to prevent it and other morally wrong behaviour. The older neo-Malthusian discourse on limiting unwanted reproduction, and therefore certain populations, appears more subtly in Luana's argument compared to those discussed above, and it is still framed overall as an individual's right to control their own reproduction. Edila's (27, *negra*) account of the right to sterilisation mixes both discourses more clearly, but still with an overall focus on rights. She believes that "everyone has the right to sterilisation:"

If a person wants it... I think that nobody should 'have to' [get pregnant], everyone knows what is the best for their life, right. If in Japan people can only have one child, and there they don't have beggars (mendigo), everyone has a good life. If it was like that everywhere, right, it would be good! (Laughs). And because here in Brazil we have beggars, we have poor people, I think it is because of this: the people cannot decide what they want from their life, you know? So I think that everyone has to have this right, to decide. mhm. "I don't want", don't want, don't want, gosh! Nobody is forced to it! "I want to tie and finish", and after if there is regret, the problem is hers. It was she who wanted it: "sign here the form that it is you that want it", you know? Mm. So afterwards there won't be a problem. End the chaos! People that want it, damn, it's the opinion of each individual!

Participants' accounts of the right to sterilise in this subsection draw on a neo-Malthusian discourse on reproduction. These narratives discuss collective notions of community and the nation, and refer to the suffering, violence and urban criminality that they link to poor (black) women's uncontrolled reproduction. Such mothers are considered to be irresponsible and generally blamed for behaving immorally. This subsection illustrates again the importance of the role of the mother, but from a negative point of view, where failure to fulfil the role can lead to social judgement, censure

and even provoke extreme emotional reactions in others. This context highlights, from another angle, the significance of the reproductive ideal of two children, as well as the crucial part that sterilisation can play in achieving this ideal. The prevalence of this discourse, as well as the majority opinion on the necessity of forced sterilisation, illustrates the boundaries around socially accepted reproduction and the consequences of failing to fulfil the role.

Despite the predominantly neo-Malthusian discourse in these accounts, each narrative is nonetheless situated to various degrees within a critique of poverty. Participants acknowledge and criticize the context within which these poor mothers live. This perspective reframes the matter as not merely an issue of individual morality and failure, but instead highlights how society disregards or fails poor women. This contrasts with De Zordo's findings on the same topic for instance, where healthcare professionals who drew on a neo-Malthusian discourse both perceived poor black women as victims of poverty, but also blamed the women's culture and ignorance for their irresponsible behaviour (De Zordo 2012).

The fact that each account in this subsection contains a parallel critique of the neo-Malthusian discourse woven into them is significant, as almost every woman cited a 'lack of conditions' as her reason for being sterilised. Although each participant clarifies (often in detail) why they do not fall into the category of the irresponsible mother, there is also the implication that it was a possibility for many of them, particularly considering how difficult it was to access sterilisation for most, as detailed in Chapter 7.

The final accounts demonstrate how an individual can draw on both neo-Malthusian and reproductive rights discourses on reproduction within the same narrative. The neo-Malthusian discourse is associated with collective notions of community, and poor 'other' women, while a rights-based discourse is used when referring to individuals and their ability to choose sterilisation. This latter discourse will be discussed in detail in the following subsection.

8.3.2 Sterilisation as an Individual Choice: A Discourse on Reproductive Rights

As already noted, after the decline of the dictatorship in the late 1970s, women's movements in Brazil became allied with other popular movements to end injustice and to advance democratisation and citizenship rights (*cidadania*) (Pitanguy 1991, Corrêa 2015). Feminist groups in Brazil formed just one part of a larger and diverse women's movement that aimed to create opportunities for women's political participation. The movement's focus on *cidadania* signifies the recasting of individual rights as social rights through the creation of political subjects who learn to exercise their decision-making capacity. Their emphasis on daily life needs, including reproductive and sexual rights, forms the common ground connecting the various streams within the Brazilian women's movement (Diniz, De Mello e Souza et al. 2004 [1998]).

Women's reproductive rights are integral to the political agenda of the feminist movement in Brazil. During the democratisation period in the 1980s (Stepan 1989), Brazilian feminists formulated an ethical and political understanding of reproductive rights as an essential part of *cidadania*. The demand for a 'woman's right to control her own body' along with critiques

of health and population policies and practices (including sterilisation), came to occupy an important place in public debates. Thanks to feminist movements, it became possible to think of reproduction as a sphere of social responsibility where rights were, and are, being shaped (Diniz, De Mello e Souza et al. 2004 [1998]: 38-39). As discussed previously, the new Brazilian Constitution defined family planning as a right in 1988 and SUS started to provide free contraception and family planning education. The discourse on reproductive rights steadily grew more widespread from this time, even though sterilisation was not legalised until later.

When talking about who has the right to be sterilised, just under half of participants emphasised that it is the individual's right to decide and to control her own reproduction as she desires. Isabela (67, *branca*) and Andrea (68, *branca*) for example, both argue that it "has to depend on the person" and that it is "a personal decision." These discussions highlighted women as autonomous agents who have knowledge of themselves, their life conditions and the capability to act in their best interests. The accounts of reproductive rights fall roughly into two groups. The first includes participants who were already sterilised at the time of the interview, and their accounts prioritise individual autonomy. The second consists of the women who were planning to be sterilised and while their accounts also focus on autonomy, they add a further focus on sterilisation access issues.

Most who talked about the right to sterilisation emphasised the difficulties of parenting, but those who drew on the reproductive rights discourse still framed it as an issue of individual choice. For instance, Amanda (47, *branca*) says:

*Everyone should have this right. You know about your life, you know to where you can go, mm. There are many women that suffer because they can't take contraception, these things cause a lot of harm. You don't have conditions to have a load (monte) of children, especially in a country like ours [...] everything is very expensive, everything is very difficult. Even for you to guide (orientar) your child in this difficult world, **mhm**. So I think yes, the person has to know "can I have one, can I have two." You have to have the right to opt for what you choose.*

This is a similar position to that taken in Amanda's account of her decision to sterilise. The right to sterilise is framed within a negative context, as she highlights the suffering and struggle of life in her society along with the cost of parenthood. Within this limiting context, her focus is still, nevertheless, firmly on autonomy and the individual's right to decide. In contrast with the unwanted medical intervention participants frequently described in the previous chapter, she emphasises that women have the 'authoritative knowledge' (Davis-Floyd and Sargent 1997) about their lives and reproductive aims/futures. However, in Amanda's hypothetical example above the person is deciding how many children to have, rather than refusing to have any at all. Most participants who said that "everyone" has the right to sterilise also qualified that this is only for someone who already has two or three children. Paloma (59, *negra*) says that "everyone has the right to sterilise" as:

If people don't want to have children, they shouldn't have to. I think it's good. But only if we already have a child. Not without having a child, or even having two or three.

Maria (30, *parda*) also highlights this view, saying:

Everyone that wants to (sterilise) should be able to, yes. But I don't think so with only one child. But I think with two children you already have the right to do the sterilisation. Everyone has the right to do it, everyone.

For most participants, there is no contradiction between the statements that 'everyone' has the right, 'but only if you have at least two children.' This seemed to be a clear line for such a right, linking to the ideal family size of two children that pervades reproductive discourse as discussed in Chapter 4. Here this idea is so strong that it is not seen as contradicting 'access for everyone'. The importance of the family and motherhood that was highlighted in Chapter 4 is emphasised again here in relation to sterilisation. This strong ideal of having two children is also evident in the law on sterilisation (which states that one must be 25 years old *or* have at least two children), however this number of children is usually seen as a requirement by participants.

In contrast, Sofia (22, *negra*) is the only participant who says that anyone who wants to be sterilised should have the right to do so:

Yes, it should be decided by the person [...] The person who is of age and certain, should have the right to sterilise, mm, independent of... the quantity of children, they have, or don't have.

Although the way Sofia spoke was quite hesitant, this is still the strongest departure a participant makes from the ideal number of children and the right to sterilisation. This is probably due to the very distressing experience she had with her first birth and her attempts to sterilise. Sofia is therefore the only one who talks about a woman's right to reject motherhood completely. In general, the 'right' to sterilise is thus limited, as it is generally embedded within a wider pro-natalist discourse.

Most of the accounts mentioned so far that draw on the reproductive rights discourse use more general terms such as 'person' or 'individual,' when discussing the subject of sterilisation. This is quite a departure from the usual gendering of reproduction and sterilisation, and perhaps indicates the increasing reach of the public discourse on reproductive rights. Conversely, the majority of participants who discuss the right to sterilise use the terms "mother" or "woman," as will be seen in the remainder of this section. This gendered language is a further indication of the responsibility that women have for both the parenting role and for contraception and sterilisation.

Most other participants who talked about the right to sterilise as a personal choice emphasised this point along with the issue of regret, as the following examples demonstrate. Monica's (34, *parda*) framing of this right is unusually positive:

It comes from the couple really, what they decide they want from life, everything is talked about [...] I think that when a person resorts to this recourse, it is for certain that they will be doing something good for themselves. So I think yes, everyone that has this decision well thought through, so as not to regret afterwards, should have the right to sterilise.

Monica clearly draws on the current reproductive rights discourse, but she also explicitly adds how sterilisation will be of benefit to the individual personally. Unusually, Monica describes the right to sterilise in terms of the couple instead of the use of individualised terms as in accounts above, or the gendered language in the accounts that follow below.

Paula (52, *morena*) argues that everyone has the right to sterilise: “as long as she is wise, that she knows exactly what she is doing, because it is a thing that nobody else can tell you (to do), [...] So as long as she acts conscientiously so that she doesn’t regret it.” Paula focuses on a woman’s right and ability to make moral decisions about their own lives, but she is also quite cautious and warns about the risk of regret. Sterilisation is characterised as here a responsible and rational practice. Participants’ repeated arguments that individuals should have the right to make their own decisions over sterilisation highlight how the law and practices around the operation have constructed women as incapable of making decisions regarding their own reproduction and lives on their own. Women who want to access sterilisation often must be assessed according to medical and legal guidelines on what the ideal family and motherhood role is, instead of the women’s own understandings of their lives. This point regarding the medical-legal assessment is frequently found in the literature on reproductive rights and on abortion research in particular (see previous chapter, and Beynon-Jones 2009).

Generally, most of the participants who drew on the reproductive rights discourse were from more privileged or secure backgrounds, although this does not apply for all cases, as Juliana and Laura both struggled with income and relationship issues.

The second group of participants who drew on the reproductive rights discourse when discussing the right to sterilise include all the participants who were planning to be sterilised at the time of the interviews. Their perspective was distinctive in that, although they focused on an individual’s right to control their own reproduction, they each emphasised that many

women do not have this right in reality due to access issues. The following analysis illustrates how the women who are planning to sterilise engage with the wider discourses on responsibility as discussed in the accounts above, as well as associated concerns around blame, while also focussing on issues of class and life conditions.

Similar to accounts already addressed in this section, these participants talk about the desire of women to sterilise, however they add a further focus on their lack of power and control. Livia (37, *preta*) who, earlier on, described the difficulty of experiencing a teenage pregnancy (stigmatised as irresponsible), is now pregnant with her third child, despite the fact that she only wanted two. In contrast to the descriptions in these accounts of 'other' women who were unable to sterilise, Livia places herself in this category:

Everyone should have the right. There are people that 'run after,' but there are people that don't get it, you know? Mm. I am one of those, and I will 'run after,' if I don't get it, (lowers voice) I will do it wherever I can get it, I will! Mhm mm. I don't want to have more children, nor put a child in the world to be stuck suffering... Suffering! It's not right, no.

The issue of the suffering of children resonates with the discourse on irresponsible reproduction detailed in the previous section. However, none of the blame is placed on the woman, as can be seen in the accounts that contain elements of a neo-Malthusian discourse on reproduction. Instead, the context of the inefficient health system and the barriers it creates to accessing healthcare is foregrounded. This perspective on those who 'fight for' and 'run after' sterilisation but do not succeed, appears to provide another moral space for those who are outside the reproductive ideal. The fighter description may therefore be a way to position oneself as outside the ideal of

two children, but also avoiding the blame for reproduction often characterised as irresponsible.

These accounts relate to the women's narratives in the previous chapter on accessing sterilisation, where those who were attempting to obtain the operation generally discussed the uncertainty and stress that characterised the process. Drawing on Cussin's (1996) notion of ontological choreography, the discourse of the fighter highlights the point that these women are actively pursuing and trying to negotiate the health system in the attempt to achieve their desired, embodied identity. In this case, although objectification without successful reintegration does lead to a felt *denial* of agency, the fighter discourse highlights that – despite encountering obstacles during the process - it does not lead to the *loss* of agency in itself.

Participants who are trying to be sterilised therefore seem to have a distinct perspective on the right to sterilisation. They mostly highlight the fact that “everyone has the right” to sterilise, although they often appear to contain elements of the neo-Malthusian discourse where poor women with out-of-control reproduction are the focus. These accounts, however, place the blame for their inability to sterilise on the inefficient health system, rather than on the women. Instead, the women in all of these examples are characterised as ‘fighters’ who ‘run after’ their goals, a position which may be a strategy to manage their position outside of the reproductive ideal. They are not characterised as immoral mothers who do not care, because they are actively seeking sterilisation.

These participants focus on individual autonomy and the right to control one's own reproduction. However, this discourse on reproductive rights is

constrained by a pro-natalist conception of motherhood and the ideal of two children. Some of these accounts can be seen to be speaking back to a historical, and legally codified concern about regret, mostly emphasising women's ability to take responsibility for their own decisions and lives. All who were planning and struggling to be sterilised emphasised women's right to sterilisation, but they foregrounded the current context regarding the difficulty that many had achieving it. Similar to Chapters 5 and 7, these accounts discussed the obstacles that some women face in the form of the health system and law/policy around sterilisation. The discourse of the 'fighter' appears to function in this case to provide an alternate moral position regarding reproductive responsibility. This discourse focuses on critiquing structural inequality, thereby absolving women of the potential blame that the discourse on irresponsible reproduction would assign to them.

8.4 Sterilisation Evaluation: Reducing Worry, Sexual Pleasure and the Discourse on Regret

The majority of participants said that they were happy with their sterilisation as it reduced the amount of worry in their lives. Queries regarding the effects of sterilisation and about participants' thoughts on their own operation (e.g. how did you feel after the operation? What did you think about it?), provoked quite short answers. Some probing questions clarified the women's positions (e.g. did anything change? Did it improve your life? Were you happy with it, or not?), but again usually did not lead to any sort of extended narrative. This may be due to the fact that the expectations around sterilisation are so uniform and taken-for-granted that most women appeared surprised and confused by the question. It may also be because

many women talked earlier in the interview about their difficulties with contraception, childcare and accessing healthcare, and so sterilisation was often implied or stated as an obvious solution to deal with these issues. Nevertheless, despite the brief answers, several significant themes are still evident in the mostly short accounts on sterilisation evaluation, particularly regarding the overarching focus on reducing worry.

8.4.1 Reducing Worry and Improving Sexual Relations

Most participants said that sterilisation had a positive effect, particularly by reducing the amount of worry in their lives. Earlier in the interviews participants discussed their understandings of health and health practices (Chapter 5). Two thirds of the women talked about an expansive notion of health and wellbeing, which generally focused on reducing mental or emotional stress. These participants spoke about the importance of going out, for walks to the beach and the countryside, as well as going to the theatre, cinema and out on the street to meet and chat with others. It is significant then that every account on evaluating sterilisation illustrates in various ways how the operation reduces worry, and by implication increases general wellbeing, including both happiness and health.

Twenty-six of the 35 interviewees provided some details in their evaluation of their sterilisation. These coalesced around a general theme that sterilisation reduces worry, and frames it in terms of the improvement in participants' sexual relations. This is discussed first. Second, how the women responded to the wider discourse on regret (as raised in Chapter 7 and the subsection above) is examined further.

When asked how they felt about their operation, or if sterilisation improved their lives, nine participants talked about how it improved their sexual relations. Five of these responses were positive and relatively short. For instance, Sara (47 *parda*) explains that it was better as, “I was more at ease (*vontade*) to have sex without worrying.” There is a clear consistent notion that sterilisation causes participants to become calmer, reducing or eliminating the worry or stress associated with sex. These participants were quite calm when mentioning these thoughts, although they all responded quickly and confidently. Other women responded more strongly to the question. Elise, Juliana and Eliane, for instance, were more enthusiastic when asked how they felt about sterilisation and responded with longer narratives. Juliana (40 *parda*) responds: “Eeeee! [claps hands, laughs] It improved my life one hundred percent, my love, one hundred percent! [...] I can do it now without fear, without worry.” Similarly, Elise (41 *negra*) says:

It was a very good thing (pulls shocked face and winks) (laughter). I loved it! I loved it so much. It was the only thing in my life that was good, that I loved! (laughs, laughs).

So it changed your sex life?

*Exactly! That's it exactly! (laughs) The sex life is now marvellous, it's wonderful! (laughing) **How good!** It is! I am so happy!*

While Juliana mentions the reduction of worry, it is not the main focus in these two accounts. Rather than simply focusing on the fact that sterilisation improved their sexual relations, here the participants emphasise how their improved sexual relations enhanced their whole lives. The accounts convey how this affected their emotional wellbeing, as the quite joyful and laughing tone is different from the shorter accounts above. This emotional tone is also a particular contrast with the tone evident in the majority of Juliana and Elise's interviews. Eliane's (51 *negra*) evaluation of her sterilisation was

similar to Juliana and Elise's, however as her response was the only extended narrative on the topic, more of it is included here. When asked how she felt about sterilisation in general, Eliane said:

Eeeee! (laughs)... I was left with a calm head [mind]. Ah really? Yes!

You think it improved your life?

It improved my mind, it improved my conscience, you know? Ah. Even though I didn't have a sexual relationship anymore, you know? Mm. But also if I had lived with someone I knew that I wouldn't become pregnant. I went many years like this, I preserve myself a lot.

Why? Ah! Men are all dirty! Ah! Mm (laughs)

At my age I'm not going to find a clean, fresh, young one, right? (laughs)

[...] But also if I do have a sex life, it's calm because there won't be a pregnancy. Even if it's really crazy, I won't get pregnant, you know? Mhm.

So sterilisation for me is... (sits back, relaxed) no stress, no problems at all.

Ah I see...

Eliane then goes on to talk about how her mother told her that she would lose her libido if she had a hysterectomy, also implying that this is a potential negative side effect of sterilisation:

My mother, "you become cold..." Cold? Yes, they say "you lose it, you don't have orgasms anymore, you don't have desire anymore (vontade)." This is a lie! Oh mm? My sister took out the uterus and she doesn't stop! (laughs) She takes lovers like crazy (pra caramba) (laughs). She gets a crazy boyfriend and you know... a woman of almost 50 years, but the fire that she has is only from Jesus! (laughter). And she did sterilisation at 25 years old! Ah! 22 years later and now it's two years since she took out the uterus and the fire of her, her sex life has intensified, you know? Mm, I see. She doesn't have a problem, and I am the same, I also don't have any problem with sterilisation no! (laughs).

This account highlights how sterilisation works at the individual level. Eliane emphasises that sterilisation is not about her relationship with her partner, instead she clearly focuses on her own emotional and sexual needs. Her

narrative emphasises, indirectly, that despite her lack of a sexual relationship at the time, the operation did not affect her libido negatively.

Finally, Luana (31 *parda*), who was planning to sterilise, provides a contrast as it is focused more on her relationship:

I think it will improve my life yes. Because now, I'm with him all the time (laughs), I don't want to always use the condom! Really, I wanted something better, for us, so I really want the sterilisation. Ah, you do?
I do, I think it affects everything, you know? Everything? It's for your whole health Oh? A good sex life is part of having a life that is less stressed, and it is a form of care (carinho) right? Mm. And so it's important for your relationship certainly.

This account links back to participants' prioritisation of their sexual relationships and their discussion of health as emotional wellbeing. The accounts on wellbeing relate the importance of reducing stress and various means of doing so. These accounts illustrate how sterilisation reduces worry and stress in general, but also improves women's sexual or intimate relationships.

8.4.2 Reducing Worry: Sterilisation and the Discourse on Regret

When participants were asked how they felt about their sterilisation in general, seven of the 26 women also spoke about how it reduced worry in their lives and they particularly emphasised that they did not regret it. I initially found these responses surprising, as I had no intention of asking them if they regretted it. However, their interpretation of the broader question as focusing on regret reveals the extent to which this discourse impacts on their experience and understandings of sterilisation. This is

evident, for example, even in the following two very short explanations by Paula and Paloma.

When asked how she felt about her sterilisation, Paula (52 *morena*) responded simply with three words, “Complete, satisfied, happy.” When asked the follow-up question of whether sterilisation improved her life, she declares quite strongly: “Yes, because I became unworried. Everything was done conscientiously, after discussion with my doctor and my husband, **mhm**. [Folds arms] I decided and I *don't* regret it!” Paloma (95 *negra*) responds similarly when asked how she felt about her sterilisation, saying straight away: “I didn't have any feelings at all of guilt! [wags finger] I didn't feel anything like regret at all, no, **mm**. Not even did I feel that I wanted more children! [Folds arms] **Mhm** [...] It was calm, I was happy. I had decided it.” While mentioning that sterilisation caused them to become ‘unworried’ and ‘calm,’ both of these short accounts also illustrate how significant the wider discourse on regret is around sterilisation. Both Paula and Paloma are very emphatic about the fact that they were happy with their sterilisation, emphasising in particular that it was their ‘decision,’ which appears to link back to a reproductive rights discourse. Although both of these women were sterilised before the 1997 law, their responses directly reflect the discourse that became further solidified due to the framing of the law and the requirements that enforce barriers to accessing sterilisation.

Edila (27 *negra*), who was planning to sterilise, said that she believes that sterilisation will improve her life, because “at least it is one less worry, right, to not have children.” She then goes on to explain the case of her mother who was “tied” 17 years ago after her fourth child and is very happy:

Nowadays she does not regret it no. Mm? Nowadays my mother is 47 years old, and all calm, she doesn't look it, you know? Mhm, so pretty my mother is, you'd have to see! So she is happy to be tied.

Edila is not quite so emphatic in her account, but the same idea of sterilisation reducing worry, and not causing regret is mentioned. In addition, she illustrates this point by describing how sterilisation can improve one's life, as less worry means that you are healthy, beautiful and happy. Lowering worry can then have a significant impact on one's overall wellbeing. This evaluation of sterilisation as not causing any issues is reminiscent to the findings from Chapter 6, where a contraceptive technology works well by not causing any problems. This notion also appears similar to the ideas discussed in Chapter 7 where the best kind of sterilisation operation is subsumed within another and therefore not actually experienced or visible in any way.

Amanda (47 *branca*) was the only participant who discussed these issues during her evaluation of sterilisation account at any length. Her account illustrates the effects of the variously phrased questions, the associated multiple discourses on sterilisation, and how she responds to them:

What do you think about your sterilisation now?

Well, I don't feel any different about it even today, I never felt any type of difference. I'm not going to say to you that I'm missing something, that I have a sensation that something is missing, some pain, I didn't have it no! Mhm mm. I was even talking to a friend last weekend and she was saying that she also did the caesarean and now she can't sleep on her stomach since she did the operation. I never had this problem, I sleep on my stomach, the same way, I never had anything! You didn't? No, I didn't feel anything, it was all good! (laughs) How good! (laughs)

Did the sterilisation improve your life then?

No, it was the same, normal. Nothing changed. Oh? I was sure I only wanted the two, mm, and were/ and I didn't change my mind no!

So you were happy with it?

*I was...mhm?... things were more calm... mm... Calmer... Calm? Now to improve the life of someone who wants to have tranquillity in relation to her active sex life, without needing to worry about taking medicine... these things sometimes make you fatter, make you sick... then it is calmer, mm. For those who are certain that they don't want more children, this is the best thing that exists! Ah! For me it is the best thing ever invented! **The best thing?!***

It was, it was the best thing anyone has ever invented! (laughs/laughs). For me, for my style of life, for what I want, as I was sure about what I wanted, and that's enough, mhm. To say to you, "Ah, I regret today because I wanted to have a child from my boyfriend"... hm? Ah. No I will not!

Amanda's account provides further details on the sorts of things that women might fear about sterilisation, including both emotional and physical pain or loss. Amanda's tone here is quite fiercely confident and almost annoyed or exasperated. She very clearly emphasises that she did not change her mind, raising again the idea of the importance of her knowing her own mind and the ability to make her own decisions regarding her reproductive aims. The emphasis on life being 'normal' and nothing changed' is again associated with the negative fears around sterilisation and a discourse of regret.

There is a clear narrative break in this account, with several pauses, as Amanda moves away from the framing of regret, to one of sterilisation as increasing calm and enabling a more relaxed, active sex life. With this focus sterilisation moves from: something not regretted, to normal, to 'the best thing every invented.' This switch seems to move from the (rejection) of a particular type of motherhood, to the level of the sexual individual. Here the emotional tone changes from quite emphatic to initially thoughtful and then quite joyful. Finally, after joking about how sterilisation was so positive for

her, she returns to emphasise how the notion of regret from this perspective is literally laughable.

Only one participant unambiguously said that she regretted her sterilisation. This was because her second son died when he was several months old, however she was clear that the decision she made was the best for her at the time. Elise (41 *negra*) mentioned at one point that she was initially sad after her sterilisation, probably because she was pushed into the decision because of her doctor (Chapter 7), but then changed her mind after a while and was happy with it at the time of the interview. And Paula (52 *morena*) said that she was delighted with her sterilisation for herself, but also experienced regret later for her new partner who wanted to have children.

8.4.3 Summary

This section examined women's assessments of the effects that sterilisation had on their lives. These accounts contrast with the previous ones involving the historical and wider discourses around sterilisation that focus on population and reproductive responsibility. They also contrast with the accounts that focus on family size and parental responsibility. Instead, when sterilisation is examined at the individual level and effect on participants' lives, it is portrayed as improving women's health, wellbeing and sexual pleasure.

The first group of accounts in this section focused on how sterilisation reduced the amount of worry in participants' lives and also improved their sexual relations. These accounts therefore relate to earlier analysis regarding wellbeing and how to achieve it, and the stress or ill health associated with reversible contraception. The second part continues the focus on how

sterilisation reduces worry, but also demonstrates how women respond to the wider discourse on regret that is discussed earlier in this chapter and in Chapter 7.

8.5 Conclusion

This chapter has examined women's conceptualisations of sterilisation in various ways, including participants' decision to be sterilised, their understandings on the right to sterilisation, and their assessments of the effects of their own sterilisation. The analysis illustrates how accounts of the decision to sterilise generally share a strong narrative regarding the difficulty of parenting, particularly in precarious living conditions. These accounts build upon the context of women's everyday lives and family relationships outlined in Chapter 4. They focus on the necessity of controlling fertility and keeping to the reproductive ideal of a smaller family size. These narratives follow on from participants' earlier accounts of how their unsatisfactory experiences with reversible contraception also led to their decision to sterilise. In this chapter, participants highlight the difficulty of fulfilling the responsibility involved in assuming the role of the mother, especially in difficult circumstances, and emphasise that sterilisation enables women to fulfil this role. Accounts on the decision to sterilise also highlight how sterilisation allows women to achieve their own life goals, such as returning to education and therefore improving their living conditions. Sterilisation is also seen as a means to guaranteeing an end to distressing experiences related to reproduction, such as miscarriage.

This chapter has also explored women's understandings of the right to sterilisation, thus contextualizing their experiences of fertility and

contraception within wider discourses on reproduction in Brazil.

Participants' draw upon two reproductive discourses, highlighting the different ways of conceptualising sterilisation as a tool for population control, or as the right of an individual to control their own fertility. Most of the accounts that contain elements of a neo-Malthusian discourse, however, also contain a parallel critique of poverty, thereby variously reducing the attribution of blame on the mothers. Furthermore, the participants that focus on individual autonomy emphasise the fact that women are capable decision-makers regarding their own fertility, thus critiquing the discourse on regret that the sterilisation law seems to have solidified. They emphasise women's authoritative knowledge, capacity to act responsibly and the fact that sterilisation should be a careful and rational practice. This discourse is, however, often shaped by pro-natalist accounts of motherhood that limit sterilisation to those who have already fulfilled the ideal number of children. Sterilisation is therefore more about attaining a socially acceptable form of motherhood, as opposed to rejecting it entirely. Women who are planning to sterilise can be seen to position themselves in relation to both of these discourses. They argue that they have the right to choose sterilisation, but highlight that women can have great difficulty accessing the operation. The 'fighter' discourse, in this context, highlights their active agency, despite the fact that it can be blocked institutionally, and therefore absolves them of the blame associated with irresponsible reproduction.

Finally, when sterilisation is examined at the individual level, the analysis illustrates how the operation improves women's wellbeing by reducing worry and stress. It also highlights how accounts generally link this to improving sexual pleasure and intimate relationships. Overall, this chapter demonstrates how women were able to control their fertility through

sterilisation, thereby drawing upon and enacting the discourse of reproductive rights for all women. Nevertheless, wider structural violence, inequality and barriers in the form of legal and medical institutions challenged their access to the operation. Furthermore, the morality around excessive child-bearing in conditions of poverty highlighted the necessity of sterilisation for other women. In contrast to the discourse on irresponsible reproduction of other women, sterilisation for these participants increased their wellbeing by reducing stress, offering them the ability to enjoy physical intimacy calmly, and avoiding difficult experiences around child-birth. This chapter thus illustrates how understandings of sterilisation vary depending on the macro contexts of wider reproductive discourses, as well as institutional, familial and intimate relationships, and the individual embodied levels.

CHAPTER 9. CONCLUDING DISCUSSION

9.1 Introduction

This thesis set out to examine women's experiences of contraceptive technologies, particularly focusing on the case of sterilisation in Brazil. Chapter 1 outlined my reasons for examining the topic of contraceptive practices, highlighting how they are implicated within the fluid processes of international population policies, the construction and conception of nations, families, gendered social relationships, and individual bodies. I emphasised that a sociological perspective acknowledges that contraceptive practices take place within a wide range of reproductive and sexual health contexts, and argued that they can be examined at various analytic levels. This thesis, therefore, aimed to examine female sterilisation in Brazil, focusing on how it is understood in terms of wider social discourses, medical institutions, personal relationships, and individuals' embodied experiences and beliefs.

This concluding chapter will provide a final discussion of the thesis findings, providing a concise review of the themes and situating them in relation to both previous and broader research on the topics. Following this, I outline some implications for policies regarding sterilisation. Finally, I discuss the limitations of the thesis and make some suggestions regarding future avenues for research around sterilisation.

9.2 Discussion of Findings

9.2.1 Discourses on the Right to Sterilisation

Few studies of sterilisation in Brazil have examined sterilisation users' perspectives on the right to the operation in any depth. When the topic has

been raised, it was generally regarding the need to open access to the operation and in relation to individual women's desire to obtain a sterilisation (Potter et al 2003). The right to sterilisation has been discussed more widely among the black and feminist movements, legal, political and biomedical scholars; debating, for instance, issues around family planning, population control, genocide, or reproductive rights (Coutinho 1998, Roland 1998, Correa and Avila 2003, Minella 2013). The results from this research show that participants drew upon two reproductive discourses when discussing the right to sterilisation more generally. These varying discourses emphasised the different ways of understanding sterilisation as an instrument for population control, or as a means for an individual to regulate their own fertility.

De Zordo's (2012) study of family planning rationalities in two health clinics in Salvador in between 2003-2005 also found the coexistence of both types of reproduction discourses within the public health sector. While the healthcare professionals viewed women as citizens entitled to rights, they were also seen as both victims (of poverty, lack of healthcare, education, *machismo*) and as irresponsible mothers and bad patients due to their culture and irrational beliefs (ibid: 219). Her study also found that women experienced family planning as a moral and social responsibility that they must perform in order to avoid stigmatisation and for the wellbeing of their family, but that they also used it as a means of personal enhancement (ibid: 218). The findings of this research, however, show that, while women spoke about the moral responsibility around family planning and critiqued the 'irresponsibility' of excessive childbearing in poverty, they did not position such women as irrational or blame their ignorance or culture. Instead, a consistent critique

regarding structural violence and inequality contextualised their narratives, tempering the elements of the neo-Malthusian discourse.

When discussing wider society, sterilisation was thus often correspondingly conceptualised as a tool of population control. The analysis demonstrates that within the critiques of structural violence, sterilisation becomes a means to avoid increasing the victims of this violence, including abandoned or homeless children and wider violence in society. Most of the women who drew upon this discourse were from low-income backgrounds. Those who talked about forced sterilisations, in particular, were either living in or surrounded by extreme poverty, and talked about how they encountered the victims of this structural violence on a regular basis. Drawing upon participants' conceptualisations of a responsible and protective maternal love, sterilisation becomes a way to avoid the horror and morally reprehensible circumstance of having to abandon one's child on the street.

Participants also drew on the reproductive rights discourse, emphasising women's individual autonomy and the right to choose their own methods of fertility control and family size. These accounts can be situated within more recent, broader discourses on women's rights and citizenship (*cidadania*) in Brazil (Pitanguy 1991, Diniz, De Mello e Souza et al. 2004 [1998], Corrêa 2015). These narratives emphasise women as capable decision-makers, while also engaging with and critiquing the discourse on regret that the sterilisation law appears to have codified.

Several participants draw upon both discourses within the same accounts, illustrating how these discourses are particularly associated with and frame discussion of sterilisation differently at a population level and the level of the

individual. Finally, the women who wanted a sterilisation but were still in the process of accessing it had a distinctive perspective on the right to sterilisation. They emphasised that it is a woman's right to control her fertility as she chooses, but highlight the difficulty of accessing sterilisation. The discourse of the 'fighter' appears to provide these women with a morally acceptable position regarding their reproduction, despite the fact that it is outside of the ideal of two children, thus avoiding the blame associated with the discourse on irresponsible reproduction.

9.2.2 Family Formations and Motherhood

The various views on and discourses around the role of sterilisation produce particular family formations, and particular kinds of mothers. This thesis also aimed to examine sterilisation at a relational level, as a practice that is embedded within individual women's everyday relationships and lives. The findings illustrate how accounts of the decision to sterilise generally share a strong narrative regarding the difficulty of parenting, particularly in precarious living conditions. These narratives can be seen to relate to the wider discourses on reproduction, and must therefore be contextualised within the specific socio-economic circumstances and family relationships of women's lives.

The analysis shows how participants' paid and unpaid occupations were highly gendered, often focused on domestic work, and thus blur women's roles both within and outside the home. Accounts illustrate how these experiences are shaped by both race and class. Most of the women who identified as white were in higher-income employment outside the home, or happy to stay at home and be supported by their partners. The majority of women who identified as brown or black worked in lower-income and

precarious jobs, particularly as *domésticas*. These findings are consistent with previous research, where Black women form the majority of those employed in the domestic sphere in Brazil and how they face the double discrimination of gender and race in the workforce (Carneiro and Santos 1985).

These works link this to the part black women played during the period of slavery and the transition from slave to 'free' labour in Brazil (Azevedo 1985). The historian Sandra Graham (1995 [1988]) for instance, outlines how servant women were the largest single occupational group of women through the early 1900s and that the majority worked and lived under conditions similar to those of slaves. Feminist campaigns, along with policies tackling inequality during the Workers Party governments, have led to a reduction in inequality and increased regulation of domestic workers' rights (Senna 2007). However, household manual labour remains symbolically significant within racial commentaries (Goldstein 2003: 73), and the ability to hire others to perform it is a clear signifier of the divide between popular and upper classes (Owensby 1999).

Although the difficulty of domestic work and childcare was evident in participants' accounts, and despite the lack of social recognition for women's domestic work in the workplace, all participants emphasised how important the family is. Participants frequently conveyed a collective ideal of the family, where a good family was seen as "united," and involved practices such as spending time together and informal care work. These types of family practices have been examined by scholars such as Dermott (2011) and Morgan (2011). The central role that the family plays as a support system was highlighted, as for most women in this study "a person alone is nothing." This importance of the family network as a source of social contacts that can

operate as a means to solve problems has been documented in earlier research on the topic (DaMatta 1991, Diniz, De Mello e Souza et al. 2004 [1998]). A tendency towards matrifocal family networks, alongside fluid family structures, was evident in the findings of this research. These findings are similar to previous research on family structures and processes in Brazil, such as work by Scott (1996) and Fonseca (2000) and contrast with earlier studies on patriarchal *parentela* family structures (Sierra 2012).

Within this context, the role of the mother was described as crucial by all participants, no matter their socio-economic background or race/ethnicity. Extending social science studies of motherhood (Carsten 2004, Davis 2008, McKie 2012), these findings illustrate how maternal love was conceptualised as a 'natural' instinct, coming from or located 'within' the body or self, for the majority of participants. The analysis illustrates how this notion is elaborated in terms of particular types of mental and emotional practices or enactments, such as 'worry.' Furthermore, these descriptions of maternal love are highly gendered, as they are contrasted with notions of men's absence of this type of care. These findings contribute to the studies on gendered understandings of parenthood within both wider sociological, as well as Brazilian, studies of the family (Jamieson 1998, Rebhun 1999, Dalsgaard 2004, Rebhun 2007).

Furthermore, in this research, good mothers were seen as being responsible, reliable, protective and jealous; both keeping children safely close at home, and actively fighting for and prioritising their children above all. These notions of maternal love and the role that mothers play are similar in some respects to earlier research on kinship in Brazil, as, for example, the sacrificial aspects of motherhood found in Mayblin's (2010) ethnography. The

depictions of maternal love in this thesis, however, are far more active and at times violent, where good mothers are described as “fighters” who would “kill and shoot” for their children. The conceptualisation of maternal love in terms of the home and in opposition to the public arena of the street is also similar to Da Matta’s (1997) work, as well as Hecht’s (1998) research on street children. These findings, however, contrast with Scheper-Hughes’ (1993) earlier study of mothers in extreme poverty who adopted a stance of ‘letting go.’

Work and family circumstances, alongside the particular understandings of motherhood, can be seen in relation to participants’ accounts of their decision to be sterilised. The majority of women emphasised how their living conditions influenced their decision to sterilise, particularly for those living in poverty or precarious circumstances. Most participants talked about the cost of raising children and several spoke about their own childhood experiences of poverty. Some women also went into further detail about the difficulty of parenting in unstable living conditions, from both practical and emotional sides.

A strong shared narrative can be seen in these accounts regarding the difficulty of parenting within constrained living conditions. These accounts focus around issues such as structural inequality in society, with women critiquing poverty and social insecurity. Within this discourse, sterilisation is positioned as means of managing the living conditions of the family, and allowing women to fulfil the role of motherhood. Sterilisation is a way to gain control of a life in conditions of uncertainty, or a means of preventing increased precarity, through control over one’s own reproduction and body. These results are similar to findings from earlier research on women’s

motives to be sterilised (De Oliveira and Hoga 2005, Caetano n.d.).

Corossacz, for example, argues that sterilisation is an “effort to redefine maternity and productive work” (2004: 78). Similarly, De Bessa concludes that sterilisation “represents women’s attempt to gain a measure of control and to construct a better life, if not for themselves, then for their children, and is a mark of responsible motherhood” (De Bessa 2006: 226-27).

Dalsgaard’s research also emphasised a discourse on the responsible adjustment of fertility to a family’s economy (Dalsgaard 2004: 17).

In contrast to this focus on fulfilling the role of the mother and providing for one’s children, several younger women talked about their sterilisation as a means to focus on their own aspirations to return to their studies and achieve their own “dreams.” These narratives positioned education as a means of individual, personal fulfilment outside of the role of motherhood.

Nevertheless, their motivations to study were also about obtaining a higher income and achieving a better standard of living. Therefore, these narratives were also positioning sterilisation as a means to increase control over and stability in their lives. The framing of these accounts, however, are perhaps similar to Corrosacz’s findings that, through sterilisation, women “affirm their desire to not be only mothers” (2004: 171).²⁹

9.2.3 Contraception: Emotional and Sexual Wellbeing

The findings of this thesis also illustrate the role that sterilisation plays in relation to more individual goals and intimate relationships. These narratives contrasted with the previous accounts regarding sterilisation discourses, as

²⁹ For several women, sterilisation was also seen as a means to guaranteeing an end to distressing experiences related to reproduction, such as miscarriage.

well as the accounts that focus on family formation and the role of mothers. Instead, when sterilisation is examined at the individual level and its impact on participants' lives, it is portrayed as improving women's own sexual pleasure and intimate relationships. These understandings of sterilisation can be situated within wider sociological approaches to contraceptive technologies that show how contraceptives can be employed for a variety of reasons beyond limiting births (Bledsoe, Banja et al. 1998, Davids 2000).

Overall, the findings of this thesis show that women's decisions to be sterilised were not conflicted, as was the case in earlier findings on the topic (De Bessa 2006: 255). Nonetheless, participants' decisions to be sterilised before it was legalised appear to have been 'constrained' due to a lack of alternative contraceptive options, as highlighted by earlier research (Corrêa 1983, Merrick and Berquó 1983, Corrêa 1994, Corrêa and Petchesky 1994, Giffin 1994). However, in this research, these women were aware that it was permanent, in contrast to findings from studies such as Vieira and Ford (1996). Additionally, they all were satisfied with both the spacing of their births and the control over their fertility provided by the sterilisation.

The context within which this research took place was significantly different from earlier research on sterilisation in some respects, as the rates of the contraceptive pill were higher (34.2%) than rates of female sterilisation (21.4%) according to research conducted that year in 2013. The findings illustrate this context, and that policies aimed at increasing knowledge of reproductive and sexual health, such as the 2005 National Policy on Sexual and Reproductive Rights and the 2011 Stork Network, seem to have had a noticeable impact. The participants who had been sterilised after the operation was legalised, and those women who were planning to be

sterilised at the time of the interviews, demonstrated both knowledge and experience of a variety of contraceptive options such as the IUD, injection, implant, various hormonal pills and barrier technologies. Younger participants, for instance, talked about learning about contraception from family, in school and only having sexual partners who supported their use of both barrier and hormonal contraception. The lack of available alternative options was therefore not as significant an issue compared to previous research.

Nevertheless, my analysis illustrates that despite these options, participants' experiences of reversible contraception were often implicated in their decision to be sterilised. This is perhaps not surprising due to the research design, which focused exclusively on women who had been, or wanted to be, sterilised. Regarding reversible contraceptives, the findings show that the women were not satisfied with the design of the technologies themselves. The majority of women prioritised their own sexual pleasure, particularly in relation to their decision not to use barrier methods of contraception. Most of these participants focused on their own understandings and experiences of sexual pleasure, highlighting how the artificiality and materiality of barrier methods were undesirable in this context. These findings contrast with those from earlier studies on sterilisation that emphasised women's lack of power to negotiate their sexual desires due to gender inequality in intimate relationships (Giffin 1994, Goldstein 1996, Serruya 1996, Minella 1998).

The findings, though, also highlight how contraceptive technologies are practices that are embedded within gendered relationships. Although participants were generally frustrated by the gendered nature of women's responsibility for contraception, the women who spoke about the influence

of their partner's sexual pleasure tended to blame the design of the technology itself and highlighted the importance of prioritising their sexual relationship. Furthermore, the findings show how most types of reversible contraceptive technologies were unsuitable within the context of fluid intimate relationships and daily lives. Technologies such as the condom, the pill and the injection assume a certain level of stability within sexual relationships. This design does not account for the unexpected resumption of sexual relations, whether due to breaks or disruption in a relationship because of distance or arguments. These design assumptions also do not take account of situations involving domestic abuse or sexual violence.

Additionally, contraceptive technologies that require forward-planning (e.g. injection), stability and regularity (e.g. the pill) in daily life are often not suitable for women who live in precarious circumstances, or dealing with a large amount of stress. Finally, the physical side effects of hormonal contraception were a further issue for many participants, who often spoke about it in terms of '*mal estar*.' The analysis illustrates how the 'otherness' of hormonal contraception was emphasised, leading to an experience of bodily alienation. Most of the participants who experienced this alienation described strategies of varying or selective resistance or evasion, with only a few women conveying an attitude of acceptance. Overall, these findings demonstrate a variety of understandings and experiences of reversible contraception. While some participants were distressed or frustrated by their experiences of reversible contraception, others laughed about it or were accepting. A few women had no problems with these technologies, but because they were certain they did not want more children, they still preferred sterilisation over the hassle and responsibility involved in reversible contraception.

The findings discussed above contrast clearly with participants' accounts of health practices, where women move beyond a narrow focus on the biological to describe an expansive notion of wellbeing. These accounts emphasise emotional health and quality of life, where women aim to reduce worry and stress. Additionally, the analysis illustrates how these accounts position wellbeing practices as accomplished outside the home. This indicates that the responsibility associated with the domain of family needs to be managed or negotiated for individual women's health. Similar work by Backett-Millburn et al. (2005) also reveals how wellbeing intersects with women's structural and familial circumstances, influencing their experiences of caring roles.

These accounts relate directly to the findings regarding women's evaluations of their sterilisations, as every participant said that they were satisfied with it because it reduced the stress and worry in their lives. However, only one participant talked about this in relation to her living conditions and ability to perform childcare. Every other woman talked about sterilisation reducing stress and worry in relation to their sexual relations. The emotional tone of these accounts were quite joyful as most of the women were delighted about the improvement in their sex lives, describing it as the "best thing they had ever done," or the "best thing mankind has ever invented." Only one participant regretted her sterilisation, because her second son died when he was nine months old. Nevertheless, she was sure that it was the right decision at the time, as it enabled her to leave an abusive relationship.

These findings are similar to some of the previous studies on sterilisation. While much of this research has shown that women choose this operation to

improve their lives, in general these works have focused more on gaining control over fertility in order to fulfil the role of the responsible mother and provide for children within conditions of financial constraint. Nevertheless, earlier studies did incorporate issues around women's health and sexual relationships, although this is often in the context of their motivations rather than focused on their evaluations of the operation. The findings from this research contrast with these works that argued that sterilisation indicated women's positions as victims, and would, for example, put pressure on women to be constantly available for sex (Giffin 1994, Barbosa and Villela 1995, Gregg 2003), or that sterilisation relieves them of the burden of having sex due to lowered libido (Citeli, Mello e Souza et al. 1998: 67).

More recent, qualitative works, however, focus more on women's desire to improve their health and sex lives, although the topic is not covered in detail (De Oliveira and Hoga 2005, De Zordo 2012: 220, Caetano n.d.). Although Serruya frames women's use of sterilisation as "voluntary mutilation" and the loss of authority and knowledge over their bodies (1996: 152), she also argues that women sought the operation as a way to free themselves from worry over reversible contraception and in order to improve their sex lives. Additionally, De Bessa (2006), for instance, argues that sterilisation indicated women's challenge of male control over their sexuality (2006: 252). This thesis details conceptualisations of sterilisation in relation to individual emotional and physical wellbeing, women's own sexual pleasure and priorities around sexual relationships. This research thus contributes to the literature on contraception as shaped by socio-cultural contexts and which must be understood within local notions of wellbeing, sex and love (Paxon 2002, De Bessa 2006, Schwarz, Dumbaugh et al. 2019).

9.2.4 Legal and Institutional Contexts

This research illustrates how sterilisation was complicated or difficult to access for most participants. This process can be seen in relation to both the specific workings of the health sector in Brazil, as well as the shifting socio-legal context shaping the law and policies around sterilisation. Issues around obtaining contraceptive technologies must be situated within the broader context of participants' experiences of accessing healthcare in general.

The findings of this thesis show that, although healthcare is largely understood as a right for everyone, all participants were critical of the lack of funding and mismanagement of the health system, as well as associated wider political corruption. In addition, accounts that are critical of doctor-patient encounters focus on asymmetrical power relations. These are generally conceptualised as a lack of care and experienced as disregard or dehumanising. The analysis points out how these relationship dynamics interact with wider systemic barriers to accessing healthcare, thus reinforcing inequalities along race and socio-economic divides. These findings around health inequalities and systemic barriers to accessing healthcare contribute to the literature on health inequalities in Brazil (Leal, Gama et al. 2005, Sanabria 2010, Biehl and Petryna 2011, Caldwell 2017), as well as wider studies on the topic (Modood, Berthoud et al. 1997, Bridges 2011, Harding 2016).

Although the results of this research demonstrated how participants face barriers to healthcare at multiple levels of the system, the findings show how women were generally positioned as actively pursuing healthcare in these narratives. Drawing upon the concept of the *jeitinho*, the analysis illustrates the varied ways that women negotiated these barriers, mainly focusing on practices that include the role of social networks, financial resources and

social savviness. As such, these findings contribute to debates on the *jeitinho* as an institutional by-pass (Rosenn 1971, Levine 1997) and an example of a workaround dealing with rigid bureaucracies or inefficient systems (Duarte 2006, Ser, Robertson et al. 2014, Bouskill, Smith-Morris et al. 2018).

Alongside the systemic issues within the health sector, this thesis shows how the ambiguous legal status of, and policies around, sterilisation clearly shaped participants' experiences of accessing the operation. The majority of women who were sterilised before it was legalised were sterilised postpartum, which accords with previous research on the subject (Merrick and Berquó 1983, Caetano and Potter 2004, Dalsgaard 2004). These women, however, were generally positioned as actively pursuing the operation, as they employed *jeitinho* practices to by-pass the rules, relying upon the support of partners, doctors and financial resources. The findings show that negative experiences of this process consisted of dealing with various obstacles, such as lack of support, finances, contacts, or unhelpful doctors, and a lack of healthcare facilities. The significance of power dynamics within the doctor-patient relationship play a greater role in these accounts. These performative narratives emphasise the significance of social capital (Bourdieu 1993, Duarte 2006) - particularly the attribute of *simpatia*, the ability to negotiate and the importance of social-savviness in navigating unequal hierarchies (Vieira, Costa et al. 1982, Barbosa 1992, Prates and Barros 1997). The differences between these positive and negative accounts therefore highlight Levine's (1997) argument that acceptance of the *jeitinho* as a 'para-legal' system (Campos 1966) cements the unfair advantage given to those who know how to bypass the system when resources and payoffs are involved (ibid: 84).

Furthermore, the findings of this research demonstrate how sterilisation was still difficult to obtain for most participants after the operation was legalised. The analysis illustrates how the law actually introduced new obstacles to accessing sterilisation, including banning postpartum procedures (except under certain conditions), restricting either age limits or number of children, as well as stipulating the partner's signed consent, and attendance of a family planning course. However, the measures designed to reduce regret and regulate the operation increase the difficulty of obtaining sterilisation and appear to be unnecessary in the current context, due to the increased availability of reversible contraception, for example.

Additionally, the law appears to have formalised a discourse on regret, probably due to the high rates of sterilisation and the debates around genocide at the time the operation was legalised. Confusion and misinformation regarding the rules around accessing the operation seemed to persist at the time of the interviews. Furthermore, the ambiguity around the status of postpartum procedures, caused by the exception of cases involving multiple caesareans, has paradoxically undermined the ban. These findings show that this has led to continued unregulated operations, as well as further increasing inequities in access and therefore perpetuating wider intersections of multiple inequalities within society.

Finally, drawing upon Cussins' (1996) concept of ontological choreography, the findings of this thesis illustrate how women can enact agency and subjectivity through the medical objectification of their bodies and fertility. Pursuing sterilisation necessitated a high personal investment and active attempts to realize their dreams and the desired changes in their embodied identities. Moreover, these results also illustrate when objectification was

experienced as in opposition to personhood. These negative experiences involved a rupture at least at one point in the sterilisation process, involving for instance, bureaucratic objectification, doctor interference, or dehumanising facilities. This thesis thus explores the interplay between objectification, agency and the limits to autonomy, thereby avoiding the dichotomy that was frequently set up in earlier accounts on reproduction or sterilisation that employed concepts such as medicalisation.

9.2.5 Advancing Understandings of Sterilisation

Examining the various findings on sterilisation above in relation to one another provides an overview of the significance of this research for understandings of the operation both in Brazil and within a broader theoretical context. This subsection will thus draw out the main findings regarding sterilisation in the contemporary context, including: the conceptualisations of the right to sterilisation, the significance of reversible contraception, and the continued issues regarding access to the operation. These findings will be discussed briefly in terms of the broader social healthcare context, as well as theory focusing on health development in the Global South. Additionally, the usefulness of concepts such as the *jeitinho* and ontological choreography will also be outlined in relation to wider theory on STS and on reproductive technologies.

The analysis of the two reproduction discourses makes a new substantive and theoretical contribution for both those interested in contemporary understandings of sterilisation in Brazil, and for the field of the sociology of reproduction (see subsections 8.3.1 and 9.2.1 above for details). It highlights how the earlier neo-Malthusian discourse is now used in the contemporary

context, and how sterilisation is correspondingly conceptualised as a tool of population control at the wider community and national level. The analysis thus shows how, within this context, Brazilian women's concerns about responsible motherhood feed into reproductive healthcare decisions. Moreover, the use of the more recent rights-based reproductive discourse highlights the increased concern with individual choice and autonomy in Brazil. In this thesis, this seems to appear in the form of gendered resistance to discourses on sterilisation regret. These findings suggest that grassroots movements around *cidadania* and policy changes aiming to democratise healthcare in Brazil, such as PAISM and the Stork Network (see sections 1.2 and 1.3, and subsection 8.3.2 above), are influencing current uses and understandings of sterilisation.

Furthermore, the thesis highlights how both neo-Malthusian and rights-based discourses can be drawn upon concurrently when discussing the right to sterilisation. This particularly emphasises how closely each reproductive discourse is linked to the various conceptual levels of the population, community or individual fertility control. These accounts may possibly indicate a potential critique of the rights-based discourse, where women are using it to defend a choice that was made primarily to guarantee that they will not abandon a future child. However, considering these accounts in relation to those on sterilisation evaluation provides another perspective (section 8.4). In this context, the same women focused solely on the individual benefits of the operation as improving their sexual relations and emotional or mental health (see also section 5.2). In other words, women can discuss the right to sterilisation in neo-Malthusian terms for the 'other' or population level and use the rights-based discourse to conceptualise it at the individual level, while also experiencing sterilisation in their daily lives as a

means to bodily or sexual autonomy and individual wellbeing. It is thus clear that sterilisation can be understood by drawing upon different reproductive discourses simultaneously at various conceptual levels.

The increased prevalence of reversible contraception (sections 1.2 and 1.3) is a significant difference for studies on sterilisation in Brazil in the contemporary context. This thesis shows that there are now a wider variety of reversible contraceptives available, an acceptance of the notion of a woman's right to use them and a greater awareness of contraceptive options (see subsection 9.2.3). As mentioned above, the earlier concern in the literature on sterilisation in Brazil about women being pushed into the operation due to a lack of available alternatives seems to be less significant now (subsection 9.2.3). This adds further evidence suggesting that the grassroots feminist and health movements that emerged in the post-dictatorship period have had a positive influence on women's reproductive and sexual health and wellbeing (Diniz 2004 [1998]; Correa, McIntyre et al. 2005) (see subsection 8.3.2).

However, the progress regarding alternative contraceptives does not account for the lived experience of reversible contraceptive use. The analysis highlights how use of these technologies remains a relational and embodied tension that is assessed and negotiated in an ongoing process (subsection 9.2.3). Thus, this thesis illustrates how problems with the available reversible contraception still contributes to the demand for, and satisfaction with, sterilisation. This indicates a broader critique of the reproductive rights discourse, suggesting that, in this Brazilian context, the focus needs to now move beyond concern over the availability of current methods to focus more closely on the development and design of contraceptive technologies.

Furthermore, despite the advances outlined above regarding reproductive healthcare, including support for opening access to sterilisation, this research shows that there are still significant barriers to accessing the operation in the contemporary context (see subsection 9.2.4). Illustrating the continuing, multi-level and intersecting barriers to accessing (reproductive) healthcare in detail, as well the effects these can have on women, provides an understanding of how health inequalities persist and are reinforced currently in Brazil. This thesis therefore offers various concrete means of addressing these issues in practice in the following subsection 9.3. These findings can also provide greater awareness of potential barriers when attempting to introduce healthcare policies or improve reproductive rights in other socio-cultural settings (United Nations 2017) (see section 1.1).

Additionally, considering this case study of sterilisation in relation to the overall trajectory of healthcare rights in Brazil contributes a further lens on development theory focused on a Global South context (Sen 1999, Corrêa 2015, Gibson 2018). The literature on social movements and development generally focuses on their potential contribution to the codification of rights and adoption of policies, instead of their implementation (Amenta, Caren et al. 2010). Acknowledging the gap between the codification and the enactment of laws or policies, recent research in Brazil examines how healthcare movements can also influence implementation outcomes (Lavalle and Bueno 2011, Gibson 2017). Gibson's (2017, 2018) work, for example, examines the effects of Brazil's most important contemporary health movement, the Sanitarist Movement (*Movimento Sanitário*). He demonstrates how a "minimalist" trajectory of health democratisation took place in Rio de Janeiro (Gibson 2019), where traditional politicians often blocked *sanitaristas*

from occupying SUS directorships. This context led to little democratic oversight of the sector, as well as relatively incapacitated local state ability to deliver basic public health services. The findings in this thesis (on the uneven barriers to accessing healthcare or sterilisation and the corresponding *jeitinho* strategies) contribute a concrete insight into how efforts to implement reproductive healthcare reforms interacted with this particular kind of development trend.

Moreover, this thesis highlights the value of using indigenous concepts and theories, such as the *jeitinho*, for sociology of science and technology (STS) scholarship. STS as a theoretical field and community has been engaging with postcolonial, transnational and Global South theory (Law and Wen-Yuan 2017) (see Chapter 2). These findings provide an example of how to work with and integrate these multiple perspectives, contributing to the ongoing decolonisation of the field of STS. Finally, the use of concepts such as the *jeitinho* and ontological choreography contributes to a deeper conceptualisation of the structure/agency debates around sterilisation in Brazil (O'Dougherty 2008). The findings trace specific ways of understanding the interplay of structure and agency, delineating when objectification aids or hinders individual autonomy. As such, this thesis avoids binary constructions of agency and contributes to wider theory on the medicalisation of reproduction (McNay 2000).

9.3 Implications of Research

Following on from these conclusions, the findings of this research suggest several implications for policies and clinical practice related to contraceptive

sterilisation. First, however, it is possible to point out some broader implications from the wider critique that participants made regarding their experiences of work and the health system. For instance, increasing the recognition for women's work by increasing wages and reducing the gender pay gap, and extending social welfare programmes, such as the successful *Bolsa Familia*, to ensure women's unpaid labour is supported. Furthermore, each participant critiqued the lack of funding and infrastructure evident in the public health system. Increased funding, staff and facilities would support the valuable work that the SUS undertakes. It is crucial to improve the workings of the health system more broadly, as this is necessary to enable women to access reproductive and sexual healthcare. Additionally, further investment into the development and availability of reversible contraceptive technologies would be of benefit.

Focusing more closely on issues around sterilisation, this research has demonstrated that information and courses regarding reproduction and contraceptive technologies are perceived very positively when women are initiating sexual relationships or strategically spacing childbirth. However, the requirement to attend a full course on family planning options in order to obtain a sterilisation on the public health system appears to be unrealistic and unsuitable for most of these participants. While clearly initially designed to raise awareness of contraceptive options and reduce the possibility of regret, this stipulation now appears to create further barriers for women who have already decided to be sterilised. This seems to particularly be the case for women in more precarious or vulnerable circumstances.

I would suggest that the availability of alternative, reversible contraceptives could be mentioned, if a woman raises the topic of sterilisation during a

consultation. An accessible leaflet outlining these options could be made available, and the family planning course could be made optional for women who request sterilisation. In addition, or alternatively/in the mean-time, the family planning courses could be made available at more flexible hours, such as after the general work-day or at weekends. Childcare facilities for those attending the course, as well as reimbursement for travel, would also significantly increase the accessibility of the course, and therefore facilitate access to the sterilisation operation.

There is a need for clearer information regarding rules for accessing the operation, both within wider lay populations as well as among clinical professionals. There was significant confusion among participants over how to obtain a sterilisation, particularly on the public health system. They also appeared to receive incorrect information on this topic from healthcare professionals. This may be due to a clinician's personal bias, or historically differing requirements for a sterilisation when by-passing the rules (e.g. at least three children), or perhaps general confusion regarding the change in the law. Further training and awareness-raising campaigns would probably facilitate the process of accessing sterilisation for both women and clinicians.

Furthermore, the ban on postpartum sterilisation operations was originally intended to reduce the high rates of caesareans. Postpartum sterilisations, however, are readily available in the private sector, and available on the public health system in cases where the woman's health is at risk, which includes having multiple caesareans. The findings of this research illustrate how the formulation of the law has not removed the link between caesareans and sterilisations. In line with several works on the topic (Potter, I.H.O. Perpetuo et al. 2003, Soares and Brollo 2013), this thesis shows that the ban

on postpartum sterilisation has instead formalised the inequities in access, creating further barriers for more vulnerable women, and paradoxically increased demand for caesareans. I therefore recommend removing the ban on postpartum sterilisations, and instead focusing on providing access to the operation, including measures such as reducing the waiting period and providing transport or childcare options.

Finally, I would recommend removing the need for the partner's signed consent in order to obtain a sterilisation. Due to the fact that rates of female sterilisation are significantly higher than male, this stipulation effectively extends patriarchal and sexist norms regarding gender relationships and reproduction. It unnecessarily limits women's bodily autonomy and reduces their ability to make decisions about their own reproductive capacity and desires. Additionally, this requirement is only for those who are in a relationship, but does not appear to be needed for single women. Finally, it seems that the partner's signature may not actually be needed in practice for most cases at the time of data collection for this research.

9.4 Limitations and Future Research Avenues

The sample for this research was chosen to focus on women who were sterilised and planning to be sterilised, and provide a variety of socio-economic backgrounds and racial identities. However, despite the patterns that emerged in the data, it was not intended to be representative. This design provides scope for further research, including a larger sample, from diverse regions. Furthermore, the lack of women who were happy with reversible contraception may have led to more negative perspectives on

these types of technologies in comparison to the rising rates of use within the wider population.

Regarding methodological issues, my decision not to include the data that were gathered from the contextual research, (e.g. observations and document analysis) was based on concerns raised by feminist post/de-colonial theorists on the importance of centring the voices, experiences and authority of the participants of this research (Harding 2016). This decision has, however, perhaps excluded a broader perspective on the findings of this thesis.

Following on from the discussion above, there are several possible areas for further research regarding sterilisation in Brazil. There is a clear need to understand more fully the opinion of healthcare professionals on the topic of accessing sterilisation. Further investigation into how the process of how policy is both enacted and by-passed informally, in practice, would be of benefit. Additionally, research into why there is so much confusion and misinformation around the rules on accessing sterilisation would possibly clarify how to solve this problem. Although it is clear that women can obtain sterilisation far more easily within the private sector, this is another area that merits further study. More concrete information on this practice would clarify how the inequalities in sterilisation access are reproduced. Another aspect of sterilisation in the private sector that warrants further research would be in relation to what kind of judgements are made regarding eligibility for sterilisation, outside of the issues such as the ability to pay. Relatedly, sterilisation access and understandings could be examined in more detail in alternative regions in Brazil, as there is a wide variety of cultural backgrounds and differing population characteristics across the country. Finally, there is a particular need for more research focused on

understanding the opinions and experiences of men regarding sterilisation, particularly as the rates of vasectomy are still very low in relation to female sterilisation.

9.5 Final Conclusions

Moving beyond a focus on motivations and debates about agency enables a more in-depth examination of how sterilisation is understood and employed across various domains of social and personal life. Focusing on women's perspectives reveals how sterilisation is conceptualised in terms of broader reproductive discourses, how it is embedded within family relations and used as a tool to construct particular family formations and mothers; and, how it relates to women's sexuality and sexual relationships.

This thesis has attempted to move beyond notions of contraceptive technologies as artefacts that are diffused from more industrialized to less industrialized nations (Basalla 1967), and that can be applied within international family planning and health policies uniformly across a variety of international and cultural contexts. Drawing inspiration from fields such as the sociology of medicine, STS and intersectional postcolonial studies, I aimed to understand sterilisation as a contraceptive technology that is shaped by the local, socio-historical, political and economic cultures within which it is embedded (Holmes, Marques et al. 2014). This thesis illustrates how understandings of sterilisation were influenced by specific post/colonial notions of the reproduction of race, citizenship and rights within a 'modern' nation-state.

The ambiguous socio-legal contexts around sterilisation within the health sector highlights how historical power relations embedded within the structures of the state can be both reproduced and altered. The *jeitinho* practices employed to access sterilisation provide an example of how workarounds can be used to negotiate power relations within the fluid contexts of the interplay between excessive formalism and norms of social personalism (Hess and DaMatta 1995). Additionally, the prevalence of postpartum sterilisations provides an example of how a technology is adapted as a creative local form of surgical innovation. The role that sterilisation still plays in a specific Brazilian 'reproductive culture' (Mello e Souza 1996, in De Bessa 2006: 224) also illustrates how the adaption of a contraceptive technology to local circumstances can shape the circulation of understandings of fertility, and reformulate women's experiences of reproductive trajectories (Cabral 2011). Finally, examining lay perspectives highlights how contraceptive technologies are understood in relation to and actively used to shape family formations, as well as individual women's health, wellbeing and sexual relations.

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Appendix A: Ethical Approval Application Details

CPHS, University of Edinburgh

The ethics application for CPHS involved several different forms and assessments, including: Research Protocol (translated into Portuguese for CONEP below), Fieldwork Risk Assessment, Lone Working Risk Assessment, and an Overseas Travel Assessment. Included here is the revised and updated Research Ethics Level 2/3 Application Form from April 2013, with identifying details removed for anonymity and ethical reasons.

Format altered from the original form to fit the thesis:

University of Edinburgh
School of Health and Social Science
RESEARCH ETHICS COMMITTEE



Ethics review form for level 2 and level 3 assessment
for CPHS MPH/PhD

1 THE RESEARCHERS

Date form submitted	
Your name and position	Aoife McKenna PhD Researcher
Proposed title of research	A sociological study of health-related enhancement technologies: Female sterilisation in Brazil
Funding body	Wellcome Trust
Time scale for research	Remainder of PhD – 2 years
List those who will be involved in conducting the research, including names and positions (e.g. 'PhD student')	Aoife McKenna – PhD Student

2 RISKS TO, AND SAFETY OF, RESEARCHERS

Do any of those named above need appropriate training to enable them to conduct the proposed research safely and in accordance with the ethical principles set out by the College?

No

I have completed methods courses and specialised fieldwork training as part of my Master of Research in Social Anthropology, and the first year of my PhD at CPHS.

I also completed a Fieldwork Planning and Safety course, and a HSE approved First Aid course, organised by the Health and Safety Department.

Safety and ethics have been discussed with supervisors and CPHS fieldwork assessment guidance and lone worker guidance has been read.

Are any of the researchers likely to be sent or go to any areas where their safety may be compromised, or they may need support to deal with difficult issues?

No

If I decide to conduct participant observation (e.g. by volunteering with an NGO) I will submit further forms detailing any safety issues.

As my research location will be at the University hospital and clinic, it seems unlikely that I would have to enter a dangerous area.

However, if such a situation arises while conducting interviews I will try to go to such an area accompanied by someone, preferably who knows the area well.

I will also follow the University's Lone Worker Policy and Safety procedures.

I will use procedures from the Risk Assessment part of the Fieldwork Safety course. For example:

I will only go to an area once I have researched it, and know that it is reasonably safe.

I will have the phone numbers of local researchers at the universities, and several friends from Rio who are living there, whom I can call if I need to.

Could researchers have any conflicts of interest?

No

3 RISKS TO, AND SAFETY OF, PARTICIPANTS

Could the research induce any psychological stress or discomfort?

Yes

Unlike the U.K., sterilisation is not a taboo topic in Brazil. However the more in-depth interviews could in particular raise sensitive issues relating to identity, family relationships, the body and sexuality.

Anticipated or unanticipated personal issues may be raised by participants themselves during second interviews, once rapport has been built up.

It will be explained before the interview that the participant does not have to answer any question they feel uncomfortable about.

I will check with participants throughout the interview, if sensitive topics are raised. If they seem uncomfortable in any way then I will stop the interview.

I will also have a list of resources available, for example, details of local support groups that can help.

Does the research involve any physically invasive or potentially physically harmful procedures?

No

Could this research adversely affect participants in any other way?

No

4 DATA PROTECTION

Will any part of the research involve audio, film or video recording of individuals?

Yes

Audio recording of interviews. Permission will be asked to record at the beginning of each interview. If permission is not given, written notes will be taken.

I will always have a back-up recorder in case there is a problem with the first. I will transfer the data to my computer as soon as possible. This will then be password protected. The recorder data will then be deleted.

The audio data will then be transcribed, backed-up separately on my private files on the University server, and password protected on an encrypted hard drive.

Will the research require collection of personal information from any persons without their direct consent?

No

How will the confidentiality of data, including the identity of participants (whether specifically recruited for the research or not) be ensured?

The confidentiality of data and identity of participants will be ensured following the University of Edinburgh guidelines, and awareness of the researcher's obligations under the Data Protection Act.

Confidentiality will be discussed before the interview, and confirmed if necessary after it, and during analysis.

Anonymity is one way to ensure confidentiality. The identifiable details of participants will be kept separately, and password protected. Participants will be assigned or choose a pseudonym. Any third parties mentioned in the course of an interview may also be assigned pseudonyms. Significant identifiers can be removed if necessary.

Anonymity may be harder to ensure if close friends or family members are interviewed, or also in the case of professionals within a medical institution. In addition, if there are potential participants possessing a combination of attributes that make them readily identifiable, they will be reminded that it can be difficult to disguise their identity in published material.

In this case, identifiable attributes can be removed, with consideration for issues around the distortion of data and transparency of research practice. There could also be a reciprocal dialogue about the level of details to be given.

Who will be entitled to have access to the raw data?

I will have access to the raw data.

If participants explicitly ask to see their transcript, it will be negotiated how to do this ethically, in consultation with my supervisors.

Participants will be told that other researchers, e.g. supervisors, may access transcribed and anonymised data.

How and where will the data be stored, in what format, and for how long?

Audio data will be downloaded and stored electronically in a private file on the University of Edinburgh server, and backed-up on an encrypted hard drive, which will be stored securely both in the field and on return. Details of participants will be kept separately in a locked filing cabinet and all transcripts will be anonymised.

Data will be preserved for the duration of the PhD and writing up period. Anonymised data will be archived for my future research at the CPHS archive system. This data will be reviewed for deletion five years after the end of the PhD.

What steps have been taken to ensure that only entitled persons will have access to the data?

The password to access the electronic data will be known only to the PhD student and will not be shared with anyone. All other data will be stored in a securely locked cabinet.

How will the data be disposed of?

Audio files will be deleted from the portable recording device and stored on a PC until the conclusion of the study when they will be deleted. Transcripts will be stored on the PC until the end of the study, and then stored at CPHS for a further eight years. Data will then be destroyed or archived according to the policy of the Wellcome Trust.

How will the results of the research be used?

The results of this research will be used to write a PhD thesis, and will also be used for posters, presentations, or the publication of articles.

What feedback of findings will be given to participants?

The PhD thesis will be available upon request. A summary of the results will also be available for participants and non-academic audiences, both in English and Portuguese. This will be circulated to contacts and participants if they wish and give their contact details.

Is any information likely to be passed on to external companies or organisations in the course of the research?

No

Will the project involve the transfer of personal data to countries outside the European Economic Area?

No

Data will be gathered outside the EEA, but held on the University of Edinburgh server system and external hard drive.

5 RESEARCH DESIGN

The research involves living human subjects specifically recruited for this research project (If 'no', go to section 6). How many participants will be involved in the study? Please give a justification of the sample size decided.

Yes

In-depth interviews:

The primary focus of the study will be in-depth interviews. Around 50 participants will be involved in the study, including 30 women, 10 men and 10 clinicians. 10 of the women will be interviewed twice, resulting in a maximum number of 60 interviews.

These estimates are based on guidance from previous studies on the topics, readings on methodology, and following the advice and experience of my supervisors.

[Updated to focus only on women, aiming for 30-40 interviews]

Ethnographic Observation

As I will be living in Rio for around 10/12 months in total, ethnographic observation will also be used. This method includes the use of behavioural analysis and recording information in fieldnotes as a means to learn about the explicit and tacit aspects of a culture. In-depth descriptions will therefore be made in fieldnotes from the very beginning regarding daily life and culture in Rio.

Clinic Observations:

In the later stage of my fieldwork I may follow the usual method of recruiting participants for interviews from the waiting room of a clinic, the time spent there in-between interviews will be used for observations. Observation is a typical method of qualitative research. It involves taking notes on behaviour or events, and is often considered less 'invasive' than the usual participant-observation method often employed in anthropological research.

Although the primary aim is to access participants for interviews, the location can provide useful observational data, for instance, to help to gain an overall sense of the type of patients that attend the clinic (for example ages or race, of the patients).

There will be no 'complete' or even 'active' participation within the clinic, as I will be neither staff, a volunteer, nor a patient. As I will not do observations of consultations or actual treatments, this will also limit the invasiveness for those attending the clinic.

However, there are still ethical concerns to be aware of, and further steps to eliminate them as far as possible. Here I can draw on my training for my taught and research Masters in Social Anthropology which included extensive readings, theoretical analysis, ethical implications, and practical experience of observational methods.

As is usual with the method of observation, the main ethical issue is that you cannot get the consent of everyone who enters the location. In a large clinic, with people entering and leaving all the time, it would also be impossible. Moreover, to attempt to do so would cause a lot of disruption, which would negatively affect both patients and staff there. I will proceed in the normal way by ensuring consent is gained from the Clinic staff (as done by other researchers, such as Corossacz 2009, Cabral 2011), who will have the details of my research.

Furthermore, I will consult with the staff of the clinic beforehand, to make sure that the observation will be conducted in the manner that they are accustomed to, or feel comfortable with there (e.g. where to sit, how to approach potential participants, etc).

Indeed we have already spoken about how to proceed in a way that will keep the disruption to patients and staff at a minimum (see section on Recruitment).

Although I will stand out as a foreigner, I will try to remain unobtrusive. I will however make my researcher status clear by keeping my note-taking activities obvious. Staff can also inform any patient who is curious, or concerned, that I am from the University and am doing research. And I will follow the guidance of authors such as Adler and Adler (1994), and Agar (1996) on explaining what I am doing to anyone who asks or approaches me. Reflexivity will also be crucial for this method, and extensive notes will be taken and analysed continuously, as with the notes on everyday life in Rio.

I will submit further ethics forms if I decide to conduct a more 'active' participant observation later during the fieldwork, if it is deemed feasible or productive. My participation however, will obviously always be limited, as I am not a mother or sterilised.

What criteria will be used in deciding on inclusion/exclusion of participants?

Criterion-based sampling will be used where the samples are chosen because they have particular features or characteristics which will enable detailed exploration and understanding of the central themes that I am focusing on. I will also use 'stratified purposive sampling', which is a hybrid approach that enables the comparison of different subgroups that are each fairly homogenous.

A range of criteria will therefore be used when selecting the sample, for example: I will attempt to interview both lower and middle-class women. Data on lower-class women is important to obtain, as it will provide continuity with the previous studies on sterilisation, and also clarify how the recently changing context has affected the approach to and use of sterilisation. Middle-class women will be interviewed, as they have not been included in any previous studies on sterilisation, and this economic class is expanding greatly with the growing economy of Brazil.

The majority of interviews will be with women who were sterilised recently. This will allow a focus on the period since the Rede Cegonha Programme was started in 2011, and a comparison with previous studies, the majority of which were completed soon after sterilisation was legalised in 1997 (a very different social and economic environment). This will help to increase understanding of the issues involved around sterilisation today. It will also facilitate discussion on the personal feelings of the experience, allowing a focus on both fresh memories, or a short time where feelings or changes have been processed and made sense of.

A small subgroup of women that are thinking of becoming sterilised, or who were sterilised years ago will also hopefully be interviewed, as this will illuminate any continuity or change across generations.

A small subgroup of clinicians will also be interviewed because this will allow a comparison with a medical perspective. These professionals can often influence the ability of women to be sterilised in Brazil.

A subgroup of men will also be interviewed, as this will provide a gendered perspective. Men are often left out of studies of reproduction and contraceptive technologies, especially in Brazil. Cultural ideals of gender, sexuality and the body have a significant impact on contraceptive practices there. It is therefore also important for my research to interview men as I am linking reproduction with the wider kinship networks within which it takes place.

How will the sample be recruited?

The sample will be recruited in several ways, and I will follow the usual method in Brazil of getting in touch with people through mutual contacts. My main way of contacting participants will be through academic contacts, i.e., through my colleagues at the Institute for Social Study of Medicine (IMS) at the State University of Rio de Janeiro (UERJ) where I will be a doctoral fellow, or the Latin-American Centre for Research on Sexuality and Human (CLAM), also at UERJ. My supervisor at IMS has conducted a lot of research on health issues and has contacts at Municipal health clinics, private clinics and also the public [facilities].

My main research location will be at [two clinics]. I met with the head of Reproductive and Sexual Health, and staff to discuss my research, and they confirmed that they would be happy for me to conduct it there. Although the hospital is public, it attends patients from a range of backgrounds as it has a good reputation. They attend lower class women, but also middle class and sometimes even attend patients from outside of the city.

The department has a gynaecological section, where I can meet women who have recently been sterilised (younger and older). They also have a Family Planning Programme, where women come to learn about contraceptives and sterilisation. This would be a good way to meet women who are thinking of becoming sterilised. The [other] clinic has a small gynaecological health session [each week], which I could use to supplement my interviews. The staff said that they would be happy for me to interview several clinicians as well. Finally, I could meet men who attend the general family health sessions too.

After consulting the staff and director of the Hospital clinic, colleagues at IMS and researchers who have interviewed women on health, contraception and sterilisation (e.g. Cristiane de Silva Cabral, and Sonia Corrêa), I have decided that my recruitment process will consist of two main approaches.

Firstly I have decided, in consultation with the medical staff, that the best approach to start off with would be for the doctors to speak to the women after their consultation. They will ask if the woman has been sterilised, describe my research briefly and ask if they would like to talk to me.

They will highlight that it is not compulsory and that it will be a private discussion. They will bring her to a private room to talk with me, where I will then introduce myself, describe my research, and outline the information that is supplied on the information leaflet. I will also give them time to read it in private, and then the opportunity to ask questions, before discussing and signing the consent form.

Secondly, as time goes on and I become more familiar with the setting and how things work, I may switch my approach (again in consultation with colleagues and the medical staff) and follow the usual method of recruitment here: i.e. waiting in the clinic waiting room, and approaching the women directly there. Approaching people directly fits into the general way that things are done here in Rio, as face-to-face meetings are usually preferred. Furthermore, the women often have to wait one or two hours to be seen, so it is generally more convenient for them to talk there.

On approaching a potential participant:

I will give a brief explanation of who I am and what I am doing there (following the ethically-approved information leaflet as a guide). 2) I will highlight that it is not obligatory, and they can decline after I provide them with more information. 3) I will go with them to another room for the interview for more privacy. There I will give them the information leaflet, give them time to read through it alone, and explain it again in more detail. 4) I will emphasise again that they don't have to do it, or can do it another time, and provide the consent form if they accept. 5) If the participant wants to talk but cannot do it then, we will arrange to meet elsewhere at another time. I will give them my contact details if they are unsure, so they can have some time to think it over and can contact me later if they wish to talk.

Finally, although the clinic will be my main focus, the sample may also be recruited through the traditional method of snowballing. This will be done through my contacts, and with primary participants' acquaintances or family, for example: recruiting friends, mothers, husbands, and their adult children if they have any. This method will also be used to recruit middle-class women, and men.

Will the study involve groups or individuals who are in custody or care, such as students at school, self help groups, residents of nursing home?

No

Will there be a control group?

No

What information will be provided to participants prior to their consent? (e.g. information leaflet, briefing session) Please provide copies.

Potential participants will be provided with an information leaflet prior to their consent. This will include a short summary of the study, who is funding it and responsible for it, an explanation of what will be involved for the participant, and issues of confidentiality and how the data will be used and stored. It will also include details of whom to contact for further information.

The leaflet provided here is a guideline only. The preparatory phase of fieldwork will allow it to be translated into Portuguese and worded appropriately with due consideration for the socio-cultural context of the participants in Rio de Janeiro.

There will also be a conversation before the interview to provide participants with the opportunity to clarify any issues or ask any further question.

Participants have a right to withdraw from the study at any time. Please tick to confirm that participants will be advised of their rights, including the right to continue receiving services if they withdraw from the study.



Will it be necessary for participants to take part in the study without their knowledge and consent? (e.g. covert observation of people in non-public places)

No

Where consent is obtained, what steps will be taken to ensure that a written record is maintained?

Consent forms will be prepared in advance, and used for each interview. There will also be an audio recording of consent if possible. They will be stored electronically on an encrypted hard drive, or in a locked filing cabinet.

In the case of participants whose first language is not English, what arrangements are being made to ensure informed consent?

Interviews will be conducted in Portuguese.

Will participants receive any financial or other benefit from their participation?

No

Are any of the participants likely to be particularly vulnerable, such as elderly or disabled people, adults with incapacity, your own students, members of ethnic minorities, or in a professional or client relationship with the researcher?

No

However, I have taken courses (with a practical element) that address issues of power relations and positionality in research, such as 'Reflexivity in Qualitative Research'. It will be crucial to be aware of these issues throughout the research, particularly as sensitive topics may be raised that might make the participant feel vulnerable.

Prior research has been done on class, gender and race relations in Brazil, and further research will be done on Rio de Janeiro during the initial embedding phase.

Taking notes straight after each interview and continuous self-assessment over the course of the research should increase my awareness of the power relations and impact that I have on the participants and data.

Will any of the participants be under 16 years of age?

No

Do the researchers named above need to be cleared through the Disclosure Scotland procedures?

No

Will any of the participants be interviewed in situations which will compromise their ability to give informed consent, such as in prison, residential care, or the care of the local authority?

No

IMS (State University of Rio de Janeiro) and CONEP (National Research Ethics Council of Brazil)

The Ethics Committee (CEP) of the State University of Rio de Janeiro required a review of the ethics application and documents from Edinburgh University (as above). The only subsequent change involved the format of the consent form, so that it aligned with the CEP and CONEP requirements (see Appendix C below).

Changes required by CONEP included further additions to the consent form, including points on: financial reimbursement, assistance provided in case of distress, guarantee from supervisor and explanation of the role of the University Ethics Committee. See Appendix C below for details. Details of the ethics application approved by CONEP follow:

COMISSÃO NACIONAL DE ÉTICA EM PESQUISA

Título da Pesquisa: Um Estudo Sociológico das Tecnologias de Aprimoramento Referentes à Saúde: Esterilização no Brasil

CAAE (Ethical Approval Reference Number): 14260213.8.0000.5260

Instituição Proponente: Instituto de Medicina Social-Universidade do Estado do Rio de Janeiro-UERJ

Apresentação do Projeto:

Trata-se de um projeto de doutorado, que está sendo realizado na Edinburgh University em uma parceria com a Universidade do Estado do Rio de Janeiro e que conta com financiamento da Wellcome Trust.

Hipótese: O aprimoramento corporal e vital é uma questão sociopolítica e cultural. Uma pesquisa empírica sobre as tecnologias de aprimoramento referentes à saúde pode explorar como as questões a respeito do aprimoramento (tais como envelhecimento, beleza e identidade) podem ser profundamente afetadas por categorias de identidade social (por exemplo, gênero, raça e classe), normas culturais, e entendimentos relacionados sobre o corpo.

Metodologia: Trata-se de um estudo qualitativo, no qual serão realizadas entrevistas semi-estruturadas, em profundidade e observação. Serão entrevistadas aproximadamente 48 pessoas, sendo 30 mulheres, 10 homens e 10 profissionais de saúde. Dez das mulheres serão entrevistadas duas vezes, somando um número máximo de 58 entrevistas. Os participantes serão recrutados nos [clinic names and locations]. O processo de recrutamento consistirá de duas abordagens principais. As entrevistas serão conduzidas com as mulheres e os homens, após suas consultas, numa sala particular com privacidade. Há ainda a possibilidade da pesquisadora aguardar na sala de espera da clínica e abordar as mulheres ou homens lá diretamente. O recrutamento pode se dar também através de indicações dos participantes da pesquisa. A observação etnográfica também será realizada e visa compreender a vida e a cultura cotidianas no Rio. O tempo passado entre entrevistas na clínica será usado para observações também. Embora a meta principal seja ter acesso a participantes para entrevistas, o local pode fornecer dados observacionais úteis para ajudar a ganhar uma ideia geral do tipo de pacientes que frequentam a clínica (por exemplo, idades e raça dos pacientes).

Crítérios de inclusão: a amostra será "baseada em critérios". Pretende-se incluir mulheres de diversas idades, classes e lugares. Uma faixa de critérios será usada, portanto, para selecionar uma amostra, por exemplo: tanto mulheres de classe baixa e média serão entrevistadas. A maioria das entrevistas será com mulheres que passaram pela esterilização recentemente, nos últimos cinco anos. Isso ajudará a aumentar a compreensão sobre as questões envolvidas em torno da esterilização

atualmente. Também facilitará uma discussão a respeito dos sentimentos pessoais sobre a experiência, permitindo que sejam focadas tanto memórias muito recentes ou de um período curto, no qual sentimentos ou mudanças tenham sido processados e raciocinados. Um subgrupo menor de mulheres que estão pensando em realizar a esterilização será entrevistado, e mulheres mais idosas também serão entrevistadas, pois isso poderá evidenciar a continuidade ou mudança ao longo das gerações. Um pequeno subgrupo de profissionais de saúde também será entrevistado, porque isso permitirá uma comparação com a perspectiva médica. Um subgrupo de homens também será entrevistado. Os mesmos serão homens que tenham sido esterilizados, ou cujas parceiras o foram. Os critérios para selecionar participantes para uma segunda entrevista incluem: mulher que tenha sido esterilizada recentemente; que forneça um bom número de dados relevantes ao assunto, especialmente nas áreas primárias, como aprimoramento, o corpo, e esterilização; que esteja contente em falar mais; e que tenha tempo disponível.

Cr terios de Exclus o: Mulheres que nunca usaram contracep o ou fizeram a laqueadura. Homens que n o t m companheiras esterilizadas, ou que n o fizeram a vasectomia. Profissionais de sa de que n o participam em programas de planejamento familiar. Jovens menores de 18 anos.

Objectivo da Pesquisa:

Objetivo Prim rio: 1) Explorar os sentidos do corpo/indiv duo (n o) reprodutivo saud vel no Rio de Janeiro, Brasil; 2) Examinar os entendimentos (relacionados) sobre a tecnologia de esteriliza o; 3) Fazer uma contribui o  s teorias sociol gicas sobre o conceito de aprimoramento. O aprimoramento   uma quest o problem tica, de uma perspectiva sociol gica, uma vez que n o est  claro o que distingue uma tecnologia de aprimoramento de uma terap utica. Esta pesquisa almeja fornecer uma nova perspectiva sobre a defini o de aprimoramento.

Objetivos Secundários: Explorar as perguntas seguintes: A) Quando e como as mulheres são esterilizadas no contexto brasileiro? (Objetivos Primários 1 & 2). B) Como a esterilização afeta a identidade (gênero, paternidade, sexualidade, status social etc.) e experiências relacionadas (como são percebidos a saúde, envelhecimento, libido etc.)? (Objetivos Primários 1 & 2). C) A esterilização é vista como um procedimento (ou parte de um pacote de procedimentos) que melhore o funcionamento ou características além do necessário, reparando o corpo ou sustentando a saúde e o bem estar emocional? (Objetivos Primários 2 & 3). D) Quais são as implicações da esterilização na forma como entendemos as identidades e corpos humanos? (Objetivo Primário 3). E) Como as descobertas empíricas desafiam ou apoiam os conceitos prevaletentes de "terapia" e "aprimoramento"? (Objetivo Primário 3).

Avaliação dos Riscos e Benefícios:

Riscos: Algumas questões de ordem pessoal durante as entrevistas podem causar algum desconforto às participantes; contudo, os participantes são livres para não responder a nenhuma pergunta que não queiram ou parar a entrevista em qualquer momento. A pesquisadora descreve uma série de cuidados, que incluem: tocar em temas mais sensíveis (como sexualidade, por exemplo) apenas na segunda entrevista, fazer uma pergunta geral e só colocar a questão no âmbito pessoal se a reação à pergunta geral for boa e modificar a ordem das perguntas.

Benefícios: Os benefícios poderão ser a oportunidade de compartilhar as experiências e opiniões sobre contracepção e esterilização. Essa pesquisa aumentará o entendimento das experiências no tratamento de saúde e necessidades das mulheres e dos homens. Também fornecerá informações que melhorarão a política e práticas de tratamento de saúde no Brasil, e no exterior, particularmente saúde da mulher.

Appendix B: Recruitment Leaflet

Leaflet format altered from original 'landscape' layout to 'portrait' in order to align with the thesis format:



The University of Edinburgh | College of Medicine and Veterinary Medicine
Centre for Population Health Sciences

Sterilisation: A Study of Reproductive Health and Family Life in Rio de Janeiro



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THE UNIVERSITY
of EDINBURGH

An invitation to take part in a research project

You are invited to take part in '*Sterilisation: A Study of Reproductive Health and Family Life*'. I am interviewing women living in Rio de Janeiro about their views and experiences of their health and family life. My name is Aoife McKenna and the study is a PhD degree research project at The University of Edinburgh. This research will increase understanding of the healthcare experiences and needs of women, and will provide information that will improve healthcare policy and practices in Brazil.

Who is invited to take part?

For this study, I am looking for women that have been sterilised, or are thinking about being sterilised. Taking part is voluntary and you can withdraw your information from the research at any time before the research report is completed.

What happens next?

If you are interested in taking part please contact me by phone (2181257465) or email (A.McKenna@sms.ed.ac.uk). I will arrange an individual interview at a time and place convenient for you. The interview will take around one hour or 90 minutes, and you may be asked to do a second one.

I plan to audio-record the interview and type up a text of the interview. Anything you say will be confidential within the research team. No real names, addresses or other identifying details will be used in any printed material. Material stored on a computer will be password protected. Any printed information where real names are used will be kept separately in a locked cabinet in accordance with data protection regulations.

What will happen to the information you collect about me?

The research will be published as a PhD thesis, in reports and articles. I will send you a summary of the research if you wish. I may quote your words, but will not reveal who is speaking. After the study, text files of interviews will be stored for five years in the archive of the Centre for Population Health Sciences at The University of Edinburgh. Any details that might identify participants will have been removed.

Who is funding the study and who is responsible for the research?

I am being supervised by Professor Sarah Cunningham-Burley, Dr Gill Haddow and Dr Martyn Pickersgill. I am based at the Centre for Research on Families and Relationships, and my department is in the Centre for Population Health Sciences, at The University of Edinburgh. I am funded by the Wellcome Trust as part of a Biomedical Ethics Strategic Programme on *The Human Body: its scope, limits and future*.

I am also a doctoral fellow at the Instituto de Medicina Social, at the Universidade do Estado do Rio de Janeiro, where my co-supervisor is Professor Kenneth Rochel de Camargo, Jr.

CONTACT

If you would like to know more about the study, please contact me:

Aoife McKenna

The University of Edinburgh

23 Buccleuch Place, Edinburgh, EH8 9LN

E: A.McKenna@sms.ed.ac.uk

T (U.K.): xxx xxxxxxx

T (Brasil): (21) 81257465

or my supervisor:

Professor Sarah Cunningham-Burley

Centre for Population Health Sciences

University of Edinburgh

Medical School, Teviot Place

Edinburgh, EH8 9AG

E: sarah.c.burley@ed.ac.uk

T: 0131 650 3217



Information about the study and the Centre for Research on Families and Relationships can be found at: www.cfr.ac.uk

Thank you very much for reading this information.

Appendix C: Consent Form

Consent form as approved by CONEP, and translated from the Portuguese:

Consent Form [IMS Logo]

A Sociological Study of health-related enhancement technologies: Sterilisation in Brazil

You are being invited to participate, as a volunteer, in the study 'Sterilisation in Brazil,' developed through the Institute of Social Medicine, State University of Rio de Janeiro, and the Centre for Research on Families and Relationships, University of Edinburgh, United Kingdom, conducted by Aoife McKenna. The aim of this study is to increase the understanding of experiences of health treatments of women and men, providing information that can improve the policies and practices of health treatments in Brazil.

You were selected because you were sterilised, or are interested in the possibility of being sterilised. Your participation is not obligatory. At any moment, you can stop your participation in the study and withdraw your consent. Your refusal or withdrawal of consent will not cause any harm.

Your participation in this research will consist of talking to the researcher for 60 – 90 minutes, in a private room within a clinic, or in another location that you prefer to choose. You may be asked to take part in a second interview. Aoife McKenna will conduct the interview, and nobody else will be present. The content of the interview will be about topics including family, health and reproduction (contraception and birth). The interview will be audio recorded only with your permission.

The data obtained through this research will be confidential and not disclosed at an individual level, to ensure the confidentiality of your participation. The material will be stored in a private computer and will be password protected, according to data protection norms.

The responsible researcher will make the results of the research public through academic and scientific fields in a form that will not identify any individual participants. The researcher will send you a short summary of the research if you wish.

The possible risks of participating in the study are minimal, but if you feel uncomfortable with any topic, we can change the topic, take a break, or finish the interview. The researcher will provide assistance in the case of harm resulting from participation in the study, for example, recommending a service providing psychological support. A guarantee will be provided by the supervisor of the study if the participant requires it. Additionally, the researcher will reimburse any costs that occur due to participation in the study, such as transport and food, if it becomes necessary to travel to participate in the research.

If you agree to participate in this research, sign at the end of this document, which has two lines, one for you, and the other for the researcher responsible for the study. The telephone numbers and institutional address of the responsible researcher, and of the Committee of Research Ethics of the Social Study of Medicine (CEP-IMS), are provided below, where you can discuss any doubts about

the study and your participation in it, now or at any time. The aim of CEP-IMS is to analyse, evaluate and accompany the research projects, with respect to the ethical questions involved, according to Resolution No. 466/13 of the National Commission of Research Ethics (CONEP).

Initials of participant: _____

Initials of researcher: _____

End of Page 1.

Contact details of responsible researcher: Aoife Mckenna, Instituto de Medicina Social, Rua São Francisco Xavier, 524, Pavilhão João Lyra Filho, 7º andar / blocos D e E, e 6º andar / bloco E, Maracanã, Rio de Janeiro CEP 20550-900.

Telefone:___ Email:_____

Contacts of Supervisor: Professor Kenneth Rochel de Camargo Jr., Universidade do Estado do Rio de Janeiro, Centro Biomédico, Departamento de Planejamento e Administração em Saúde. R. S. Fco. Xavier, 524 7º andar Bloco D. Maracanã. 20559-900 - Rio de Janeiro, RJ - Brasil

Telefone: ___ Email: _____

Comitê de Ética em Pesquisa do Instituto de Medicina Social da UERJ: Rua São Francisco Xavier, 524 – sala 7.003-D, Maracanã, Rio de Janeiro, CEP 20559-900. Telefone (21) 2334-0235, ramal 108. E-mail: cep-ims@ims.uerj.br Office contact hours: Monday, Wednesday and Friday afternoons; and Tuesday and Thursday mornings.

I declare that I understand the aims, risks and benefits of my participation in this research, and that I agree to participate.

Rio de Janeiro, ___ de _____ de _____

Signature of participant: _____

Signature of researcher: _____

End of Page 2.

Appendix D: Interview Topic Guide

Translated from the Portuguese:

1. General characteristics and present circumstances

- Age
- What word do you use to describe your colour?
- Where were you born? How long in Rio?
- Where do you live? Do you like it?
- Do you have a religion?
- What do you do?
- How many children do you have? How old are they? How many pregnancies did you have?

2. Family

- Could you tell me a bit about your family when you were younger?
(Parents, siblings. Schooling)
- Do you think it is important to have children? Was it important for you?
- What makes a good parent? (gender)

3. Healthcare

What do you think about the health system in Brazil?

- What have your experiences been like with SUS? Good, bad etc..
- Do you hear or see information about health from other sources, like the media etc.? Types etc.

4. Health Understandings, Experiences

- What do you think it means to be healthy? / Why are some people more healthy than others?
- How is your health at the moment? Why did you come here today?
- Do you like to do anything for your health?
(If topic of emotions raised – do you there is a link between emotions and health?)
- How do you feel about your body?

(Menstruation, aging, menopause, appearance)

5. Reproductive/contraceptive experiences

5.1 Contraception

- Did you learn about reproductive or sexual health when you were younger?
- Where did you learn about contraception?
- When did you first start to use contraception? How was the experience?

(important or not, types, relationships, side effects)

5.2 Births

- When did you have your first child?
- What was the pregnancy like for you?
- How was the birth? (vaginal/caesarean)
- Did you use contraception afterwards? How were the other births?

6. Sterilisation

- When did you decide to be sterilised?
- Why? (Why no more children?)
- Can you tell me a bit about the surgery?

(Access, where, paid, partner etc)

- How did you feel after the surgery? Any changes?
- How do you feel about it now?

(happy, improvements, no change, regret)

- Do you think that everyone should have the right to be sterilised?

(vasectomy, youths, compare with mothers, recommend for children)

7. Final

- Summarise general experiences with contraception and sterilisation – check back.
- Would you like to talk about anything else? Have you any other thoughts or something I've missed?

- Have you questions for me?

Appendix E: Analysis Coding Framework

Sample Characteristics

Sample Characteristics/Age

Sample Characteristics/Ethnicity, Colour

Sample Characteristics/Religion

Sample Characteristics/Home Location

Sample Characteristics/Occupation

Sample Characteristics/Education

Family

Family/Childhood

Family/Daily work

Family/Daily work/home-maker

Family/Daily work/employed/*doméstica*

Family/Daily work/ employed/other

Family/Understandings

Family/Understandings/Collective

Family/Understandings/Reconstituted

Family/Understandings/A pair

Family/Parenthood

Family/Parenthood/Mothers

Family/parenthood/Fathers

Family/Conjugal Relationships

Family/Conjugal relationships/Emotion & romance

Family/Conjugal relationships/Distrust & cheating

Health

Health/Wellbeing

Health/Wellbeing/Emotional health

Health/Wellbeing/Emotional health/place
Health/Wellbeing/Emotional health/spirituality
Health/Wellbeing/Inequality Critique
Health/Wellbeing/Body
Health/Wellbeing/Aging
Health/Wellbeing/Plastic surgery
Health/Medical Treatment

Health System

Health System/Place
Health System/Bureaucracy
Health System/Bureaucracy/Registering
Health System/Bureaucracy/Making Appointments
Health System/Bureaucracy/Attending Appointments
Health System/Facilities
Health System/Facilities/Political & Inequality Critique
Health System/Healthcare Professionals
Health System/Healthcare Professionals/Lack of attention
Health System/Healthcare Professionals/Active dismissive
Health System/Healthcare Professionals/Errors
Health System/Positive Experiences
Health System/Positive Experiences/Spirituality
Health System/Positive Experiences/Contacts & Place

Contraception

Contraception/Access
Contraception/Access/Jeitinho
Contraception/Access/Health Clinic/Before pregnancy
Contraception/Access/Health Clinic/After pregnancy
Contraception/Access/Family

Contraception/Intimate Relationships

Contraception/Intimate Relationships/Distrust & Condom

Contraception/Intimate Relationships/Gendered Relationships

Contraception/Intimate Relationships/Sexual Satisfaction

Contraception/Intimate Relationships/Fluidity & Relapse

Contraception/Daily Lives

Contraception/Daily Lives/Fluidity

Contraception/Side Effects

Contraception/Side Effects/Mal estar

Contraception/Side Effects/Other

Sterilisation

Sterilisation/Date

Sterilisation/Operation type

Sterilisation/Legality

Sterilisation/Operation Evaluation

Sterilisation Access

Sterilisation Access/Before Legalisation

Sterilisation Access/Before Legalisation/Doctor-patient relationships

Sterilisation Access/Before Legalisation/Institution & Infrastructure

Sterilisation Access/After Legalisation

Sterilisation Access/After Legalisation/Doctor-patient relationships

Sterilisation Access/After Legalisation/Institution & Policy

Sterilisation Access/Planning

Sterilisation Access/Planning/Private

Sterilisation Access/Planning/SUS

Sterilisation Access/Planning/Barriers

Sterilisation Decision

Sterilisation Decision/Life Conditions

Sterilisation Decision/Miscarriages

Sterilisation Rights

Sterilisation Rights/Irresponsible Reproduction

Sterilisation Rights/Individual Choice

Sterilisation Rights/Fighter

Sterilisation Rights/Youths

Sterilisation Evaluation

Sterilisation Evaluation/Reducing Worry

Sterilisation Evaluation/Reducing Worry/Improving Sex

Sterilisation Evaluation/Reducing Worry/Regret Discourse

Appendix F: Process of Analysis & Theme Construction

As described in Chapter 3, the process of analysis for this thesis was complex, taking place at different times, using different approaches and multiple techniques. Two examples are presented here to illustrate the analytical process. The first relates to the construction of a primary theme, demonstrating how I worked across interview transcripts to ensure rigour in my analysis. This theme on sterilisation access provided a conceptual lens to interpret the data on sterilisation across the varying historical/legal contexts and its link to caesarean section births. At the same time, it also enabled me to trace the differences and similarities across the various groups of women in terms of social categories such as class and race. The second example of the process of analysis relates to how I used performance narrative analysis techniques. This approach enabled me to interpret the data in relation to the theme of agency and power dynamics, which emerged within, and across, various primary themes such as healthcare and sterilisation access.

1. Thematic Narrative Analysis: Sterilisation Access Theme

When thinking about women's experiences of their sterilisation operation, I was surprised that there was still a strong link evident between caesarean sections and sterilisation, and also that some women still had difficulty accessing the operation. I was therefore interested to examine the relationship between these experiences of sterilisation and the changing law and policies. I had sub-codes on sterilisation as postpartum or interval, and on sterilisation by illegal or legal means. I decided to use sticky notes to provide a concrete visualisation of the various potential ways of addressing these issues. I divided each sticky note into four parts and I wrote out: the name of a participant, the date of her sterilisation, whether the operation was postpartum or interval, and noted her evaluation of it as positive or negative.

I organised these into various groups in my notebook, first by chronological date, then by operation type. These groupings highlighted issues such as the continuities and differences across time and the relationship between sterilisation and caesarean births. The lack of significant change after the legalisation of the operation was also apparent, although it was still not very clear. Finally, I found that reorganising the sticky notes into groups - those sterilised before and after the law and those planning to sterilise - clearly highlighted the relationship between caesarean births and sterilisation, the continuities or changes after the law and the contemporaneous context, as well as allowing me to investigate in further detail why some experiences were evaluated as positive or negative. This process emphasised the similarities between these accounts of the experience of sterilisation and the accounts of women's experiences of the healthcare system, and clarified that they fit into an overall theme regarding access to the operation.

2. Performance Narrative Analysis: Analysing Agency Theme

As detailed in Chapter 3, while thematic analysis examines the content, structural analysis focuses on *how* narratives are organised. Performance analysis makes use of elements of both of these approaches, while also examining how talk between speakers is interactively produced and performed.

Many of the women's accounts contained performative elements, where they act out a story instead of merely reporting it. The linguistic features, and the organisation of the text, becomes particularly significant in this context. I thus used structural elements of narrative analysis to interpret the accounts in various ways. For instance, it was helpful to examine how the sequence of events in a narrative were organised, as well as the use of pronouns, and of repetition to emphasise key points. I also used

a voice-centred analysis to highlight the various ‘speakers’ that were involved in the narratives, such as: the participant, me, doctors, partners, community or generalised ‘others’ etc. Additionally, noting performance elements (including direct speech, asides to the listener, expressive sounds and alternating verb tenses) also enabled me to see the prominence and role accorded to each speaker. These various techniques of performance analysis helped me to trace the varying portrayal of agency in these narratives.

For instance, in Beatriz’ narrative on sterilisation access (Chapter 7), her doctor’s voice is the only one that appears in the more active direct speech (highlighted green below). The third person pronoun is used more frequently (font colour in red below), again highlighting the focus of the narrative on the doctor, whereas the first person pronoun (font colour in blue below) is used only in a passive formulation. The underlined phrases or words show which sections of speech were given more emphasis by the speaker, which also reinforces the emphasis on the role of the doctor in this account:

As I got pregnant very easily, so my doctor thought it better to do the sterilisation. So it was her.....

*Mm? ... **It was she** who decided?*

*Well, she actually decided for the third child, but I didn’t want it, because it was a boy. I always had the desire to have a daughter. So then for the fourth child she said “either way, if it’s a boy or a girl, I’m going to do it,” *she was* really going to do it, you know? So much so that she didn’t charge me...*

As my interpretation outlines in subsection 7.2.2 above, the doctor’s active agency and power is emphasised, while the content shows when Beatriz was sterilised.

In contrast, Juliana’s narratives regarding her attempts to persuade various doctors to sterilise her emphasise her own voice (subsection 7.3.2). Her arguments are given

in direct speech (highlighted yellow below), highlighting her active attempts to achieve sterilisation. The alternating verb tenses reinforce the immediacy of the narrative events, emphasising both the participant's agency as well as the emotional urgency and impact.

So you tried... three times?! And I only succeeded on the fifth! And even then, at the time there open on the caesarean table, the doctor said, "I think I'm not going to tie you..." Oh! I said "you're crazy, I already have five! How can I have more? For the love of God, enough! I'm going to put it all on your bill." He, "ah but you will regret it," "I will not regret it no. Imagine taking care of five little dolls? No, that's fine, I don't want more no." So then he tied.

I used this type of analysis to work across interview cases but also to confirm my analysis across the primary themes. For instance, these types of narratives are similar to those on accessing healthcare in Chapter 5, where negative accounts of the health system are often performative, emphasising how the women's agency was blocked by structural or interaction barriers. The accounts of positive experiences of the health system, in contrast, are generally not performative in the same way. The majority are reported speech, as is the case for Monica's account in subsection 5.5.2 above:

I in particular don't have much to complain about no. [...] I think it is because my family we always lived nearby, and I had my youngest daughter here [...] and since then I always only come here, [...], so there is not much to say because I don't know much about other hospitals, but here yes it is very good, I like it. I like the service, I like the doctors. I already know various [doctors] and all of them are all very good.

This account reports the participant's satisfaction, showing that there was no obstruction, conflict, difficult interaction or need to display skills of persuasion. These narratives thus do not convey the same emotional impact or demonstrate the active agency portrayed in the accounts above.

Using performance analysis techniques within individual interviews emphasises the importance of paying attention to the portrayal of agency within participants' narratives. Additionally, using these techniques to compare within and across primary themes also reinforces the interpretation, further ensuring the rigour of the analysis.