IMAGES OF THE BODY: LAY AND BIOMEDICAL VIEWS OF THE REPRODUCTIVE SYSTEM IN BRITAIN AND BRAZIL

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by

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ABSTRACT

This thesis presents an anthropological study of ordinary people's views about the body in general and the reproductive system in particular, based on two case studies carried out in Britain and in Brazil. I discuss the meanings of lay and biomedical images of the body and identify the ways the researched groups reinterpret the biomedical view of the body anatomy and physiology.

Through the analysis of ethnographic material on time, space and domestic organisation in four shantytown groups in Porto Alegre, Brazil and in three different groups in London, UK, I point out the dwelling peculiarities of the different groups and suggest there is a relationship between embodied experiences of time/space and knowledge of the reproductive system. These arguments lead to a more general phenomenologically theorised view of gendered and status-framed bodies, consequently situating this work in the interface of Medical Anthropology and a more general socio-cultural Anthropology.

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Preface

In the last decade the body has become one of the most important areas of research in the Social Sciences. But it is relevant to recall that before the 1970's, the body as the focus of social studies represented a minor research subject. (Csordas 1993; Morgan and Scott 1993; Turner 1994; Lyon and Barbalet 1994;) With the exception of Marx's theory of alienation and Mauss' focus on the techniques of the body as a development of Durkheim's views about the individual and society, the body was nearly absent from the sociological agenda.

Among the social scientists only anthropologists may claim to have given the body some attention before that, inasmuch as basic anthropological conceptualizations of "nature" and "culture" were sometimes defined in reference to the evolution of the body to its present human form. (Turner 1991) But this very central issue regarding the separation between "nature" from "culture", that later divided Anthropology into its current streams, paradoxically reduced Social Anthropology's attention to the body. That is because in the need to distinguish Cultural Anthropology from Biological Anthropology, the "socio-cultural" body was roughly ascribed to the first while the "physical" body to the latter. In that sense the body remained an object of study in Cultural Anthropology so far as it publicly displayed signs of status, tribal affiliations, or played roles in rituals, emphasising the expressive capacities of the human body taken as a passive recipient of social processes. (Benthall and Polhemus 1975; Lyon and Barbalet 1994)

Medical Anthropology's ambivalent situation does not seem to help to overcome the division between "social" and "physical" bodies (in many situations hardly considered problematic within the Western epistemology, marked by the Cartesian legacy).

On the one hand the so called "clinical" medical anthropologists engaged in clinically relevant research might have to "succumb" to the biomedical reductionism of the body since, as cultural interpreters or as

clinical negotiators, they may have to downplay cultural, social, economic and political factors. (Singer 1989; Baer 1993) On the other hand, "critical" medical anthropologists claim to have developed a critique of the biomedical reductionism of the body and alternative concepts to deal with the body related issues at different levels, within and beyond the academy into more applied fields. (Scheper-Hughes 1990; Singer 1995).

The ambivalence thus seems to be related to how Medical Anthropologists understand the human body and the socio-polical implications of such understanding. In an attempt to resolve that ambivalence, it seems significant that, anthropologists have turned specially towards issues related to the different aspects of the human body and to the importance of discerning them in anthropological studies. This is especially evident in anthropological production such as Sheper-Hughes and Lock's (1987) seminal paper on the "Mindful Body", Frankenberg's (1994) conceptualization of the three bodies, O'Neil's (1985) "Five Bodies", Douglas (1973) "The Two Bodies". The importance of these distinctions is obvious in my research. But however clear it may be that the body has many aspects, only some can be discussed in this thesis.

This thesis started with discussions specifically of Medical Anthropology because that is where, as I will show, my own researches in Brazil begun, but it is now mainly situated in the interface of Medical Anthropology and a more general socio-cultural Anthropology. It is informed by and hopefully contributes to those particular aspects of the sociology of the body elaborated by Pierre Bourdieu who situated himself intellectually and bibliographically at the interface of Anthropology and Sociology. My introduction, then, reflects my intellectual history in this area starting with the specifics of a Medical Anthropology of the Body and Birth Control in a Brazilian barrio and seeking to end with a more general phenomenologically theorised view of gendered and status-framed bodies. The movement from the specific to the general in intellectual analysis is paradoxically but unsurprisingly achieved by a movement from researching in general the body at large to the study in detail of people's perceptions of their bodies in the

specificities of their cultural and social lives. It is the relationship between the general and the specific that is ultimately the focus of the present thesis.

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Needless to say the responsibility for the ideas set forth here is wholly my own.

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Chapter One : Introduction

" The painter 'takes his body with him', says Valery. Indeed we cannot imagine how a mind could paint. It is by lending his body to the world that the artist changes the world into paintings. To understand these transubstantiations we must go back to the working, actual body - not the body as a chunk of space or a bundle of functions but that body which is an intertwining of vision and movement." Maurice Merleau-Ponty - The Primacy of Perception and Other Essays

Lay and biomedical images of the body: the dimensions of knowledge production

Within the field of Medical Anthropology, comparative studies of lay and biomedical notions of health and illness have been an important area of research promoting discussions about the health-illness processes in a broader socio-cultural context. In many studies, ethnographic findings highlight that lay people's views of health and illness differ a great deal from their biomedical counterparts, suggesting that an apparent pan-human ever-existing event such as a dis-ease is a highly complex multifaceted process, that may be better treated by healing systems other than biomedicine. (Kleinman 1978 (a), Graham and Oakley 1981, Farmer 1988, Ots 1990, Langford 1995)

Frankenberg's (1986) description of the concept of "illth" exemplifies what I mean by the multiple meanings of the dis-ease process. Defined in opposition to the idea of wealth, in the sense of well being, "illth" accounts for the broader social context and implications of what has been described in the medical anthropological literature as the biomedical perspective - the disease - and the person's evaluation of a health problem - the illness. (Kleinman 1978; Helman 1990). Alternatively to the limiting disease X illness dichotomy, Frankenberg

(1980, 1986) suggests the concept of sickness "that refers to the way that illth is socially and culturally performed" (1992:7). That places the dis-ease process in a much broader field of social interactions rather than in the physician's consulting office, by separating the issue regarding lay and biomedical perspectives from the idea of a limiting bi-dimensional interpretation of the same bodily process. In that sense differences in lay and biomedical perspectives do not merely represent problems of the type doctor-patient interaction. Rather they belong in the much wider socio-cultural realm of bodily experience.

Although differences between lay and biomedical perspectives have especially been addressed by medical anthropologists in the last two decades, in the disease-illness-sickness-suffering debate (Kleinman 1978; Helman 1990; Frankenberg 1886; Hahn 1983), the medical anthropological literature traces this controversial issue back to around 400 BC, pointing out Hypocrites' attribution to physicians the treatment of "diseases that have a nature and definite cause," implying the existence, at another level, of the "so-called Sacred Disease." (Scheper-Hughes and Lock 1987; Hahn 1983). But despite the controversy's long term history, the debate concerning lay and biomedical views of bodily processes and functions is still a fruitful field of research in Medical Anthropology and I see it as the starting point to the present discussion.

The issues that set up the basic research points to be discussed here, have been originated in a former study I carried out within an urban working class, low income group of women in southern Brazil (Victora 1991). This study showed, among other things, that even when lay people have been exposed to the medical model of the human reproductive system, their views of this system are based on other cultural notions, values and practices. Besides I observed that even when people spoke about the reproductive organs or represented them graphically according to the medical model, they conveyed particular meanings to them, based on their physical sensations, or emotional and social experiences.

In that ethnographic study, the women informants were also asked to make a drawing of their reproductive systems. They were given a drawing of a female silhouette and asked to make all the organs that were somehow related to

reproduction. The research findings showed that their graphic images of the female reproductive organs corresponded, in general, to the biomedical graphic model of the body that portrays an universal system in the sense that it is valid for every woman (except for those who have some biological "abnormality"). However, their oral accounts of the functioning of the respective systems referred to a singular body, pointing out their personal experience as basic for their understanding. This distinction was found through the employment of different research techniques within an ethnographic orientation. So, while in the drawings of the reproductive system, they reproduced the medical model of the body, in informal interviews the informants implied another image of the functioning of their reproductive systems, indicating a perception pervaded by the recall of previous experiences of pregnancy and by physical sensations related to some organs, as well as their body shapes.

Besides picturing the body basically according to the medical model and, at the same time, describing its unique functioning, the informants, in certain situations, referred to bodily processes making use of what I called a "reinterpretation of the medical discourse". This was specially true when the informants were interacting with other people, and attempting to make sense of what doctors told them about specific diseases.

At first glance, these three kinds of information could suggest contradictory ethnographic findings, since apparently each pointed towards a different direction. Instead, I suggest that some epistemological issues should be addressed in order to make sense of the informants' statements.

I suggest that for analytical purposes, the process of knowledge production about the body and the reproductive system as seen in the ethnographic findings above, could be divided in, at least, three dimensions, expressed in three different discourses.

The first discourse refers to the assimilation of the graphic image of the medical model of the body. However it is not a thorough assimilation, as some organs may be emphasised more than others in the drawings, according to the informant's physical perceptions or social recognition of them. But, in general, they coincide with the medical discourse, acknowledging the presence of key

organs in the reproductive process, i.e. the womb and the fallopian tubes. They also denote a very accurate idea about the actual physical size and proportion of these organs in relation to the rest of the body. I call this the "visual dimension," since the overall ethnographic data has shown that the informants have been exposed to the biomedical picture of the body in medical consultations at the local health centre, on television programmes, in magazines and newspapers, and have kept a visual record of it.

The second dimension refers to a practical knowledge of the body. It is a physical knowledge because it refers to their learning through bodily sensations. It is a bodily produced knowledge based on the informants' experience of their bodies as a locus of sensation, perception and interaction. (Frank 1986). Through this dimension, which I call physical, the informants take their bodily sensations as the source of knowledge production. They may, during a second stage, formulate a rational discourse about their bodily processes, thereby enabling them to express their perceptions to other people in social interactions, through the third dimension.

The third one is the social dimension. It accounts for a negotiated knowledge, made evident in the process of the making social of bodily sensations. Here, symbolic and metaphorical aspects become more visible, as the cultural legitimisation of emotions and perceptions presupposes a shared ground of beliefs and a common language of experience. The social dimension refers to culturally constructed modes of interpreting sense of physical phenomena, their interpretation and labelling, as well as the negotiated process of help seeking. This is the dimension where the process of social legitimisation takes place, and refers to communication procedures, such as healer-client, client-healer, and client-client interaction.

The identification of different dimensions of knowledge production has also been pointed out by Young (1980, 1981). He suggests, as I do, that "the actor does not know all of his medical facts in the same way," he continuously evaluates his knowledge "against his intentions, expectations of events and sometimes compares it with other bits of his knowledge of similar events." (Young 1981:379) This processual view of knowledge is one important aspect of

the present theoretical approach to the theme of body imagery, because it is related to the notion of social and cultural phenomena as dynamic processes rather than as static realities.

The field of biomedicine

Although this book does not aim at biomedical knowledge or biomedical practice, I mention biomedicine in different moments.[1] For this reason it is crucial to clarify in the very beginning of this report what aspects of such a complex world of knowledge I am pointing at when I refer to "biomedicine". In the background of my research proposal there is a basic understanding that biomedicine - also known as "modern" medicine, "cosmopolitan" medicine, "western" medicine, "scientific" medicine - is both "cosmopolitan" and culturally specific in the sense that at the more general level of principles it is an international model, but at the micro level of practice, it is adapted to local realities.

By biomedical "principles" I mean explicitly written formulations presented in books and manuals found in different languages and employed to instruct medical students and professionals throughout the world.[2] These books serve as basic references for medical rationale and practice, but also provide important evidence of changes in medical concepts and procedures through time. Some of these changes have derived from advances in science, revolutionary diagnostic procedures, or new technologies that enhance biomedical knowledge production. Other changes do not rely so much on "scientific" inputs. Rather, they are anchored on other domains,

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[1] For a discussion about the importance of cultural studies of Biomedicine see Good (1994). For an introduction to Anthropology of Biomedicine see Hahn and Kleinman (1983).

[2] Even though medical (and veterinary) books and manuals, specially anatomy and physiology ones are found in different languages, most of them are translations of English. German or French originals.

such as ethics, religion, ideology - supposing it was actually possible to separate one from the others.[3]

I suggest that there are different types of biomedical "principles", some that I have called "structural" principles, and others "operative" principles. Metaphorically speaking - in a rough comparison with the religious field - "structural" principle would be something like the belief in the existence of God(s), while "operative" principles could be compared with writings in holy books. "Operative" principles are based on "structural" principles since they assume the latter as unquestionable truth. "Structural" principles are like dogmas. There may or may not be "real" evidence of their existence, but above all they are a matter of individual, cultural, national or international faith. "Operative" principles are also based on faith but in a different way from "structural" principles since there is a greater chance of them changing. Basically they are the rules that define the boundaries and guide the believers. One example of that would be the different versions or translations holy books have suffered throughout the centuries. Changes in "operative" principles, although likely to happen are usually very slow processes that happen over extended periods of time.

Biomedical practices, on the other hand, are much more variable than principles because even though they may only exist in reference to both types of principles, they also suffer other types of influence. To use the same religious metaphor, I could say that biomedical as well as religious practice is the local reinterpretation of a belief system. Or simply that it is the way ordinary doctors and ordinary people make use of certain types of biomedical knowledge.

The main aspects of biomedicine I address in this thesis are very simple, basic, structural biomedical principles of the anatomy and physiology of the reproductive system in the structure of the biomedical body. But these principles do not exist in a vacuum. They belong in a symbolic system where such principles are recognised and valuable.

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[3] Laqueur (1987); Foucault (1973). For changes in biomedical practice in Brazil in the nineteenth century and their relationship with local politics see Costa (1989).

Good (1994) suggests that the only reasonable way of performing comparative approaches to biomedicine is if we look at medicine as a "symbolic form", since it is " a symbolically mediated mode of apprehending and acting on the world." (:87).

Considering that medical practitioners go through several years of medical school where they learn a number of skills that go far beyond the biomedical principles, Good (1994) presents a thorough account of medical education and suggests that in biomedicine "reality is formulated and organised in a distinctive manner" (:68) . As he puts it:

"Early in the course of our study of Harvard Medical School, we came increasingly to understand that learning medicine in not simply the incorporation of new cognitive knowledge, or even learning new approaches to problem-solving and new skills. It is a process of coming to inhabit a new world. I mean this not only in the obvious sense of coming to feel at home in the laboratories or the clinics and hospitals, but in a deeper, experience-near sense." (:70)

Therefore medical education requires the embodiment of a number of "qualities", not merely the acquisition of skills, these "qualities" being relevant in that specific symbolic form. It thus requires commitment to a model.

Another fruitful way of looking at the idea of embodiment of an arbitrary symbolic form is to take biomedicine as a "field" according to Bourdieu's meaning of the expression. In that case, a field is like a pitch where a game is played - to borrow Bourdieu's sports metaphor - with its basic rules and its players. There is more to the players than knowledge of the rules of the game. Through the embodiment of the rules they acquire a "feel for the game" (1995:66), made possible by the encounter between the habitus and a field. A certain habitus is essential for membership in a certain field. The habitus, as embodied dispositions and generative classificatory schemes, implies an immanent belief, "an illusion of immediate understanding, characteristic of practical experience of the familiar universe, and which at the same time excludes from that experience

any enquiry as to its own conditions of possibility". This is called doxa by Bourdieu. (Jenkins, 1992) As Bourdieu puts it:

"Practical faith is the condition of entry that every field tacitly imposes, not only by sanctioning and debarring those who would destroy the game, but by so arranging things, in practice, that the operations of selecting and shaping new entrants (rites of passage, examinations, etc.) are such as to obtain from them that undisputed, pre-reflexive, naive, native compliance with the fundamental presuppositions of the field which is the very definition of doxa. The countless acts of recognition which are the small change of the compliance inseparable from belonging to the field, and in which collective misrecognition is ceaselessly generated, are both the precondition and the product of the functioning of the field. They thus constitute investments in the collective enterprise of creating symbolic capital, which can only be performed on condition that the logic of the functioning of the field remains misrecognized. This is why one cannot enter this magic circle by an instantaneous decision of the will, but only by birth or by a slow process of co-option and initiation which is equivalent to a second birth." (1995:68)

Seen as a field, biomedicine relies on a certain habitus (and on doxa) for membership. Through that perspective it makes sense to think of medical education as a second birth or as Good suggests as "coming to inhabit a new world". In my view, the "cosmopolitan" aspect of biomedicine derives from the fact that it is a field with all its political implications and power relations reflecting competing ideologies, dispute for discovery of new viruses, technologies, etc. It is also "cosmopolitan" when it comes to the general rules of the game and the social habitus required to take part in the game. At the same time it is culturally specific because it allows culturally specific variations of individual habitus. And since the members have the "feel for the game" ("investment sense", the art of

anticipating events, etc." (Bourdieu 1995: 66)) cultural styles of playing are likely to occur. [4]

In the field of biomedicine, anatomy and physiology of the body can be compared with the rules of a game which are not the game itself but give the game its general shape. These are the "principles" I referred to earlier in this section.

Together with this "structural" principle of the body anatomy there are several "operative" principles regarding the basic functioning of the body making up what Manning and Fabrega named the "biologistic view of the body", that has been described by these authors as follows:

"1. The body can be partitioned internally into named organs, systems and functional relationships - liver, kidney, heart, nervous, muscular-skeletal and circulatory and other systems - each carrying out identifiable activities.

2. Unless external or internal causes intervene (germs, diseases), the body functions "normally." The body, unless a person is diseased and with minor variations involving age and sex, is experienced in similar ways from person to person, situation to situation, group to group, and culture to culture.

3. The senses are universal: everyone feels, sees, hears, touches, and tastes in comparable fashion.

4. Disease is a universal, cross-culturally invariant phenomenon.

5. Boundaries between self and body are non problematic, "logical", and empirically verifiable, as are boundaries between person and other, man and nature, man and the supernatural.

6. Death is a biological process that occurs when the body ceases to function.

7. The body should be seen by persons as a natural, objective, valuationally neutral entity." (1973:255)

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[4] Jenkins (1992) raises the issue that Bourdieu's views on the relationship between habitus and field are not clear since he writes that each field generates its own habitus, but also stresses that actors bring their own pre-existing habituses to the fields they take part in. But Jenkins points out that that these two possibilities are not excludent. This is also my position in relation to the field of biomedicine. People are likely to take part in fields they are generally familiar with, fields that in general terms are common to their individual habitus.

In such view, the biological body is a universal body basically organised in a similar way, with minor (and measurable) variations according to sex and age. The present research will have as a background reference these "structural" and "operative" principles that mould the biomedical models, not biomedical practices.

But I believe there are good reasons for my ignoring biomedical practices. First, the aim of the present research is to look at how ordinary people view the reproductive system. It is not a research on the field of biomedicine, or biomedical practice in relation to the reproductive system, however I must acknowledge that my very choice or words - reproductive system/reproductive health - are not neutral, rather they indicate my familiarity with biomedicine. Second, considering that I studied different groups of people in Porto Alegre and in London, it would be virtually impossible to research the different biomedical practices and the local variations all those groups of people had been in contact with. And finally, suppose it was possible to do that, it would be a different study all together.

To summarise, I take biomedicine as a field where a specific type of game is played. Membership in the field implies more than knowledge of the rules, it implies a certain habitus and doxa. Biomedical "principles" are those basic points regarding the way biomedical books describe the disposition of organs and the functioning of the human body, where the body is seen as divided in organs and fairly independent, although not autonomous, systems. I claim this is a "cosmopolitan" type of knowledge because in biomedicine the human body is seen as universal, that is, except for minor variations, the human body should function similarly everywhere. This is not to say that biomedical practice is the same everywhere. Practice, although connected to principles, presupposes a "feel for the game" and takes on cultural variations.

Research proposed

The underlying assumption that biomedical and lay views of the body differ is not an incidental one. Several contemporary researches undertaken in Brazil approach the problematic interface between health professionals' and lay views of this process, pointing out the specific representations of the body, health and illness conveyed by the latter. (Loyola 1984; Montero 1985; Duarte 1986; Knauth 1991; Victora 1991; Borges 1993; Ferreira 1995; Leal 1995; Leal and Lewgoy 1995; Knauth 1995)

Nevertheless, the described discrepancy is not restricted to Brazil or to Third World Countries. Other researches carried out in Western industrialised countries, also identify notions about the functioning of the body that differ from a biomedical one. (Martin 1993)

These facts have motivated me to carry out two case studies, one in Porto Alegre, Brazil, the other in London, UK. My aim is to understand the images of the reproductive system in different groups, all highly influenced by biomedical agents. It is also to identify the ways these two groups reinterpret the biomedical view of the body anatomy and physiology, considering that they belong to different cultural backgrounds.

The Brazilian case study was carried out amongst an urban low-income population living in shantytowns in the capital of the Southern most State of Brazil, more specifically in four shantytowns in Porto Alegre. Biomedical care is available to this population through health services from a large public hospital (Hospital Conceiçäo) which runs four community health centres in the surrounding shanty towns and a large primary health care clinic in the main hospital. This population was initially chosen to take part in the research because of the characteristics of the community health services that assisted them. The community health service's scope of activities included preventive, curative and educational programmes, and a significant number of those were specially designed to deal with reproductive health. This aspect of the context is important because one of the purposes of the study is to investigate in which ways the biomedical model of the body and of the reproductive system is assimilated by the lay population. A thorough description of the researched settings and groups is provided in chapter 2.

The British case study was carried out amongst working class and middle class groups living in West London and South East London. The informants have been contacted through three different means:

1. Women who were attending Hillingdon Hospital's obstetrics and infertility clinics;

2. Women who were taking part in the South East London Midwifery Group Practice - SELMGP;

3. women who were contacted independently of any institution.

Again the objective was to interview people who have been exposed to the biomedical view and interpretation of the body and the reproductive system.

In both case studies, even though I have taken the reproductive system as my main focus, it was clear to me that it may only be a system within a biomedical framework, that divides the human body into functional systems. This is not necessarily true in other frames of references. In order to understand other frames of reference I studied the broad context in which sexuality and reproduction exist, emphasising aspects related to family and gender relations where these issues seem to be embedded.

Considering that the socio-cultural characteristics of the Brazilian and British researched groups are very different, the research procedures were also different in an attempt to make the research culturally appropriate for each case.

My previous ethnographic experience with the Brazilian group has proved that home visits and interviews are welcome and appropriate for the area a wished to research. A community based research seems to be appropriate in this case as I will be dealing with a population who share a number of economic and cultural items. Although they may come from different ethnic groups - some descend from German, African, or Italian immigrants who have taken part in the colonisation process of the American continent -the ethnic variable in their case seems to have been taken over by a socio-economic variable since they define themselves as "Brazilians" and as "nos, os pobres" (we, the poor).

In the British study I aimed at different groups. Instead of community based research I used a system based on informal interviews with informants in

different social classes. In chapter 2, I present a thorough discussion about the methodological approach and the researcher's insertion in the different settings.

Basically the emphasis of the research is thus on ordinary people's views, and to make the research results more revealing I pursue a comparative approach at different levels throughout the text. First, in both case studies there are comparative references between lay views and biomedical views. Second, in each case study there is mention of inter-class differences, inter-gender differences and individual variations.

Bodies and imagery

The academic debate regarding people's imagery of their bodies is usually linked with two traditions, one in Anthropology and one in Psychology and it is difficult to be precise exactly where it belongs. Even within each of these disciplines there are quite diverse positions in relation to it.

On the one hand, a precise definition of body-image has been used mainly in Psychology and Psychiatry in relation to individual views of body boundaries and shapes especially to altered states of the mind. In studies of body-image drawings of the body are seen as a valid projective technique used by psychologists in addition to other diagnostic techniques to assess their patients' body-images.

On the other hand, in Anthropology traditional ethnographic studies have addressed the "tribesmen's" understanding of their bodies based on certain belief systems. [5] An example of such literature is Bateson and Mead's (1942) study about the Balinese Character where they present a photographic account about the Balinese. In their words: "about the way they, as living persons, moving, standing, eating, sleeping, dancing, and going into trance, embody that abstraction which (...) we technically call culture." (:xii)

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[5] For a discussion about why the human body has been approached by Anthropology since the nineteenth century see Turner, B. (1991).

Contemporary anthropological research has continued addressing issues related to body imagery. In this case, the authors either depart from the psychiatric definition of an individual's image of him/herself and redefine the expression body-image in terms of a cultural awareness to body and self highlighting perceptions of body organs and/or body fluids, and their meanings in specific cultures (Scheper-Hughes and Lock 1987, MacCormack and Draper 1987; Martin, 1990, 1993), or problematize and redefine theoretical assumptions calling for a more sophisticated Anthropology of the Body, where concepts such as bodies, selves and boundaries are not taken for granted, rather they are discussed and become crucial elements in their philosophical approach. (Blacking 1977, Haraway 1991, Benoist and Cathebras 1993, Turner 1995) Some of these studies have also used drawings of the body in addition to other research techniques to understand images of the body of studied groups/cultures (I present and comment on two examples later in this section).

My point is that studies about bodies and imagery are especially relevant in research that look at "bodies" in contact with biomedicine. This is because biomedicine is a very visual discipline that presently relies on visual imagery of different types for nearly all its purposes, from the simple explanations given to patients on the functioning of the body to the sophisticated diagnostic procedures. This aspect has also been observed by Good (1994) in relation to medical training:

"I was constantly impressed by how visual the teaching of human biology was. Anatomy required a training of the eye, to see structure where none was obvious."(...) " Histology and pathology required similar training of the vision. Whether examining the color pictures of a histology atlas or viewing slides through a microscope, shapes, colors, and lines all appeared as confusion to the untrained eye."(...) "Modern imaging techniques give a powerful sense of authority to biomedical reality. Look in the microscope, you can see it. Electron microscopy reveals histological concepts as literal. Look for yourself - there it is!" (Good, 1994:74)

It thus seems critical for the understanding of body imagery of people in contact with biomedicine to explore this visual dimension, considering that the image nature of biomedicine is possibly present as constitutive element of the interaction between lay and biomedical agents. The problem in the case of my research is that it would be senseless to use the drawings of the body as a projective technique in the strict sense, since the ethnographic data indicated that the visual dimension is just one among other ways of knowing our bodies. In fact the question was not so much if drawings were projective techniques, but of what were they projective. In other words, what is behind the assumption that images of the body (graphic or verbal) are the projection of a mental picture? Perhaps the best way to answer these questions is to go back to the discussion about how Anthropology and Psychology use the notion of body-image.

The notion of body-image has been defined in the psychiatric literature by Schilder (1964) as "the picture of our own body which we form in our mind, that is to say the way in which the body appears to ourselves"(1964:11). Schilder is concerned with how human beings arrive at a knowledge of their own body. His idea is that psychological and physiological laws could derive from the insight into the psychological sphere of the knowledge of one's own body. The "schema of the body," or "body schema," or yet a "postural model of the body" is for him more than perception, it is a tri-dimensional image everyone has about him/herself. When referring to the term "body-image" he emphasises that we are not dealing with a mere sensation or imagination, and although it has come through senses it is not mere perception, there are mental pictures and representations involved in it, but it is not mere representation. There is a somatic and a perceptive part of the body image. He aims to integrate psycho-physiological phenomena exploring how different brain lesion and/or physical disabilities alter people's body image.

According to Schilder's theory, the perception of the body-image does not lead to a rigid, static entity as " . . . there is a continual struggle to reach a static picture and to model something which is continually changing into a structure." (1964:297). He emphasises that the body is always the expression of an ego and of a personality, and is in a world.

Although Schilder has introduced a new approach to the study of body experience, this field of study actually began with Henry Head. Head suggested that each individual builds up from sensory experience one or more models of himself. These models are constantly changing but internally they function as organised. Every new stimulation or sensation is automatically brought into relation with an organised model (or schema) of the personal body. (Schontz, 1969)

Head and Schilder represent two types of approach to the theme of body-image. Head's perceptual research is concerned with the physiological organisations and the perception and localisation of stimuli on the body schemata, while Schilder's personality research focuses the attention upon the personality, as "something that perceives" (Schontz, 1969:18).

Under psychological or neurological orientations, most of the literature on body-image refer to clinical studies of individuals suffering from neurological, organic and psychiatric disorders that lead to distorted body images. A more psycho-sociological account on the relationship between people's body image and their attitudes towards life and towards society can be found in Fisher (1973). His purpose is to explain the relationship between certain forms of body feelings, such as concerns with the stability of the body, and a parallel life attitude, such as race prejudice.

In Anthropology, as I mentioned earlier, the approach to images of the body consists of ethnographic research in certain groups or cultures that present specific collective representations of the body and its functions. A few of them address the theme through a visual image, employing photographs and actual drawings of the body as complementary research techniques. (Bateson 1942 , Polhemus 1978, Laqueur 1987, Schiebinger 1987, McCormack and Draper 1987, Da Matta 1976) These studies hold a special interest for me since the visual dimension is part of my research protocol. I have picked two papers in the anthropological literature, Da Matta (1976) and MacCormack and Draper (1987), to comment on in this first chapter because together - although in very different ways - they have introduced me to the theme of body imagery, and motivated

many of the issues I carried further in my pursuit of an emic approach to the perception of the body in relation to sexuality and reproduction.

Da Matta's (1976) study about the morphology of Apinaye society, is a symbolic structural approach to this Brazilian tribal group. In his ethnography he employed drawings of both the Apinaye's village and their bodies. His aim was to trace the relationships between these images and the Apinaye's world views. As Da Matta puts it:

" The Apinaye are proud of the shape of their village. They know that they are not physically circular anymore, but their sociological shape - if I may say so - is a circle. In other words, even Mariazinha that is arranged in streets, is seen as circular. That is, as a community it operates as if its inhabitants were circumscribed in a circle." (1976: 66,67) (My translation)

He means that the way they envisage their community is represented in the way they draw their village even though its actual shape is not a circle anymore.

For the Apinaye people, the nuclear family is considered a natural group. The family is reified by nature and the links among its members are part of the physical world. The nuclear family is, thus, closely related to the human body, its genesis, its composition and its functioning. The generation of a new being is for them the direct result of the mingling of female and male fluids. That means that a man who marries a virgin woman, should induce the "menstrual" flux in her - indicative of her deflowering. Once there is the encounter between the semen and the menstrual blood a new being is potentially formed. For the Apinaye, it is necessary to copulate constantly to make a new being. It is the coitus that makes the foetus grows and develop in the maternal womb. [6]

According to Da Matta, the Apinaye know that the human body is made up of separate organs and that each organ has a different function. They know that there are bones, arteries, fluids and organs. In the internal composition of

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[6] The belief that repeated intercourse is necessary to nourish the fetus is also found in other Brazilian "Ge" tribal groups, such as the Kayapo described by Turner (1995).

the body they distinguish the tongue, the heart, the lung, the liver, the stomach, the pancreas, the kidneys, the bladder and the gall-bladder. However, their graphical image of their bodies corresponds to a straight vertical line with small loops alongside that represent the organs. The upper limit of the line shows a small loop that they identify as the tongue. The lower extreme is where the penis and the scrotum are.

The aspect I want to stress here is that, although the author does not mention it, the Apinaye do not have a biomedical influence in the picturing of the body. Da Matta points out that the Apinaye's knowledge about the body is based on analogies to the bodies of hunted animals. They do not make autopsies, like in other tribal groups, such as the Azande in Africa (Evans-Pritchard 1978, Da Matta 1976).

The second paper I will discuss is MacCormack and Draper's (1987) approach to female sexuality in Jamaica. Their sociological and symbolic analysis aims to explore the link between sexuality, the desire to create children and male and female perceptions of self identity and social power. Drawings of the body and reproductive system have been used by them as a technique associated with conversational interviews. The researchers presented their informants with a sheet with an outline of the female body and "women were led through a series of questions which encouraged them to draw their reproductive system and explain how it functioned." (1987:144)

According to these authors, in places where the economic roles for both men and women are scarcely compensated, adult status is given by factors such as sex, birth and the rearing of children. As one of their informants puts it: "...Until a woman has a child she is half child herself. After she gives birth and takes responsibility she is entirely a woman." (:146) Menstruation is thus associated with health and strength, a sign that a woman is ovulating regularly and therefore she is fertile. The authors' claim that the importance of having children for Jamaican women are also represented in the graphic representations of their reproductive systems, where the womb is always drawn very large, taking most of the abdominal space. The authors compared the Jamaican drawings with drawings made by American and British university students, and noticed that

whereas the first drew large wombs and hardly perceptible vaginas, the latter drew vaginas of large size and a poor representation of the rest of the reproductive organs.

Both studies, although from different theoretical perspectives, looked at lay people's images of the body within an anthropological framework. They used graphical representations of the body among other ethnographic research techniques, and tried to link people's body imagery with their everyday experience as members of a certain culture. One difference between them is that Da Matta did not give his Indian informants an empty silhouette which certainly gave them more freedom to express their graphic views, without the limitations of the physical boundaries imposed by a silhouette. Perhaps this allowed them to express a "purely" phenomenological version of the body. Besides, although the author does not mention it, it seems that they do not have much, if any, contact with biomedicine. It seems reasonable to say that Da Matta looked at the Apinaye belief system as a single coherent unit.

McCormack and Draper's study - as well as my present research - looks at groups who have been influenced by biomedicine and the medical model of the reproductive system - the Jamaican women whom they interviewed were attending an antenatal clinic in Kingston. Therefore, what we study is not a belief system, but how possibly different belief systems co-exist and make sense in ordinary people's lives.

However, there is an important difference between McCormack and Draper's and my own approach to body imagery, especially in the case of drawings of the body. Their study in Jamaica, is in one way similar to the psychological studies, which take body-image as "a picture of our own body which we form in our mind, that is to say the way in which the body appears to ourselves".(Schilder 1964) They take the drawing as a projective technique where people project on paper a mental representation they have of their bodies or organs, implying the supremacy of the mind in organising bodily experience. My ethnographic experience suggests that people do not necessarily do this. People may simply reproduce a picture they have previously seen, or express graphically immediate physical sensations.

These distinct positions I suggest, reflect two basic frames of reference in what has been known as Anthropology of the Body, regarding the position granted to the body, either as an object or as a subject in relation to culture.

Bodies as objects -subjects

Mauss's " Body Techniques" (1979) is taken as a paradigm for symbolic studies on Anthropology of the Body where the prevalent view is that although there is a "natural body", there is no such a thing as natural behaviour since all bodily practices are learnt. This means that the human body does not exist apart from the social reality where it lives. The body in this case is a social construct, a cultural product of social and historical arrangements. Mauss's approach is a refinement of Durkheim's ideas on the primacy of the social over the individual. The social fact, that for Durkheim was a massive reality which imposes itself, for Mauss consists of a network of symbolic values that is assimilated by the individual but does not eliminate him.

The anthropologist's claim to understand why different groups perceive and represent their bodies, or parts of their bodies, in different ways is based on this assumption. Anthropological studies that follow this tradition emphasise the context in which the representations of the body are created, as it is assumed that the body acquires meaning in contact with its context and can only be understood within this context.

Mary Douglas (1982) takes on Mauss's idea that the body behaves according to society's image, and that it is not possible to study the body away from its social dimension. She claims that the social body limits the way that the physical body is perceived. Physical body experience is always modified by the social categories through which it is known and incorporates a particular view of society. As a result of the interaction between social and physical bodily experience, the body is a very restricted medium of expression. All cultural categories through which the body is perceived, mirror the categories through which the society perceives itself. This means that whatever happens in the body

- its practices and bodily sensations - are shaped by the socially accepted ways of feeling and acting. Thus, the study of the social aspects of the human body is more than just another subject to be studied. It is a tool, that can provide the social scientists with an understanding of the social context.

That perspective relies on the understanding that the socialisation process grants the individual the qualities he/she needs to adjust to, to understand and to be understood in a specific culture. Socialisation in this case means a learning process that takes place especially during childhood where people learn to behave according to culturally acceptable procedures. The individual body, thus, can be seen as an object that should be studied in relation to culture, since it is "constructed" by culture.[7]

In the present research I have kept some aspects of this framework particularly the emphasis it places on the cultural grounds of social interaction. This framework has been useful in the analyses of symbolic and metaphorical aspects of communication, especially on how people express their feelings in certain contexts.

However my criticism towards such views is that it take the individual as a mirror of society. They are usually based on dualistic views of social processes, where individual and society, nature and culture, mind and body, object and subject, are taken as structural divisions rather than analytic tools.

The concern with collapsing dualities can also be found in a considerable number of contemporary anthropological studies which aim to achieve a critical view of the mind/body dualism. This orientation suggests that socio-anthropological approaches to the human body, should attend to body-self

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[7] Foucault's socio-historical views of the bodies and sexuality also reflect that idea of the body as an object of culture, and have influenced academic production about the body in the social sciences. Foulcault's ideas reflect an underlying understanding that the body is very much "a text upon which the power of society is inscribed (Lyon and Barbalet 1994:49). Concerned with both populations and the body he claims that powerful medical, religious, military and political organizations worked to discipline the body and populations in the eighteenth and nineteenth century associated with urban crises, the rise of demography and town planning. (Foucault 1977, 1978; Turner 1991) However interesting his ideas of power and control over the body might be they indicate the powerless position in which he places the body in relation to all mighty social and political forces. His attempts to show the body's resistance to the disciplines of power are acts of deviance of a "naturally rebel " transcendental body. (Turner 1994)

connectedness. (Manning and Fabrega 1973; Scheper-Hughes and Lock 1987; Kaufman 1988; Csordas 1988)

Another problem with the "symbolic approach" is the objectification of the body that follow directly from such views where a well socialised mind commands the cultural actions of the body, and that does not account for the lived experiences of studied subjects.

Csordas (1994) has clearly made this point in relation to Anthropology of the Body highlighting that:

"(...) Objectification is the product of reflexive ideological knowledge, whether it be in the form of colonial Christianity, biological science or consumer culture. Our lives are not always lived in objectified bodies, for our bodies are not originally objects to us. They are instead the ground of perceptual processes that end in objectification (...) " (Csordas 1994: 7)

These ideas propose that our bodies are not objects to us, rather they are perceiving subjects follow phenomenological principles of primacy of the perceptive bodily experience.

Phenomenology as a philosophical movement created by Edmund Husserl aimed to uncover the fundamental structures of intentionality, consciousness and the life-world (Lebenswelt) of man. It proposes phenomenological descriptions of space, time and the world of lived experiences, and has influenced philosophers and social scientists of different generations, who have reinterpreted and made more specific some of its original ideas. (O'Neil 1974)

Within this psycho-socio-anthropological tradition, Merleau-Ponty is regarded as the key figure in phenomenologically oriented studies of the bodily processes. Studying the problem of perception, he claims that there is no phenomenological result apart from the experience through which it comes about. The experience of perceiving is essential because there are no objects prior to perception. That means that perception ends in objects, so, it is preobjective. Perception for him is not an intellectual act, since it begins in the

body. Perception is "real". According to Merleau-Ponty's view, the perceptual synthesis must be accomplished by the subject, which can both delimit certain perspectival aspects in the object, the only ones actually given, and at the same time go beyond them. As he puts it: "...this subject, which takes a point of view is my body, as the field of perception and action - in so far as my gestures have a certain reach and circumscribe as my domain the whole group of objects familiar to me." (O'Neil 1974:200) In simple words, Merleau-Ponty points out that "the perceiving mind is an incarnated mind in its mind and in its world" (1964:3) therefore criticising the idea that perception is imposed by our minds on our bodies.

The assumption of the body as a field of perception and practice has been taken up by Csordas (1988, 1993, 1994) and other anthropologists (Frank 1986; Ots 1990; Turner 1994 and others) who claim that embodiment as a paradigm for anthropology is a way of collapsing analytic dualisms, such as body-mind, object-subject, individual-society, etc. Perception by the body is seen as prior to the distinction between self and body.

Bourdieu has also been committed in the project of collapsing dualities, especially between subjectivism and objectivism as modes of knowledge. (Bourdieu 1995). Although from a different perspective, Bourdieu also keeps the groundedness in the body - a socially informed body as "a principle generating and unifying all practices, the system of inseparably cognitive and evaluative structures of a determinate state of the social world." (Bourdieu 1995:124). For him the habitus, the dispositions and generative classificatory schemes, is an embodied principle.

Jenkins (1992) highlights the three meanings of embodiment in Bourdieu's work: 1. Habitus only exists because it is incorporated in the body; 2. Habitus exists in, through and because of bodily practices, it is part of behaviour; 3. Practical taxonomies, such as male/female, hot/cold, as sensory experiences are rooted in the body. (Jenkins 1992:75) In Bourdieu's words:

"The world of objects, a kind of book in which each thing speaks metaphorically of all others and from which children learn to read the world, is

read with the whole body, in and through the movements and displacements which define the space of objects as much as they are defined by it. The structures that help to construct the world of objects are constructed in accordance with the same structures." (1995:76)

However different Merleau-Ponty and Bourdieu's theoretical approaches may be, the first one based on the principle of perception, the second on the principle of practice, the concept of embodiment developed by them has been particularly useful in my research and forms the basis of my argument on how people's embodied notions of space and time are also used in their understanding of their bodily experiences.

In Merleau-Ponty's terms, the experience of time and space can be seen as embodied since the body is a pre-condition for any experience. Time and space are, as any other experience, pre-objective in the sense that they are not objects of perception, but are part of the perceiving experience. As he puts it:

"Our body is not in space like things; it inhabits or haunts space. It applies itself to space like a hand to an instrument, and when we wish to move about we do not move the body as we move an object. We transport it without instruments as if by magic, since it is ours and because through it we have direct access to space. For us the body is much more than an instrument or a means; it is our expression in the world, the visible form of our intentions. Even our most secret affective movements, those most deeply tied to the humoral infrastructure, help to shape our perception of things. " (1964:5)

That idea that space and time are intrinsically connected with the body and therefore with the way we grasp the world is an integral part of Bourdieu's theory. For Bourdieu, time and space, are crucial features of the embodied habitus, intrinsic aspects of any practice, the house - "inhabited space"- being the main site of objectification of generative schemes. (Bourdieu 1995:76)

This is not to say that the two authors have a similar approach to social phenomena, just that their perceived relationship between bodies, space and

time has inspired my data analysis. Merleau-Ponty is concerned with restoring the world of perception: he aims to collapse the duality between subject and object by pointing out the "insertion of the mind in corporeality" and claiming that perception is pre-objective. (Merleau-Ponty 1964:4) In that sense, objectification is seen as a secondary development of reflexive thinking. (Csordas 1988). Bourdieu aims to go beyond phenomenology, pointing out phenomenology's limitation to look at the conditions of possibility and explore the coincidence of the objective structures and the internalised structures. For him, as the product of objectifying operations, the process of objectification uses the same structures of the embodied habitus. The body is the basis of culture since it bears the practical taxonomies of the habitus. (Jenkins 1992)

The assumption that the body is "the existential ground of culture" (Csordas 1988) underlies the framework of this thesis, that draws its logic and coherence from the ideas of embodiment of the habitus. Within that perspective the ideas of embodiment of time and space in the distinct studied groups form the conducting line of my main argument. I discuss how different embodied habitus related to specific understandings of the functioning of the reproductive system. For this reason it seems reasonable to describe and analyse not just situations that are directly related to the reproductive function, but also approach the whole milieu where it is takes place.

Therefore, in chapter 2, I discuss the methodological approach to the research topic. I present the sources of data in Brazil and in England where I base the descriptions and interpretations. I also re-address the discussion introduced in chapter 1 about images of the body and graphic images of the reproductive system justifying the research methodology employed, and problematizing strengths and weakness of such choice. Finally, I address the reasons for a comparative approach, inasmuch as one sheds light on the other and enables me to see aspects I would otherwise have overlooked.

In chapter 3, I introduce the basic argument of this book, following on from the discussion started in chapter 1 about the connectedness in cognitive sense between bodies, space and time. I present ethnographic material on time, space and domestic organisation in both case studies pointing out the dwelling

peculiarities of the different groups. Through a number of diagrams representing different households in different times I argue that the Brazilian shantytown groups dwelling practices are viable because people conceive space organisation as fluid and time as flexible. On the other hand the British groups studied present a much more rigid experience of space and time. Finally I suggest that there is a relationship between embodied experiences of time/space and knowledge of the reproductive system, a theme that comes up again in the following chapters.

In chapter 4, I focus on the Brazilian study, exploring issues about the female world, and their experiences of sexuality and reproduction as bodily experiences. The single body and the married body; the fertile body; the pregnant body and their graphic images of the body are some of the specific topics presented. Within these topics I discuss the informants' experiences of medical and non-medical contraceptive methods in relation to their images of the body and their views of menstruation.

In chapter 5, I carry on with the presentation of the Brazilian study this time focusing on the male world. First, I explore the embodiment of male identity, looking at issues such as work and violence in the shantytowns. Then, as I present a number of ethnographic situations I point out how the embodied gender experience is a key issue in relation to marriage, sexual practices and contraception. Finally, I analyse men's explanations about the reproductive system as well as their graphic images, pointing out the relationships between those and the way they experience the embodiment of gender in that context.

Chapter 6 concentrates on the British study. I describe the different groups studied and the overall classification I proposed based on the interviews: 1) working class women living in housing states; 2) working class women living in their own houses; and 3) middle class, educated women living in their own houses. I present the differences I observed in a number of attitudes in relation to family and children. In the first part of the chapter I present six summarised life stories of informants to give the reader a clearer insight on my informants' individual habitus. From there I draw a comparative view of work, highlighting perceptions of captivity or liberation of (un-) professional bodies. I then explore

the boundaries of the sexual body through my informants' experiences of first intercourse, rape and breast-feeding, pointing out that boundaries of the lived body seem to be much more rigid among them than among my Brazilian informants. Finally I analyse their views about the reproductive system, graphic images of the body and their relationship to biomedicine through the National Health Service or alternatively through the South East London Midwifery Group Practice - SELMGP.

Chapter 7 is called "conclusion" only in the sense that it is the last part of this book where I re-address some of the findings of the present research. It obviously does not represent the end of the work or the debate. Besides, since each chapter deals with a group of connected subjects, most of the research data has already been discussed in each chapter or through dialogues between chapters. Therefore the conclusive chapter does not aim at discussing data, only at linking the previous chapters with each other, emphasising in which ways the Brazilian groups and the British groups perceive their reproductive systems and how these views relate to the biomedical view. I take ideas of fluid space and time presented in chapter 3 together with views of the body from chapters 4 and 5 to demonstrate that the Brazilian shantytown groups' experience of a fluid space corresponds to a similar way of experiencing the body. Similarly I take the experience of a more rigid space organisation of my British informants, also presented on chapter 3, and connect with their views of body boundaries and the reproductive system presented in chapter 6, highlighting possible correspondences between them and the biomedical model of the body. So, from the main argument developed on chapter 1 - that the embodied experience of a specific cultural world includes the same principles by which we experience other categories - I suggest that the biomedical model of the reproductive system is not consistent with the way my Brazilian shantytowns informants experience their bodies. However, this is not to say that they do not have "knowledge" about the biomedical model. As suggested in the beginning of this book, there are different ways of knowing our bodies.

Chapter Two : Methodology

"Everybody knows and acknowledges that the "events" that are registered are inseparably related to the mode of registration. Yet, as common-sense beings, we are used to identifying an event determined by one mode with an event determined by another, as by sight and by sound; or (at another level) by radio, press and television, or by document and by an oral communication; or (at another level still) by a theory of economics or a theory of psychology. Still, we come at once to an intractability about events; they have to be recognised, detected, or picked up by modes of registration. We must know, as much as possible about these modes." Edwin Ardener - The Voice of Prophecy

The present research has been developed in two different countries along five years of study. In this chapter I aim to describe not just the methodology employed in the Brazilian and in the British studies, but also to report the circumstances of the interviews, means of contact and relationship with the informants. This chapter is thus a mixture of what has conventionally been called in the social sciences "objective data" and "subjective data" regardless of my scepticism about the artificial opposition between objectivism and subjectivism as modes of knowledge .

Finally, I discuss the choice of doing two distinct studies which are sometimes juxtaposed in order to highlight aspects related to differences and similarities of lay and biomedical notions of the reproductive system.

The Brazilian data

The ethnography in which this book is based started back in 1990 when I was a Master's student at the PPGAS/UFGRS - *Programa de Pos-*

Graduacao em Antropologia Social / Universidade Federal do Rio Grande do Sul. Since then I have been able to add several different sources of data to the original one, collected during five years of anthropological work as an individual and in a team. I personally did one year of intensive and one year of extensive fieldwork in Brazil and six months of intensive fieldwork in Britain. I also had a research assistant in Brazil who collected some of the data regarding the "Hospital" group - described below - and anthropologist colleagues who helped me out conducting group interviews with the "Independent" group in crucial moments of this research. The data from these sources have composed most of the structure, the "skeleton", of this book.

The "flesh", if it were indeed possible to distinguish it from the "skeleton", has come from the interviews in the "WHO-Body" project, to which I was an assistant researcher.

Sources of data

The data regarding the Brazilian sample comes from three main sources:

- Source number 1:

Four shantytowns in Porto Alegre: *Vila Sesc*, *Vila Floresta*, *Vila Dique* and *Vila Divina Providencia*. Comprehensive data about these shantytowns have been generated by classic ethnographic research by myself - 1990 and 1991 - and by 200 ethnographic interviews developed by myself and other anthropologists and anthropology students within the "WHO-Body" Project - 1993 and 1994 - described below.

- Source number 2:

Conceição Hospital: A large public hospital in Porto Alegre where 14 post-natal women and 3 ante-natal with high risk pregnancy were interviewed - 1994.

- Source number 3:

Independents: 11 women who live in another shantytown - Vila Cruzeiro. They had not suffered medical intervention recently but they used public health services when necessary - 1994.

The WHO-Body Project: strengths and difficulties

The WHO-Body project was a two year long research about representations and practices regarding reproductive health developed in four shantytowns in Porto Alegre. The project revisited and expanded several issues that had been originally raised by two previous ethnographies developed in two of the four shantytowns[8].

The "WHO-Body" was sponsored by the World Health Organisation - WHO - and had an innovative approach to sexual behaviour combining ethnographic data with statistical analysis generating multivariate correspondence graphs leading to an overall anthropological interpretation.[9]

Two hundred people - 100 women and 100 men - were interviewed in depth by anthropologists (including myself) and anthropology students, most of them Master Students in Social Anthropology at the PPGAS/UFRGS, since this larger research project also aimed at training anthropology students. The ethnographic interviews followed a pre-structured guideline regarding a wide range of subjects in great detail. The outcome was a comprehensive bank of high quality data about a wide number of subjects which are directly or indirectly related to reproductive health. For example, in depth interviews explored the subjects' ideas about masculinity and femininity where representations and practices regarding sexuality and reproduction are embedded.

But there are obvious difficulties in such a venture. It is even arguable that there may be a contradiction intrinsic to the idea of an ethnographic

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[8] See Victora (1991) and Knauth (1991)

[9] See Leal (WHO Report)

approach to a specific theme - in this case reproductive health - since ethnography is characteristically broad and unrestricted. Besides, it is very difficult to be precise about the extent to which informants have been influenced by the very set of questions put together by the researchers.

That is why it is important to stress that the Who-Body project has been built on top of previous broad ethnographic researches in two of the four shantytowns with the aim of focusing on specific questions which we felt needed to be deepened. That does not mean to say that "specific questions" always obtained specific answers. On the contrary, the informants' refusals to answer, their changes of subject, their silences, their complaints, have all been recorded and incorporated as data in my research, as much as the answers to the interviews.

In any case it is imperative to analyse both the data and the interviews that provided the data. For this reason in this chapter I do not clearly separate ethnography from methodology, rather I look at the contexts where the research took place in order to expose the field work experience.

To start I have translated below the interview guideline used by the interviewers for the WHO-Body project.

Ethnographic Interview Guideline:

A. Household

A1. Household composition

A2. Number of people in the house

A3. Number of people in the family

A4. Kinship chart

A5. Description and comments about the household: history of changes, general mood, etc.

B. Housing

B1. Housing situation: size, number of rooms, privacy

B2. Housing conditions: general aspects of the house, building materials

B3. How long have they lived in the house?

B4. How long have they lived in the shantytown?

B5. Are there other relatives in the same shantytown?

B6. Internal diagram of the house

B7. Number of houses in the same allotment

B8. Number of rooms in the house

B9. Number of bedrooms

B10. Toilet: yes/no; if yes, description: inside/outside the house; conditions in general

B11. Water

B12. Electricity

B13. Building materials

B14. Sewage

B15. Rubbish

B16. If more than one cooker, how many?

B17. Cooker

B18. Comments regarding the living conditions

C. Family

C1. Type of alliance

C2. How many times have they been married?

C3. If married, for how long?

Descent:

C4. Number of children (natural and adoptive)

C5. Children of how many different partners

C6. Adoptive children

C7. Children given for adoption

C8. Children who have died

C9. Have you taken responsibility for all your children?

C10. Comments about parents' responsibility.

C11. Comments about family situation

D. Social origin

D1. Ethnic origin

D2. State

D3. City

D4. Social origin

D5. How many generations have lived in Porto Alegre?

D6. Parents occupation

D7. Comments about social origin

E. Education: Years of school attendance

F. Work

F1. Present occupation/profession

F2. Partner's present occupation/profession

F3. Other activities

F4. How long in the present occupation?

F5. Comments about work situation

G. Religion

G1. Religious practice

G2. Frequency of religious practice

G3. Comments about religion

H. Leisure and communication

H1. Favourite television programme

H2. Favourite radio programme

H3. Do you watch soap operas?

H4. Which ones?

H5. Do you watch news programmes?

H6. Which ones?

H7. Do you read books or magazines?

H8. Other activities when not working

H9. Comments about leisure activities

H10. Social distinction indicators

I. Representations of the body

I1. Drawing and explanation about the female reproductive system

I2. Drawing and explanation about the male reproductive system

J. Contraceptive disposition

J1. Present contraceptive method

J2. Which one?

J3. Are you pleased with the method (comments)

J4. If you do not use any, why?

J5. If necessary, which method would you use?

J6. Which other methods have been used by you or partner?

J7. Which methods do you know?

J8. How did you get to know them?

J9. Which method is more reliable?

J10. Why?

J11. Which method did your mother use?

J12. Comments about contraceptive methods

K. Sterilisation

K1. Have you or your partner had a tubal ligation?

If yes:

K2. Why?

K3. Who suggested?

K4. Who performed it?

K5. Did the partner agree?

K6. Was there a caesarean section because of the tubal ligation?

If not:

K7. Female informants only: Would you have a tubal ligation?

K8. In which situation would you have a tubal ligation?

K9. Who would you see to have it done?

K10. Male informants only: What would you think if your wife decided to have a tubal ligation?

K11. Comments about tubal ligation

K12. Do you know what vasectomy is?

If yes:

K13. What do you think about it?

K14. Comments about vasectomy

L. Non-medical contraceptive methods

L1. Talk about non-medical contraceptive methods

L2. Have you ever used any type of vaginal douche?

L3. Which one?

L4. With which purpose?

L5. With which substance?

L6. Have you used "gotas" (drops of bleach)?

L7. Do you know anyone who has used "gotas"?

L8. Comments about vaginal douche and "gotas"

M. Fertility

M1. When is the woman more likely to get pregnant?

M2. Comments about fertile period and menstruation.

N. Abortion/miscarriage

N1. Have you (or your partner) had a miscarriage?

N2. Have you (or your partner) had an abortion?

If yes:

N3. How many?

N4. Why, in which situation?

N5. Who mad the decision?

N6. Who paid for it?

N7. Which method was used?

N8. Who performed it?

N9. Did you see a doctor afterwards?

N10. If a woman has an unplanned pregnancy, is there any situation she should have an abortion?

N11. In which situations is an abortion recommended?

N12. Comments about abortion

O. Sex-gender disposition

O1. When should a men get married?

O2. When should a woman get married?

O3. Describe a "good husband"

O4. Describe a "good wife"

O5. Describe a "good father"

O6. Describe a "good mother"

O7. Describe a "good male lover"

O8. Describe a "good female lover"

O9. Is marital faithfulness important?

O10. Comments about marital faithfulness?

O11. Agree or disagree with the proverbs regarding female/male role? (Not possible to translate the proverbs)

O12. Comments about the proverbs

P. Sexual practices

P1. How old were you when you had your first sexual intercourse?

P2. How frequently do you have intercourse?

P3. Are the male and female sexual pleasures similar?

P4. Does sexual intercourse give you pleasure?

P5. What gives you more pleasure in an intercourse?

P6. What is allowed (or not allowed) in a sexual intercourse?

P7. Comments about the above questions

P8. Have you ever used a condom in sexual intercourse?

P9. In which situation?

P10. Comments about condom

P11. Are oral and anal sex recurrent practices?

P12. Are these practices used with contraceptive purposes?

P13. Comments about anal and oral sex

Q. Illnesses

Q1. When do you consider yourself ill?

Q2. What resources do you seek first?

Q3. When do you seek medical care?

Q4. When the children are ill, what resources do you seek?

Q5. Comments about illness

R. AIDS

R1. Have you ever heard about AIDS?

R2. Where have you heard about it?

R3. What is AIDS?

R4. Do you know anybody who has AIDS?

R5. How can someone get AIDS?

R6. Comments about AIDS

S. Final report

The WHO-Body interviews were carried out in the shantytowns in three or four encounters with each informants, although the interviewers ended up making twice as many visits to the informants who sometimes were not at home, or had other problems and could not attend the interviews. The researchers were encouraged to report all the data gathered in formal or informal interview situations, as well as comments about any other aspect they had observed in their visits to the household, even if not in an interview situation.

The informants were usually recommended by someone who had been interviewed previously. Close relatives, or people living in the same household were not eligible - such as husbands and wives or siblings - for ethical reasons. Neither were women who were out of the reproductive age for whom reproductive health experiences would perhaps bear little interest.

The shantytown settings

The reason I originally selected the four shantytowns as part of the research is because each has a Community Health Post linked to Hospital Conceição which has a pioneering Community Medicine service in Brazil. The presence of the Community Health Posts should guarantee, as much as possible, that people in the researched groups had easy access to health services and that they possibly had regular contact with biomedical practice.

The issue of access to medical services was important in the design of the research mainly to avoid empty explanations such as: "people who do not have contact with biomedicine have peculiar representations of the body because they are ignorant about the "real" facts about the body and its functioning". Or even, "women in Third World Countries do not use contraception properly because they are ignorant about medical facts".

This type of reasoning has, for many years, been used as justification for procedures that range from mass sterilisation to abduction of babies for international adoption. The arguments that rely on the alleged ignorance and inappropriateness of the populations, if taken to extremes, are also at the root of actions such as the killing of street children in Brazil by death squads or for organ transplantation. [10]

To avoid such reasoning, I aimed at these shantytown groups who I was certain had contact with biomedicine. It is obviously very difficult to

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[10] For poor childrens' death by the police or the FEBEM as well as the trade of poor children in Brazil see Scheper-Hughes 1992.

measure how much contact people have with biomedicine in a complex society like the one in question, multi-class, multi-ethnic, multi-cultural. The simple number of consultations attended by someone per year would not in itself be illuminating, since medical consultation may not account for all the exposure to biomedicine by someone. Television, magazines, hospital visits to other patients, contact with employees and work colleagues may also be important sources of medical contact. But again, this is very difficult to qualify or quantify.

The health professionals who work at the Community Health Centres are in any case, as well as seeing patients in their consulting offices, supposed to take part in the community's fights for sanitation, water supply, legalisation of the area, etc. Many of them think that a large part of their duty as health professionals is to help the people to organise themselves politically. Actually they are paid to perform such tasks since in their work contract they are assigned a considerable number of "community work" hours. Among their community activities are meetings on a regular basis for women interested in female health matters (usually held out in someone's house, not in the health post premises), parent-craft classes for pregnant women, self-help groups for alcoholics, or the hypertensive, talks at the local schools, crèches, etc.

A shantytown snapshot

The ethnographic description of the studied shantytowns is in fact an attempt to fix an image that is extremely fluid. In fact as I argue in chapter 3, one of the characteristics of the shantytown organisation is its fluidity. An ethnographic description is thus an attempt to freeze a moment, that the ethnographer believes representative, while reality plays on changing its face. More than changing its face in time, reality is multifaceted, and a slight move by the ethnographer can present a different face. My diary in 1990 reflected one of the faces of Vila Divina Providencia:

Green, red, purple, orange, the clothes hang side by side on the clothes' line in front of a wooden house painted with different faded colours. At 5:30 in the afternoon the Vila is full of colours and life! Boys play *taco* in the middle of the street. Girls take their dolls for a walk around the house. Many children and teenagers, ages ranging from 2 to 15 run, shout and play. It is summer and the weather is wonderful. Dogs are everywhere, running after shrinking balls. Some women stay at their gardens' gates chatting while their men go to the nearest *buteco*. It is the end of a day at Alberto Barbosa Street.

Each house is so different from the other: at the corner of Gioconda Street the houses are better built, made out of bricks. Towards Mirim they become mixed bricks and wood, then only wood and finally become shanks in the surrounding *becos*.

The pathways, irregular and tortuous either full of rubbish and high grass, or made of flattened earth, replace the pavement. They are left aside by the people who prefer to walk in the middle of the streets. There are no cars around anyway. Besides, dogs faithfully guard their houses, and the pathways become the nearest way to get bites.

The dogs and the children are there: morning, afternoon, evening; on the streets, in the gardens, on the pathways, on the walls, in the Health Post. The everyday is marked by the effervescence of a life lived in small groups.

Walking on the streets and *becos* is an experience in itself. Plastic bags, rusted oil tins, rags and single old shoes; empty crisp bags, bleach bottles, sweets wrappings, horses' droppings, dead rats, sewage water cutting the ground in different directions. Smell of sewage. Children's voices. Small shacks built virtually on top or at the edge of the sewage ditch. These sewage ditches are crucial in the shantytowns. They run like a water stream, but they concentrate the untreated sewage of the area. It also attracts a significant part of the rubbish produced in the area which remains at its edges and bottom, frequently causing blockages and small pools.

The Independents' group

The group I call "independents" are also women with a working class background, living in another shantytown - Vila Cruzeiro - in Porto Alegre. The major difference between the shantytowns described above and Vila Cruzeiro is that the latter does not have the presence of a Community Health Centre. Supposedly people living at Vila Cruzeiro might not have so much contact with biomedicine. But as suggested earlier, it is difficult to estimate the amount of contact because as in any urban population in Brazil, they potentially have access to a number of biomedical contacts. What is possible to say in this case is that they do not have the - intrusive sometimes - presence of Community Health Workers coming round their houses for health visits. They will attend a regular public health post for minor problems, or go to a hospital if they consider it necessary.

At Vila Cruzeiro I conducted group interviews with 3 groups of 3-4 women who had known each other either by being neighbours, friends, relatives, or all of those things at the same time. The approach at Vila Cruzeiro was not an ethnographic one although my previous ethnographic experiences in other shantytowns have made it much easier for me to carry out group interviews which have been very useful to the research. The atmosphere of the interviews was very relaxed which enabled all of us to share intimate experiences in a fun and unthreatening way.

The interviews were tape recorded and transcribed. The graphic images of the reproductive system made by them have been classified using the same typologies used for the WHO-Body project. At Vila Cruzeiro the "independent" group's drawings of the reproductive systems were less similar to the biomedical model while the oral accounts of bodily events followed the same cultural model as seen in all shantytowns. This finding suggests that the presence of the Community Health Post might have some influence over the graphic representation of the body in the first shantytowns. This issue will be discussed further in chapter 4.

Regarding the independent's group way of living, in terms of general characteristics of their households, income, family structure, morality, values, taste for food, music, there were few differences in relation to other shantytowns. But although many shantytowns share similar aspects, there are usually some differences that make each unique.

The presence of rubbish and poor sanitation, for example, is common to all shantytowns. The rubbish collection by the City Council is not as frequent as it should be especially in the summer when the temperatures between 30 and 40° C make organic rubbish deteriorate very quickly. Another problem is that in the absence of proper rubbish bins the rubbish is disposed on the pavement, in plastic bags, usually the type of carrier bags provided by supermarkets for their customers' shopping. The bags are invariably torn by dogs, cats or even people in search of any useful items, and the rubbish spreads.

But even though this is what I would call a general characteristic of shantytowns, the fact for example that many people at Vila Dique (one of the four in the WHO-Body Project) make their living out of rubbish recycling, the rubbish there acquires other meanings. Rubbish there is life, wealth and leisure for the children who find plenty of playful elements in the dust. At the same time, because there is so much rubbish, there is a profusion of flies, cockroaches, mosquitoes and rats who live on the non recyclable rubbish everywhere and gives the place a distinct appearance and smell that cannot and must not be ignored. Quite a few families raise pigs for sale or for the family use. They are fed on leftover vegetables picked up in the rubbish of a nearby market and brought to the Shantytown in pushable wooden trolleys.

I am not saying that the other shantytowns are free from the above cited pests or the health problems generated by their contact. Shantytowns, rubbish, lack of proper sanitation and water supply, insects and health problems seem to be inseparable circumstances. Among the most common health problems found in shantytowns related to environment are infant diarrhoea, caused mainly by unclean water or utensils and contaminated food. Food contamination is especially due to contact with flies and

cockroaches. Skin problems are also abundant, especially in children who play around the sewage ditches. From simple rashes and itching to important abscesses and mycoses, not mentioning the marks left by mosquito, flees or bedbug bites the children's skin is often reddish and rough. These events are so common in infants that adults pay little attention to them. They are seen as part of growing up, not necessarily a problem, things that will go away after 4 or 5 years of age.

Hospital Conceição's group

Conceição Hospital is a public hospital, part of the largest public hospital group in Brazil. Within its many different sectors Conceição Hospital develops preventive, curative as well as direct or indirect educational activities focused on approximately 5000 people among patients and their relatives/friends who visit the hospital premises daily. The outpatients clinics see over 2000 patients/day and the emergency sector approximately 1100 people/day. [11]

Conceição Hospital is located in the Northern part of Porto Alegre, near the four shantytowns involved in this research, but it comprises a much wider area of Great Porto Alegre. Some patients might even come from smaller cities from other parts of Rio Grande do Sul State.

Although Conceição Hospital has some private beds which receive privately ensured patients who need specific medical technology only available there, the hospital is a public one and aims at the patients who are either covered by the Brazilian equivalent of the National Health System - INAMPS - or who are not covered by any type of insurance but need free treatment.[12]

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[11] Data from SEDI-CAP - Hospital Conceição Sevice of Information.

[12] The Brazilian National Health Service depends on monthly payments partly by the employers, and partly by the employees. The amount paid by the employees is 9% of their monthly salary and it that garantees health insurance and

The women who have been interviewed in the hospital had been there just temporarily either because they had recently had babies or have a risk pregnancy. They live in different parts of the city, they are all low income working class women. The fact that they are in that specific hospital, which is a public one, also indicates their working class background.

Although the contacts with the women in the hospital were usually briefer than the other groups studied, the contacts were very intense. They were also easy to make since the women had just given birth and were very responsive, even happy to speak about the body and the reproductive system. To illustrate the intensity of the hospital interview situations it is relevant to recall a field work situation:

One of the nurses introduced me to V., 33 years old, who had just had a baby the day before. She stayed in a room with four other women all of them with new born babies. There was little space between the beds in the room, so that very soon her room mates got to know me and I, them. There were no chairs in the room so I sat on V.'s bed. All of the women had delivered a baby in the last 3 days. In that particular room were:

- A., 25 years old, was a housewife, She had delivered her second child a few days earlier and was released from hospital on the day of my first visit to their room.

- T., 23 years old, had just had her first child who arrived earlier than she expected. She lived and worked in an itinerant Circus, temporarily presenting a show in Porto Alegre, coincidentally in the neighbourhood of the Hospital.

- M., 45 years old, having her 7th child. She was diabetic and overweight, and her new-born baby who weighed over 10 pounds was under medical observation.

- E., 19 years old, who was slightly mentally handicapped and was said to be unfit to look after her new-born baby by the others in the room.

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retirement salary. Many hospitals in Brazil may only see a patient on proof of health insurance membership. Concieção Hospital, however, takes in any patients, even those who are not covered by any type of insurance. Therfore the majority of patients seen at Conceição Hospital are people coming from the lower class.

They complained that because of that they had to change her baby's nappies and look after him and demanded from the nurse that E.'s partner stayed longer after visit times to perform those tasks.

- And V., who became my informant, first at the hospital and later at her home. The first thing she told me when we met was that the doctor had mentioned that her new-born baby had some type of kidney problem. She thought her baby's problem was caused by a fall she had when she was 3 months pregnant. She told me she was doing a cleaning job and fell off a ladder hurting her back. She did not know what the problem was, but she feared it was something very serious, so serious that the doctors did not dare tell her. The only thing the doctors told her was that the baby would either need an operation or some special medication. A couple of days after the birth the doctors started to give the baby a drug and my informant's major concern changed when she realised that she would not be able to buy the drugs after the baby had been released from hospital. (The Brazilian equivalent of the NHS (INAMPS) does not cover medication expenses outside the hospital)

Of field work situations, informants and...elephants

I could understand V.'s concern better when I first went to her house. She lived in a small and very precarious shack in a shantytown - Vila Pinto. Her house was so unstable that she once told me: "when it is windy I pick up the children and go to my neighbour's house because I am afraid the house might fall down."

V. lives with her 6 children of three different partners. She had her first child at 18 by a man who she describes as a "ruffian" (*barra pesada*). Their relationship did not last very long. They separated after the birth of the child, who was a girl and is now 15 years old. She soon "got married" (common law marriage) again with someone who took her and her child on and moved to

the outskirts of a small city near the border with Argentina and Uruguay. There, her "husband" got a job as a tractor driver in a farm. Soon she gave birth to her second child who was also a girl and is now 14 years old.

Not very long after that her "husband" decided to move back to Porto Alegre. According to her, her "husband" who used to be a nice, hard working man, but who was easily influenced by spiteful friends. When they got back, her brother-in-law who was left in charge of her house, had sold it and kept the money. After some time he ended up giving her another house, but the new one was considered much worse than the first one. That is the shack she lives in presently.

But if her partner's brother was not very kind to her, the relatives on her side did not seem much better either. When they settled back in Porto Alegre, V.'s sister had an affair with V.'s "husband". V. told me the situation became intolerable, everybody - family, neighbours - put a lot of pressure on her to do something about it. In retaliation she ended up having an affair with another man. That apparently solved the initial problem as her "husband" decided to come back to her, but brought her another problem, since she had became pregnant as a result of that love affair. Initially she thought the child she was bearing was her husband's but after the baby was born she realised he was not. His skin was fair like her lover's skin, and not dark as her husband's. That was a baby boy who is now 11 years old.

After that V. and her "husband" got back together and had three other boys who are 8 years old, 2 years old and the new born. V. and her "husband" do not live together in same house any more. Although she says he is a nice man who pays her water and electricity bills, he turns mad when he drinks and beats her and the children up.

Her 11 and her 8 year old sons work as shoe polishers in central Porto Alegre. This is the family's main income source. V. used to do house cleaning jobs but she fears this will not be possible any more if the new-born baby's kidney problem remains. She will have to stay home to look after him. She seemed prepared to do whatever it takes for her new-born baby although her

financial situation was appalling. The new-born did not yet have a crib, nappies, clothes, or even a name.

As we talked about different subjects in the hospital room, the interaction among the six of us had quite effective results. T., the lady who worked in the Circus, offered V. a crib, which she had to spare. The only problem was that it had to be picked up in the Circus campsite and taken to V.'s house about 5 miles from the hospital. As I was the only one who could go out of the hospital, I went to pick up the crib. V.'s 8 year old son came with me to help me get it and to show me were their house was.

I do not think he or I will ever forget the experience of going to the backyard of a Circus. Everything seemed so simple yet so magical, such as the experience of turning a corner and being face to face with two huge elephants gazing indifferently. It took us some time to find the indicated caravan where we were supposed to pick up the crib. But we did not mind.

When we got to V.'s house her 15 year old daughter was looking after the others. More than 10 children who were playing on the narrow street came running after the car to find out what was going on, whose car was it, and how come their little neighbour was riding inside.

I chatted with the children for a while as I looked around the house. I immediately realised that they did not have anything to eat at home. The bread winning boys had gone to hospital to see their mother and the baby and could not get to work. But that is another story...

As I was leaving their home that day, my 8 year old friend looked at my shoes which were filthy dirty from walking in the mud in the Circus backyard, and said: " I didn't even give a shoe polish..."

And I promised to return...just for that...!

The British data

I followed a similar procedure when selecting the groups for the British study, that is to have a range of subjects who have experienced more or less

influence from biomedicine. As mentioned earlier there is no possible way of defining or measuring such influence. What it was possible to do in this case was to interview a group of people who refused, to a certain extent, the traditional biomedical/hospital care for child birth - the "home birth group" - another group who during the research were under biomedical care - the "Hillingdon Hospital group" - and an "Independent group", who were not under any medical care. A brief description of the three sources follows:

Source number 1:

South East London Midwifery Group Practice -SELMGP-: The "home birth group " was contacted through the South East London Midwifery Group Practice which is a midwifery practice pro home birth. Six women have been interviewed, most of them are middle class, educated women who have deliberately opted out of the official medical system in favour of an alternative system where according to them, they could have more "control" over the birth process.

Source number 2:

Hillingdon Hospital: Six women patients from the Obstetrics and Infertility Clinic have been interviewed. They have a working class background and most of them live in the areas surrounding Hillingdon Hospital.

Source number 3:

Independent: Eight "independent" women have been interviewed, most of them live in South or South East London. Most of them live in Council Estates, have a working class background, and are not under medical intervention presently.

The "home birth group"

My contact with the South East London Midwifery Group Practice was made through one of the midwives who also runs post-natal groups. There I contacted several women and actually interviewed six of them for this part of the research. I attended some of the weekly group sessions, and having explained to them the nature of my research, asked for volunteers who would be willing to take part. Each session gathers around 12 women who usually bring along their young babies.

The fact that they attended the group sessions run by a home birth practice does not mean that they have had a home birth experience. A significant number of women who booked in the practice for a home birth end up having hospital births although attended by the midwife from the SELMGP. These are usually cases that the midwife detects a possible problem during labour which might require hospital equipment.

The women who attend the SELMGP come from a variety of ethnic and social backgrounds. The access policy reserves 75% of bookings for women:

- who previously had low birth weight babies;
- from Vietnam and minority ethnic groups;
- from certain specific housing estates;
- with housing difficulties;
- on income support;
- who are unsupported;
- with disabilities;
- with mental health difficulties;
- who are under 18 or over 38;
- who are lesbians;
- with a previous childbirth or pregnancy bereavement;
- women with particular needs, who are referred by their GPs or health visitors;
- who are HIV positive;
- with a history of substance misuse.

Nevertheless very few women in the above categories attend the practice. And although all the women I made contact with were extremely helpful, the large number of women who actually volunteered to be interviewed belonged to a very homogeneous social stratum: middle class, educated women.

After attending a few meetings and performing in depth interviews with six women in this category I learned that women with other backgrounds do not usually come forward to be interviewed. One of the midwives made specific requests by letter to a few women who we considered typical of the other categories. No reply was obtained leading me to the idea that the way the project was presented in the SELMGP did not make sense to groups other than the middle class educated.

The interviews with the "home birth group" followed basically the same structure as the WHO-Body Project interviews, except the last part regarding representations of HIV/AIDS. In fact this has not been a topic of the interviews in Britain at all. Another feature of the "home birth group" interviews was that the women were allowed some time to tell their recent or previous birth experience since these stories were very revealing of their understanding of the reproductive system.

In general, after the first contact with the women in the SELMGP I conducted three interviews of about one and a half hours each in the informants' homes in the London Borough of Lewisham.

The Hillingdon Hospital group

The contact with Hillingdon Hospital Gynaecology, Obstetrics and Infertility Clinics was necessary in order to interview women who had been in contact with biomedical care recently.

The process of having the present research approved by the local ethical committee was extremely long and labour intensive. The process went through several stages and contact with different people in order to have

access to some patients. After ethical committee's approval I was allowed to sit in the waiting room of the Hospital and approach obstetrics and infertility patients directly.

At Hillingdon Hospital I was focusing on women with a working class background to be able to have a wider view of the relationship between perceptions of the reproductive system in different social groups.

Contrary to the predictions of the Hillingdon Hospital staff, the women approached were accessible and willing to take part in the research. A few exceptions were those who had come to hospital in the company of a male partner.

Similarly to the SELMGP, six women were interviewed in an average of three interviews of 1 hour and a half each, in their homes, after a first contact at the Hospital.

The Hospital formalities required written consent by the informants before the onset of the interviews, as well as a written information sheet with details about the research and the researcher. They can be found in the annexes of this book.

The interviews followed the WHO-Body project guideline - except the AIDS part. In fact the exclusion of that section or part of that section was "suggested" by Hillingdon Hospital doctors in the process of negotiation of the ethics committee approval.

The interviews took place in the informants' homes which were in West London, in the London Borough of Hillingdon.

The women interviewed were either pregnant or undergoing infertility treatment. The advantage of speaking to women who are in those categories is that they are usually interested in subjects such as reproduction and sexuality and felt at ease to speak about the proposed topics. They easily shared opinions and concerns regarding fertility, pregnancy, and reproductive health in general.

The Independents' Group

As in the Brazilian sample, I wanted to interview women who were not explicitly associated with any alternative group, or under medical treatment, or pregnant.

I met the women who I classified as "independent" by direct contact or contact through friends. Some were also referred by other informants. With their consent I arranged an interview date at their homes. Here again I followed the same type and same number of interviews as the other groups.

The "independents"' were selected mainly among women with a working class background living either in Hillingdon or Lewisham.

Further information on these groups is given in chapter 6.

Researching images of the body

One of the most important results of the present research is that people know their bodily facts in different ways. In other words, knowledge of the body is a process that is permanently being re-evaluated by subjects in contact with different life experiences.

This issue has been previously examined by Young (1981) who states:

"(...) an actor's medical knowledge (beliefs) and his statements are not epistemologically homogeneous. that is he does not know all of his facts in the same way. This is accounted for by the fact that his knowledge is recursive and presocial, in the sense that he continuously evaluates it against his intentions, expectations, and perceptions of events, and sometimes he compares it with others bits of his knowledge of similar events." (Young 1981:379)

This understanding had first come to me during traditional participant observation situations and has helped me to think and develop other techniques to pursue the matter further. During traditional visits to my

informants in 1990 I realised that the same informant could tell me the same fact, for example, an specific medical consultation or a child birth experience, in different ways depending on whether we were on our own or whether there were other people present as well; depending on whether it was a recent or a past event, depending on whether the informant had had other similar experiences to compare with, and in this case the experiences would never be told on their own but comparatively. Similarly relevant to the narrative were neighbours or relatives experiences or opinions about the event that was recalled or similar events they - neighbours or relatives - had been through. Also if the informants had had a medical opinion about the event described, the medical discourse would be used as an endorsement of what the person has been through or as proof of medical error. What was interesting to find out was that even if the same story was told differently in different situations each was usually coherent in its own terms.

The informants' discourse was thus explored in different situations, individually, collectively (in group conversations), immediately after an event (such as delivering a baby), some months after important events, in recollections of other people's events, in opinions or gossips about neighbours and relatives.

Graphic images of the reproductive system

As mentioned earlier, I was particularly interested in learning to what extent biomedical views of the body's anatomy and of the physiology of the reproductive system were assimilated, rejected or re-interpreted by my informants. I hoped that this would help me understand how contraceptive advice was taken on or refused by women in the shantytowns. I decided to use a technique frequently used by the health centre and by the media, especially television and magazines, to investigate womens' knowledge of their reproductive system, that is a diagram of the body. The difference was that instead of presenting a diagram filled out with organs, as it is usually

done by the above cited media, in a manifest attempt to educate lay people in the medical idiom, I presented them with an empty silhouette and required them to make a drawing of the reproductive system or in simpler words, a drawing of everything in the body that was related to making and bearing a child.

There were two explicit purposes in that exercise:

(1) To motivate the informants to talk about the reproductive system. It was used as an "excuse" to talk about the internal parts of the body as besides the actual drawing the exercise elicited a series of comments that were recorded by the ethnographer. The interpretation of both types of data, one regarding the drawing and the other regarding the comments, together or separately, have been extremely important in the understanding of the different ways people understand the functioning of their reproductive systems.

(2) to check how much these diagrams of the reproductive organs, which have been one of the most common ways of biomedical education, influence lay people's images of the reproductive system.

The choice of this research technique has not been an easy one. The first problem that comes to mind is the actual technique. To require a drawing from semi-literate informants, as it was the case of several people in the shantytown group, could prove the whole activity impossible. But on the other hand, drawings can be seen as an elementary means of communication and the actual making pictures, as a research technique, has been part of anthropological research among literate as well as completely illiterate groups. Anyway, questions whether how much the skill in itself would jeopardise the purpose of the activity could only be answered afterwards when I had a sufficient number of literate, semi-literate and illiterate people's drawings to compare. What I have found is that the state of literacy of the informants proved not to be relevant for the results. Factors such as gender and exposure to the medical message were rather more closely related to different types of drawings.

Another difficult decision concerned whether I should ask the informants to make their own drawing of a body and picture the reproductive system inside it, or present them with a ready made silhouette. The choice for the latter reflected my concern that if I asked them to make a complete drawing of the body the exercise would be compared by the informants with psychological tests that often use the drawing of the human figure to assess applicants' psychological appropriateness for jobs or driving licence in Brazil. Apart from that I had neither interest or know-how of psychological tests, or in the features of personality revealed by my informants' drawings.

But once I had decided to present them with a ready made silhouette a third concern emerged regarding the pictures themselves. What kind of silhouette should it be? A unisex body or a body emphasising stereotypical male or female differences? In this case, the problem was handed over to a local artist who produced the silhouettes that were standardised for the whole WHO-BODY Project as explained earlier in this chapter. Once more I felt that I could only speculate until an evaluation could be made in the light of the experience itself. Many men refused to make a drawing of the reproductive system - this is discussed in depth in chapter 5 - and several informants, male and female, complained, laughed and produced comments about the silhouettes such as: "poor girl, she doesn't have a face. I will make a face on her".

When I was about to start field work in Britain, some colleagues pointed out that the silhouettes looked very sensuous in the sense that the female silhouette had small waist, large hips and tights while the male silhouettes represented a "macho" type of body, maybe representing an ideal "Latin" body, not necessarily shared by an "Anglo-Saxon culture".[13] I incorporated the question about the appropriateness of the supposedly "Latin" silhouette in my ethnographic interviews in Britain. My informants were unanimous in considering them as good as any other, indicating that the

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[13] The problem was mainly discussed following a presentation I gave at the Medical Anthropology Post-Graduate seminar at Brunel University.

actual shape would not influence their drawing. As, in any case, I did not have any other picture to compare the outcomes, it is very difficult to say whether they were right.

The pictures of the reproductive system as a research technique both because of its strengths and because of its weaknesses have proved to be very useful in this project. The results of this exercise have gone far beyond my expectations and the outcomes, far more complex to analyse than I had thought.

I have been very conscious of the risk of the technique actually shaping the outcome of the research. The question here is obvious: if presenting my informants with a ready made silhouette and asking them to make a drawing of the reproductive system, or everything that is related to making and bearing a child, would induce them to make a biomedical model of the body. Unfortunately there is no obvious answer. Looking at the outcomes - presented in chapters 4, 5 and 6 - we will see that 35% of the female informants tended to make drawings that were relatively similar to the medical model, while only 9% of the male informants have made that type of picture. Could I assume that female informants are more likely to be "induced" by the technique to make a biomedical body than male? But in this case, I would have to consider the stereotypical "Latin" sensuous female and the "macho" male pictures as representing the biomedical silhouettes. In other words, would not the stereotypical lay image contribute to a less medical model in favour of a representation that recalls a more sensual dimension?

Apart from that, nearly 30% of the men refused to make a drawing while only 3% of women did so. At the same time 25% of men when asked to make a picture of the reproductive system made a drawing composed of face, breasts and vagina without any internal organs and 17% of them pictured only a vagina on the silhouette without any other features, clearly distinct from the complex biomedical model.

The questions are once again obvious: should the 3% of refusals among women and the 30% among men reflect that the graphic picturing is

more meaningful to women than to men? Or just that in the power relations intrinsic to ethnographic encounters women informants are bound to comply with requests while men feel that they do not have to submit to the ethnographer's wishes? Or is it just the opposite, that female ethnographers and female informants have established higher levels of rapport in relation to male ethnographers and male informants and have managed to engage the female informants in the project altogether?

What makes me think that I was able to go beyond the virtually endless questioning is the fact that the pictures did not comprise the whole research. Instead they were actually a small part of the whole project, and have been used with specific purposes as described earlier. They have been used to add another dimension to the "cultural picture" that I am trying to portray, together with interviews and participant observation. But precisely because I am looking at images of the reproductive system among people who have regular contact with biomedicine, I realised that I had to address their graphic features. As mentioned in chapter 1, biomedicine has become increasingly "graphic" in the sense that it presently relies much more on visual information than previously either for educational or for diagnostic purposes.

Has the development of graphic technology promoted a higher sophistication on diagnostic and educational methods or the other way round? It is difficult to know what has motivated the drive towards graphic imagery in the medical science. Laqueur (1987) has looked at the beginning of this process of imagery production in medicine pointing out that although modern anatomists had drawn human skeletons since the sixteenth century it was only in 1796 that a female skeleton appeared in an anatomy book (Schiebinger 1987:42).[14] Laqueur, among others, have pointed out that "scientific discoveries" are often motivated by political reasons. In relation to the female reproductive system he claims that actually no one was interested

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[14] Jordanova (1989), based on other historical sources mentions that male and female anatomical organs, especially the female abdomen were depicted in anatomy texts since the sixteenth century.

in looking at the anatomical and concrete physiological differences between the sexes until such differences became politically important.

This debate is relevant to the present research because the ethnographic findings suggest that information about the reproductive system relies heavily on graphic imagery. Many informants recall having seen diagrams of the reproductive system/organs at school, at the health centre, at the hospital, on the television, in magazines. Some informants have also spontaneously informed me that they had recently been exposed to the biomedical graphic image of the reproductive organs especially on television programs. But if this is true, why can't they explain the reproductive functions according to the biomedical model? Why did more than one fourth of the male interviewees refused to draw, and nearly half of them refused to give any explanation at all, biomedical or non-biomedical? At the same time, several female informants who agreed to make a drawing refused to give explanations about the reproductive system? What about those who made a drawing similar to the biomedical one but explained the functioning of the reproductive system based on other cultural notions? These issues are also discussed in this thesis.

Most of my British informants have criticised the cold way in which the diagrammatic explanations about sexuality and reproduction are given at school as well as at home. But later in the interview when they were asked how they would explain to a young person the processes of reproduction, nearly all said they would make a drawing of the reproductive system pointing out the parts and their functions. We all agreed that maybe we just do not know how to explain it any differently.

Considering all these issues regarding the features and importance of graphic models to medicine, I believe it is indispensable for the present research to look at graphic images of the reproductive system as represented by my informants. In my final analysis they are taken as a type of discourse about the body. To my understanding, in the process of complying or not complying with my request of making a drawing of the reproductive system my informants are saying much more as explained in chapter 5. Factors such

as the context where the interviews took place, the subjects involved in the conversation, the interviewees experiences about the researched topic, are all relevant and are taken into consideration when I interpret the data.

The present chapter was meant to introduce the studied groups and address some questions regarding the field work and the data collected. As mentioned earlier, the groups, the field work procedures, the data collected and the researchers all influence each other. The exchange among these variables is such that it is very difficult - if not impossible - to clearly define the confines of each one. For this reason some of the issues approached here will be re-addressed in following chapters where I present the research findings and interpret them further.

The choice of a comparative approach

My first research on the theme of reproductive health in Brazil pointed out some peculiarities on the views of the human body in general and the reproductive system in particular by the group studied, especially if compared to the biomedical view [15]. At that time I was associated with a Community Health Centre in Porto Alegre situated in the heart of a shantytown. The medical staff there found it very difficult to accept facts such as non-compliance to medical advice on the part of their impoverished patients, particularly related to women's health, since they had a range of programmes directed to the female population which were, in their opinion, under-used or misused. The case of the family planning clinic was especially critical to them since they believed that the availability of free advice on the use of contraception as well as equally free contraceptive pills and other devices should solve the problem of "unwanted" pregnancies in the shantytown. However, the doctors often found themselves attending pregnant patients who had just a few months earlier been in the family planning clinics asking

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[15] See Victora (1991); Victora and Knauth (1991).

for an efficient (sometimes definitive) contraceptive method. In those sessions they had positively stated they did not want to get pregnant at that time or ever.

I set off then to investigate these issues ethnographically in the "community" context. The results pointed out issues related to the shantytown life, family life, gender relations, importance and meaning of children, to decisions about having more children, use of contraceptives and notions of the body, among other things. As I had daily contact with both the local group and the health centre, differences between medical and lay perspectives became evident, especially in relation to reproductive health. That research supplied me with a set of answers to my initial questions, and with a much larger set of questions which developed into the present research project.

One of the questions concerned the universality of the body. If we humans have generally the same body parts, how does our perception of these parts vary and why? How do these different views of the body relate to each other in the same context?

I observed differences in the way medical and lay people in a shantytown in Brazil understood the functioning of the body, but I did not know if those representations of the reproductive system were a peculiarity to that group or whether medicine was a peculiar way of looking at the body [16], or both. One way of finding out about peculiarities and universalities is to look at two or more different groups.

Radcliffe-Brown's distinction between the two types of comparative studies in Anthropology points out the main types of research in the field. The first one, also suggested by Boas as the "first task" of anthropologists, is to "reconstruct the history of a society, or people, or region", and the second one, "to explore the varieties of forms of social life as a basis for the theoretical study of social phenomena." (Kuper, 1977:53)

In that sense, the comparative approach would either look at historical connections of features, customs or beliefs of two or more groups, or would

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[16] For an account on how medicine conceptualizes its objects see Good (1994).

analyse the present context of different groups in search of universal characteristics. In the first case a diachronic perspective departs from a historical period when two or more societies have presented similar customs and follows the development and change of each one, comparatively. In the second case, a synchronic look at different groups points out how distinct customs refer to commonalities of universal values.

In presenting two case studies - one about southern Brazilian shantytown people and the other about middle class and working class Londoners - my purpose is merely to highlight specific aspects of each case in relation to the biomedical knowledge. In that sense it draws on Geertz's (1993) ideas of a comparative approach - to art, law, etc. - who believes that talking about different groups is useful "in such a way as to cause them to shed some sort of light on one another." (Geertz 1993:11). However, I go a little further than that in my final analysis when I discuss how specific notions of time, space and domestic organisation are connected to perceptions of the body and the reproductive system in each case study.

In that sense each case study is a study in itself and therefore very different from each other even though there are general research questions that guide the thesis as a whole.

Finally I must comment on two issues related to the way I address the informants and in the way I quote their statements in this thesis. I have used my informants' initials, together with their age, marital status, profession, or social class where applicable, instead of their real names for ethical reasons. I have an understanding with my informants that because of the intimate nature of the research topic, their names would not be mentioned in any public document.

The second issue refers to the problem of reconstruction of sentences and dialogues. The data collected in Brazil was obviously in Portuguese and therefore I had to translate them into English in order to make it consistent with the rest of the text. I tried to make translations as close to the original words as possible. In both cases, in Brazil and in England most of the informants' statements had to be reconstructed from notes since the

interviews were not tape recorded. But I understand that either in translations or reconstructions there is a - small but inevitable - risk of missing or mistaking words. However I trust if that was the case, there has been no damage to the original meaning of the statement.

Chapter Three : Space, Time and Domestic Organisation

" Now my aim is clear: I must show that the house is one of the greatest powers of integration for the thoughts, memories and dreams of mankind. The binding principle in this integration is the daydream. Past, present and future give the house different dynamism, which often interfere, at times opposing, at others, stimulating one another. In the life of a man, the house thrusts aside contingencies, its councils of continuity are unceasing. Without it man would be a dispersed being. It maintains him through the storms of the heavens and through those of life. It is body and soul. It is the human being's first world. Before he is "cast into the world", as claimed by certain hasty metaphysics, man is laid in the cradle of the house. And always, in our daydreams, the house is a large cradle. A concrete metaphysics cannot neglect this fact, this simple fact, all the more, since this fact is value, an important value, to which we return in our daydreaming. Being is already a value. Life begins well, it begins enclosed, protected, all warm in the bosom of the house." Gaston Bachelard - The Poetics of Space

One of the most relevant aspects I found when researching the way of life in the shantytowns is the use of time and space in general and the domestic organisation in particular. It has also become an essential analytical tool, basic for the understanding of the images of the body and the reproductive system. It became even more important when I realised how differently time, space and domestic organisation were conceived and experienced in each case study in Brazil and in England. To look into these broad and complex issues I have focused on changes in the family, in the household composition and life stages in certain periods of time in Britain and in Brazil. [17]

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[17] The discussions about family presented in this thesis are mainly ethnographic. For a critical approach to sociological theories about the family see Morgan (1975).

The first part of this chapter presents an ethnographic account of the shantytowns' space organisation. The peculiarities of the different types of space organisation in the shantytowns will serve as a basis for further theoretical debate about difficulties in addressing space organisation in terms of known categories such as "outside" or "inside", pointing out the need to de-construct them in order to grasp the dynamics of the shantytown.

I will also address the limitations of strict analytic categories such as time and space pointing out the usefulness of de-constructing and overlapping them in order to understand the life stages in the shantytown and notions of privacy in overcrowded dwellings.

To add a comparative dimension, the second part of this chapter presents a brief description of key issues related to family and household composition in the British groups interviewed which will be re-addressed especially in the last chapter. However, less detailed and more schematic than the shantytown ethnographic study, the examination of British groups substantiates the issues previously discussed in the first part. The option of focusing on domestic space has not been taken by chance. It relies on the assumption expressed by Bachelard in the epigraph of this chapter that "the house is one of the greatest powers of integration for the thoughts". A similar idea is conveyed by Bourdieu for whom "inhabited space - starting with the house - is the privileged site of the objectification of the generative schemes..." (Bourdieu 1995:76). In that sense I suggest that the study of the way people experience domestic space helps to understand how they experience other domains such as their reproductive systems, which is the main object of the present research.

The fact that I am analysing people's experience of space - and to a certain extent time as well - to study their notions of the reproductive system does not put these categories - space, time, reproductive system - necessarily in a hierarchical position. If there were any hierarchy to account for that would point out the primacy of the embodied self since it is the body that enables the perceptual experience - of time, space and domestic organisation - in the first place. (Merleau-Ponty, 1964) In that sense the present approach to space, time, the reproductive system or any other aspect relies on the understanding that we

experience the world through our bodies. (This issue has been discussed in more detail on chapter 1).

I. The Brazilian Study

Space organisation in the shantytowns

One of the main characteristics of shantytowns is the space organisation. I will concentrate on describing three types of space: 1. The external space, meaning the geographic and political division of streets, *becos*, location of houses, types of houses, etc.; 2. The property boundaries (*terrenos*), understood by the informants as private property where there is at least one dwelling; 3. The households and their composition.

Streets and *becos*

The geographic space of a shantytown is usually organised in streets and *becos*. Streets are covered with pavement, stone tiles or flattened earth where most of the houses are built of wood or bricks, or even both. *Becos* are very narrow lanes with houses that run along both sides. *Becos* start as a slim entrance off a regular street, frequently missed by those who do not know the place. They may run parallel to the regular streets, or have other configurations (cross, "V" shape, "Y" shape)

Becos hold permanent squatter settlements, located preferably in "green areas" of the city, that is, areas that belong to the city council, and have been destined to parks in the original city plan. This is especially the case of Vila Divina Providencia as pictured in the following diagram (*becos* shown in black).

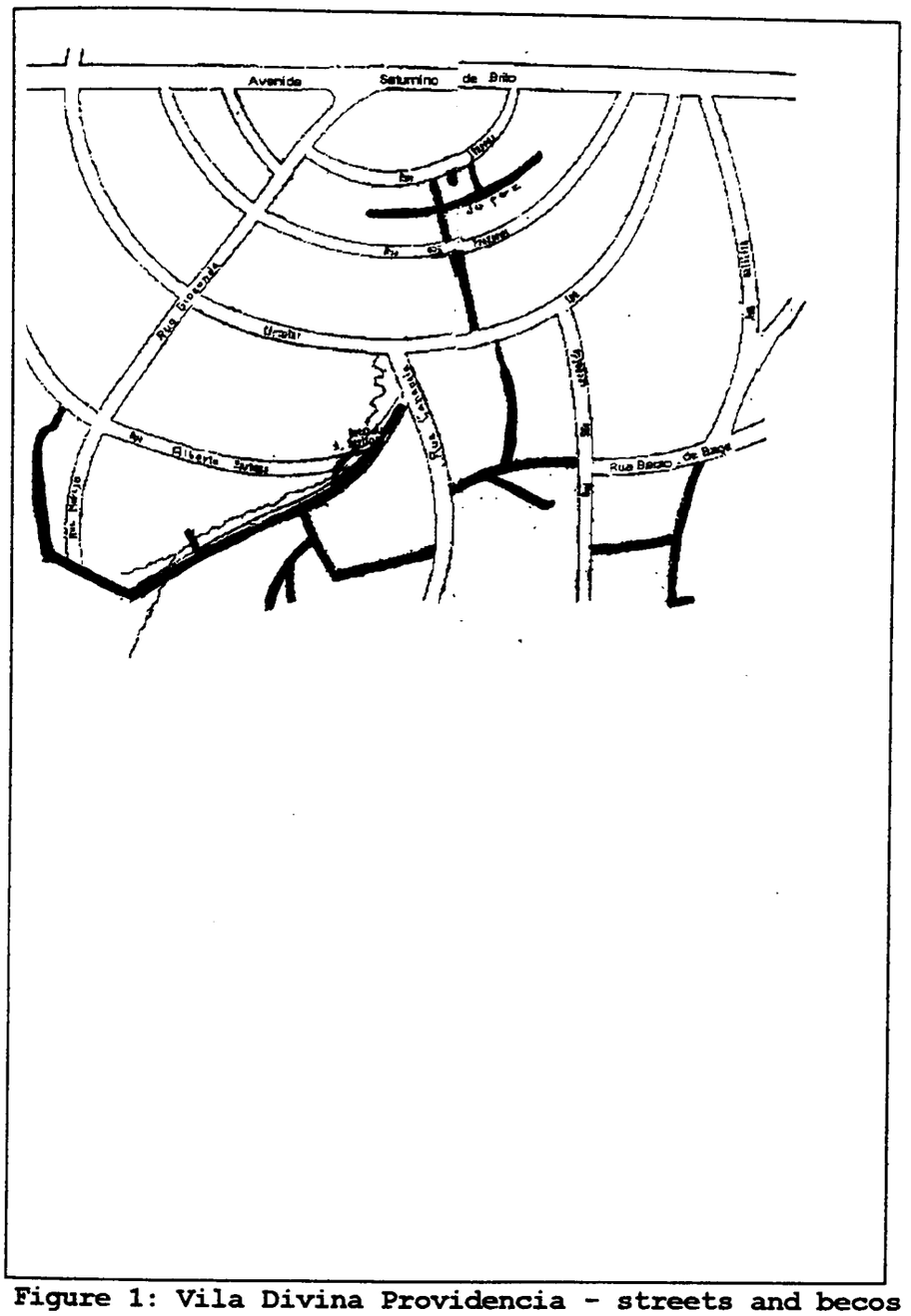

Figure 1: Vila Divina Providencia - streets and becos

A different type of squatter settlement can be seen at Vila Dique which is located at the end of the city's main airport runaway. There is only one street, in fact a very busy road, and a few *becos* that run along parallel to it. In this case, the houses - often shacks - are found even along the main road, although in a much larger number along the *becos*. Some of those houses, positioned immediately next to the airport grounds, use the airport's dividing wall as one of the houses' supporting walls. This is seen as an advantage because the airport

wall is made of bricks and stone while most of the other houses are made of thin irregular wood boards, plastic sheets or zinc plates. Most often all these materials are combined in different parts of the houses.

Another aspect of living so close to the airport wall is the proximity with the aeroplanes departing or landing just a few meters above the houses. The noise is extremely loud and the vibrations are easily felt day and night. But I soon realised that this fact disturbed me much more than any of the people who lived there. My informants and I used to joke about that because they used to say that they did not mind having aeroplanes flying just a few metres above their heads but would never risk flying one while my case was just the opposite.

In general *becos* are very crowded places. The houses are small and close to each other. There are usually four or five shacks within the same boundaries (*terreno*), some are fenced areas others not, most are inhabited by relatives. This aspect is related to the way the *becos* have been occupied which is described next.

Occupation and ownership

One important characteristic of *becos* and shantytowns is the fact that several people from the same family tend to live close together, sometimes as next door neighbours other times just down the road. Very frequently several people of the same extended family share a large number of resources such as water, kitchen utensils, electric appliances, as well as the care of children and elderly relatives. In the (frequent) case of houses that do not have in-built toilets, there is an implicit agreement that one could use the facilities of a neighbouring relative.

The phenomenon of relatives that become neighbours is not a mere coincidence. Some cases go back to the time when the first squatters occupied the green areas. As soon as an area is "discovered" by squatters, the first families usually build a fence surrounding the largest area they can and send for relatives to come and build their houses within the occupied space. Through the

years, the space tends to be re-arranged several times, in shantytowns as shown in figure 2. Besides, many people who live in the areas have become linked by affinity, through the "marriage" of their offspring. That is the case pictured in figure 3. Different people move in and out every year, but family organisation remains prevalent. Figure 2 shows Ego who lives with her husband and children in the same *beco* as her brother, two sisters and their children.

FIGURE 2

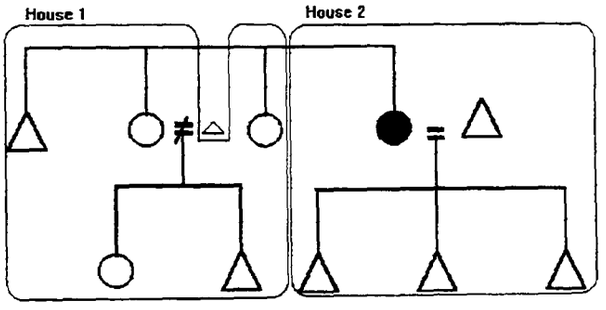

Figure 2: Ego and her nuclear family live in the same beco as her brother, sisters and their children

Figure 3 shows two neighbouring families who used to share a number of facilities such as water, electricity, small amounts of coffee, sugar, etc. Since their two teenager children - Ego and her boyfriend - had a child together the families became "related" to each other. Ego works in the local public crèche and her boyfriend is a brick layer assistant. Both remains living with their families and the child circulates in both houses.

FIGURE 3

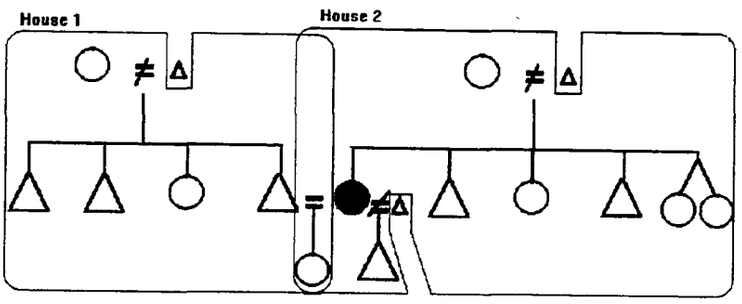

Figure 3: Two neighbouring families become "related" through the "marriage" of their teenage children

Neo-locality is quite rare for young just "married" couples. Very often young couples make a patrilocal or matrilocal arrangement to start their "married" life, until they have the means to buy their "own" house, invariably in the same settlement, if not in the immediate neighbourhood. Many informants reported that they started living together patrilocally or matrilocally, as shown in figure 4. A few have tried a patrilocal arrangement at first and changed to a matrilocal one after

a few months - or vice-versa - as the first arrangement did not work out as expected. This is shown in figure 5.

FIGURE 4

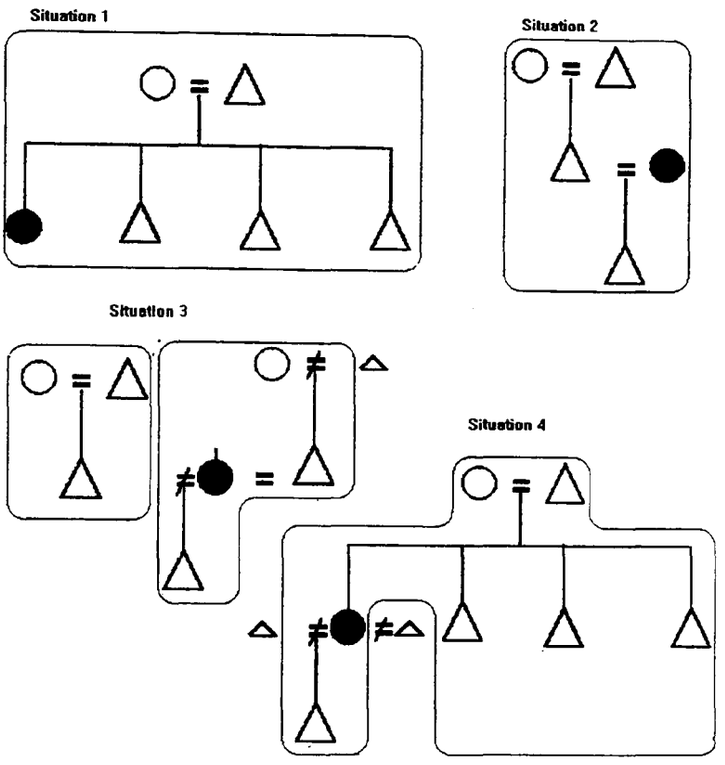

Figure 4: Changes in Ego's living arrangements described in four dwelling situations

Figure 4 shows Ego's four living situations. Situation 1 shows her still living with her consanguineous family, before getting "married" for the first time. She then got pregnant and moved to her first husband's parents house which is pictured in situation 2. In situation 3 she splits with her first "husband" and "marries for the second time. She moves in her second "husband's" mother's house with her child. She soon breaks up with her second "husband" and moves back in to her consanguineous family's house with her child, shown in situation 4.

FIGURE 5

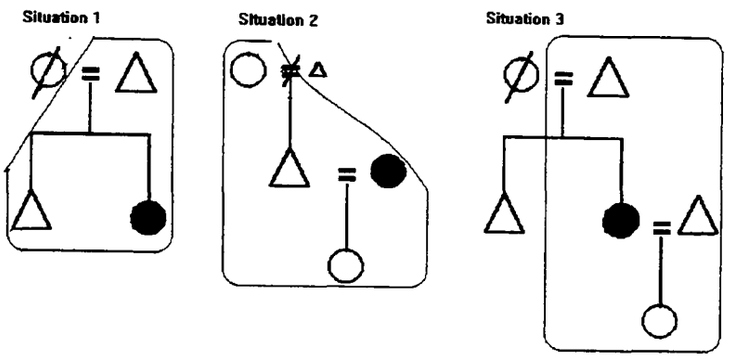

Figure 5: Changes of living arrangements by Ego in three dwelling situations

Figure 5 represents three situations lived by an informant who used to live in the same house with her father and brother as shown in situation 1. In situation 2 she got married, moved to her "husband's" mother's house and had a child. But she soon moved back to her father's house, pictured in situation 3. She states that while she was living at her "husband's" mother's house her brother had got married and moved away. Her father was then left on his own and she came back to look after him.

"Ownership" is a relative concept in the shantytowns for two main reasons. First, people "own" the house but they do not "own" the land where the house is. That is, they consider themselves owners of their houses even though they are aware that they live as illegal squatters. However, they buy, sell and exchange houses in the settlement through negotiations that might or might not involve money.

"Ownership" of a house is also relative because it is strictly related to the actual occupation of the house. A shantytown house cannot remain unoccupied because there is always the risk of being taken by someone else. In that sense, ownership also means residence by the owner or by friends or relatives who come in to "hold" the place.

This feature of housing in shantytowns is a literal example of what Ingold (1995), re-addressing a theme originally approached by Heidegger, means by the complementarity between building and dwelling. According to that perspective - called "the dwelling perspective" by Ingold - building is related to the physical structure of the house, while dwelling is related to living in a home. Different from the " building perspective" where dwelling appears as a secondary action, a function of building, the "dwelling perspective" claims that humans are able to built (in the architectural sense) because they already dwell. Through this distinction he wants to overcome dichotomies such as evolution and history, biology and culture, design and execution, etc., in the study of people and their environments. On a much smaller scale, I wish to apply his ideas of dwelling and building to the context of the shantytown. They offer a framework to think the relationship between ownership and occupation, the first one being related to building and the second to dwelling. Dwelling is thus strictly related to building, so much that an empty house in the shantytowns is hardly ever seen. Besides, the constant acts of building, re-building and changing houses, are ongoing adjustment processes of different forms of dwelling.

Pride and prejudice

Contrary to what many prejudiced middle class and upper class people think, that there is shame in living in impoverished shantytowns, all the people I have met who live there are usually very proud of being able to have a house in such good locations, near all sorts of health resources - such as hospitals, health centres, super markets and transport facilities. Besides, they do not have to pay taxes, water or electricity since, in many cases, they use communal taps and take

the electricity (*puxa a luz*) from the nearest pole or from the next door neighbour's house.

A house in a shantytown is seen as an important value. They are very proud of buying a house, even a very small shack, in bad conditions, because once they own it, there is always the possibility of improving it. Sometimes the improvement takes years to be done, but it eventually comes. This is the case of S. reported below:

S. is 45 years old and has just managed to buy a small pre-fab house to replace her extremely poor shack, where she lived with her two children of her second partner. S. "married" for the first time at 17 when she ran away from her parents home with her boyfriend. They lived together for several years and had four children. Her partner used to drink and was violent towards her and the children. According to her, they used to live in a well built house, until one day when drunk he set fire to the house. She then left him and went with the children to live with her mother - now separated from her father - in the shantytown in a miserable and overcrowded shack. She has always worked very hard and has finally managed to replace her old house. Over the years her older children left home and she had two other children with a second partner, with whom she never wanted to live with. She says: "I'm not young any more. I don't have patience to share the little I have with someone else [partner]. Even if we have a good relationship, he remains there and I, here. It has worked out like that. Why should I want to spoil it?"

Having a house of their own is perhaps one of the most important things in their view. But that is not to say that once they have bought one house they remain living in it all their lives. There are a number of reasons why people move to other houses but, as mentioned earlier, they tend to remain close to their relatives.

One of the reasons for moving houses in the shantytown is disagreements with neighbours. As mentioned earlier, life in a narrow *beco* implies sharing a large number of elements. This sometimes gives grounds for gossiping,

arguments and fights which can only be solved by changing houses. This is because if someone is not on good terms with the neighbour who, for example, gives them access to water or electricity, the neighbour can easily disconnect these facilities, making life very difficult. The only way out is changing to another spot in the shantytown. They may be able to sell the house and buy another one, or find another family in another part of the shantytown who also wants to move and simply swap houses, without any money involved in the negotiation.

There are also a few who see the house as an investment, a way of increasing their income. This is the case of G., 38 years old who in the first interview said about the house he lives in at the moment: "I have refused R$ 270.000,00 for this house, but I am still improving it so that I can get more for it." In later interviews G. had changed his mind about selling it, at least for some time. He made the front room into a *buteco* putting a sign up the front door saying BAR. In the following interview he boasted about the privileged location of the house, which was considered good for business, next to a corner where people get together. He commented: " *Every night there are gatherings (ajuntamento) at the corner. Some sniffing glue, other smoking cannabis. There is even a male prostitute who stays at the corner. One of these days my brother ordered him out of there."*

The properties' boundaries (*terrenos*)

As stated earlier it is very common to find four or five houses sharing the same area (*terreno*). Two or three of the houses usually belong to the same family, and the other(s) are let out or sold to someone out of the family. This is illustrated on figure 6 below.

FIGURE 6

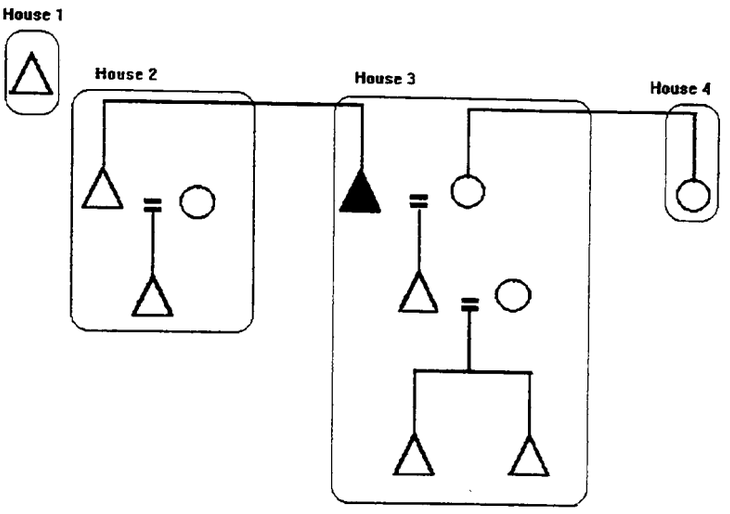

Figure 6: Several members of the extended family living in the same "terreno"

The houses are usually small, with an average of two rooms, one bedroom and one kitchen/living-room. But in the dynamics of the shantytowns, the division of rooms is not what it seems to be because there are usually more people living in the houses than beds. That is because at night the kitchen and the living-room might "become" bedrooms where the floor turns into a large bed that will lodge several people. I will come back to this point later when I discuss the idea of privacy.

As mentioned earlier, a vast exchange takes place among the houses in the same boundaries. Very often only one toilet is available outside for all. Neighbours frequently watch television together in the evening, even when they have their own television set. They may also use the fridge or just get cold water or ice from neighbours who have a fridge in the hot summer months. This is not exclusive to houses in the same boundaries, but might be extended to other

surrounding dwellings. Looking at who-or-what-belongs-where in these *terrenos* is basic for the understanding of the dynamics of the shantytown, but in these cases concepts such as "inside" and "outside" cease to be useful as exclusive categories.

For instance, the idea of boundaries that include and exclude can not be taken literally in a very crowded place. In some situations a fence limits the enclosed dwellings, other times there is no fence at all so inclusion or exclusion depends on knowledge of the place's history.

In relation to separation between houses, it might be difficult to know how many households there are in areas where the dwellings are so close together that could easily be taken as only one. There is also the case of relatives who, living next door to each other, share so many things that the fact they have separate houses may seem an insignificant circumstance. Besides, there are also "sleeping" arrangements, where children or teenagers spend the night at neighbours or relatives houses, either because their parents' house is too crowded or because they are sent to keep a someone else company, or both.

In relation to this last point it is important to note that it is very unusual for people to live on their own. People living alone are pitied by others who will then either incorporate them to their household or send them a child or a teenager to live with them.

This phenomenon has also been observed by Scheper-Hughes in Alto do Cruzeiro, a shantytown in Northeast of Brazil. As she puts it:

"Actually one is never really alone on the Alto. Should a person suddenly become totally bereft of household members, a neighbour will send someone to live with that "poor, solitary creature"." (Scheper-Hughes, 1992:99)

This is pictured in figure 7 showing Ego in situation 1 Ego with her two children and mother in the same household. When she gets "married " for the second time she builds a new house in the same area and moves in with her new husband, her new born baby and the younger daughter of her previous marriage. The older daughter spends the days with her, but sleeps over at Ego's mother's

house as shown in situation 2. Soon after Ego's mother's mother moves into Ego's mother's house as shown in situation 3.

It is also very common for a single mother who "marries" another man, to send her teenager daughter to live with someone else because there is an implicit danger of keeping the new man who comes into the household with a young girl in the same house. However this is a sort of implicit rule. Only once I heard someone openly criticise a neighbour who had let the daughter and the new husband stay in the same house.

FIGURE 7

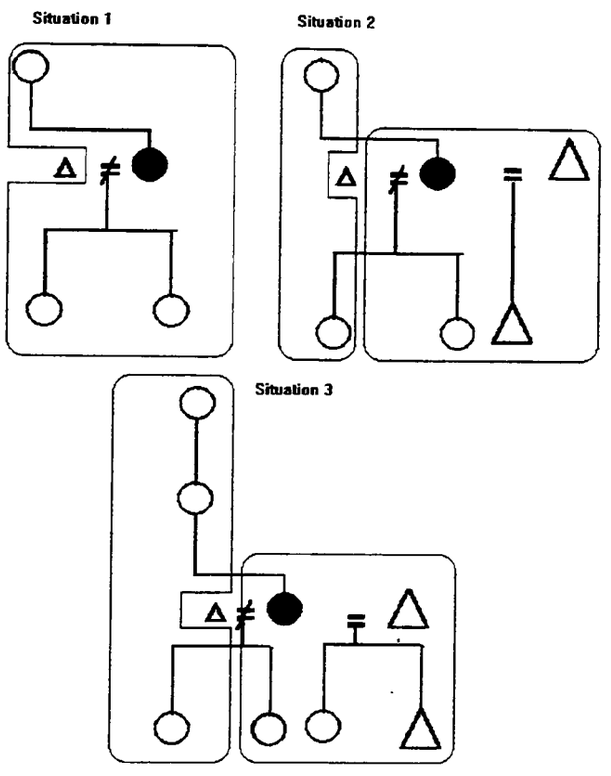

Figure 7: Living and "sleeping" arrangements involving Ego and extended family

There are different types of arrangements, and especially arrangements that change in very short periods of time. However this is not a problem for the inhabitants of shantytowns. In fact they represent "solutions" to temporary problems. What makes these arrangements peculiar is how promptly they change, making the household composition extremely fluid. (I will come back to

this point later). But even if there are many quick changes in the housing arrangements, it is very clear to them who belongs where.

The peculiarities of space organisation and housing arrangements in shantytowns in Brazil have also been observed by Scheper-Hughes (1992). In her words:

"Among the *moradores* of the Alto do Cruzeiro, money, food, medicines, and relatives (but most especially children) circulate continually in a ring of exchange that links the *mata* to the *rua* and the impoverished households of the Alto to one another. On the Alto do Cruzeiro there is no household so wretched that it will refuse hospitality to visiting or migrating kin from the *mata* or deny help to a neighbour whose *feira* basket is completely empty, even though migration and hunger are constant and ordinary, rather than occasional and extraordinary, events.

Because of the implicit rule of reciprocity among foresters (...), household composition shifts radically even over very brief periods of time. Among the more than one hundred households of the Alto on which I have been keeping records, the "actors" shift continually, so that a good deal of my time is taken up on each field visit adjusting the household censuses." Scheper-Hughes (1992:99)

Family organisation in shantytowns or working class groups in Brazil has also been studied by researchers such as Zaluar (1985), Fonseca (1985, 1986, 1987,1989), Duarte (1986), Woortmann (1987), Scott (1990), Victora (1991), Sarti (1994), Goldani (1994) and others since it constitutes a basic aspect, key to the understanding of other anthropological issues among low income groups in Brazil.

Figures 8 and 9 represent graphically changes in the household composition of some informants in a period of six months.

FIGURE 8

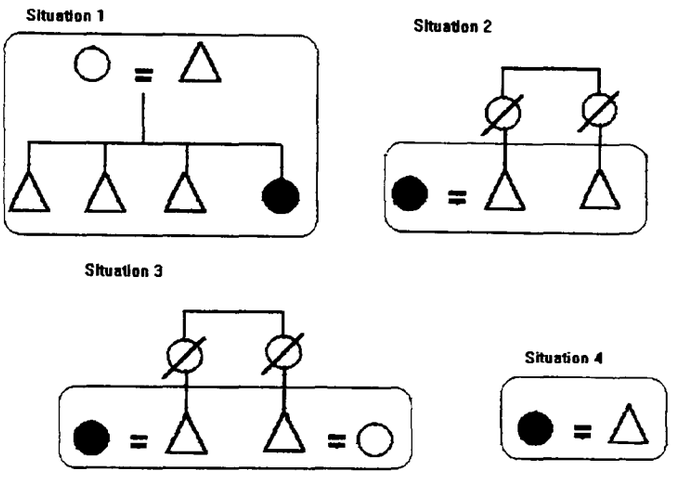

Figure 8: Four dwelling situations by Ego in a period of six months

Figure 8 shows four situations lived by Ego who is 14 years old, in a period of a few months. In situation 1 she was living with her parents and brothers. She ran away from home to live with her boyfriend, who shared a house with his cousin, pictured in situation 2. Situation 3 Ego's "husband's" cousin gets "married" and brings his "wife" to live in the same house too. In situation 4 Ego and her husband moved to a house on their own because Ego did not get along with the other woman in the same house.

FIGURE 9

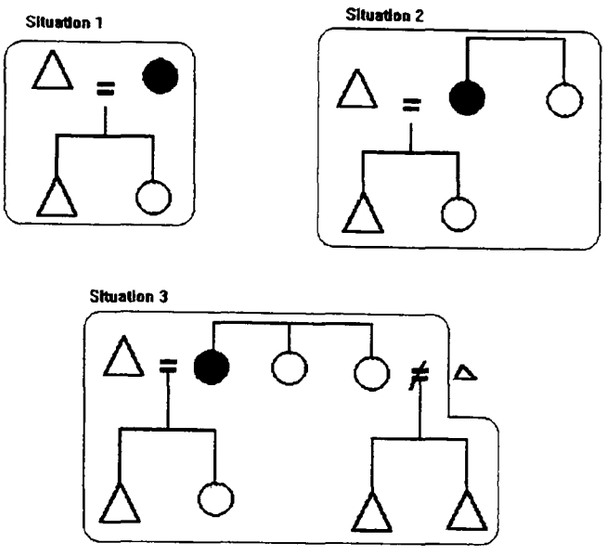

Figure 9: Three of Ego's dwelling situations in a period of six months

Figure 9 is another representation of what I mean by fluidity of the household composition. This case is typical of more stable marriages, where the couple and children remain living in the same house, often a very small one, and take in other members of the family for periods of time that range from a few weeks to several months. Figure 9 shows three situations in six months time. Situation 1 where Ego lived with her husband and children. Situation 2 where one of Ego's sisters who is single joins to help her with the housework and care of the children. And situation 3 where Ego's other sister separates from her husband, becomes homeless and comes with her two children to live with Ego's family.

Another aspect related to that fluidity is that at the representational level the number of people in a household is extremely variable and only marginally

related to the actual physical space. There are two extremely popular sayings in Brazil that I heard over and over again during field work:

"*Onde moram dois moram tres*" and "*Onde comem dois comem tres*".

They can be translated as "Where two live, three live" and "Where two eat, three eat." The numbers - two and three - are adjustable to the situation. For example, if in a household of 10 people they decide to host one more person they will say: Where ten live, eleven live. Meaning that there is place for someone else who needs. That is not the same as saying that there is no limit at all. Of course there are objective limits such as the size of the house or the amount of food available to feed the lodgers. But the perception that the house is always prepared to lodge one more person is part of an understanding that the household has fluid boundaries.

In other words, the household can be described as having a restricted size (restricted by the actual size of the house) but a fluid configuration, since the housing arrangements and the household organisation change constantly.

Representations of family: official kin, practical kin and reciprocity network

The notion that space organisation is a fluid process can also be extended to other situations in the shantytown. Even the idea of being a "relative" of the family is a dynamic one. In the researched groups' view, family is a category that includes consanguineous, relations by affinity, as well as some foster parents or children. It is a very broad category since it may include distant cousins, uncles, aunts. However it bears restrict relevance.

The relevance of consanguineous and affinal relations increases when they are physically close in the domestic household and become part of the reciprocity network in the shantytown. The reciprocity network is like a latent code that is "switched on" when relatives come to live nearby and get involved in

the social network of the family. In that sense, distant family members - great grand-aunts, distant cousins - who live in the neighbourhood will be more significant than near relatives - brothers or sisters - who live far away. This has been made clear to me when during field work I inquired about family composition and my informants referred first to the household composition, then to family members who lived in the neighbourhood, and finally, with some insistence, they "recalled" parents, children, brothers or sisters who lived in other places. There were situations when I was surprised by the arrival of an informant's brother or sister in their household of whom I had never heard of the existence before. Even though people had not been mentioned as part of the family tree, as soon as they showed up they were immediately "reincorporated" to the family, to the reciprocity network and many times even to the household.

The idea that there are two types of family, one that is defined exclusively by consanguinity and affinity ties and another that, although taking these ties into consideration, is in fact defined in contact with the household resembles Bourdieu's ideas of official kin and practical kin. For him, the official kin - as found in family charts built by anthropologists - "reproduces the official representations of social structures" (Bourdieu, 1977:35), becoming "abstract units produced by a simple theoretical division", while practical kin, is based on dispositions and interests of the groups. In his words:

" The logical relationships constructed by the anthropologist are opposed to "practical" relationships - practical because continuously practised, kept up, and cultivated - in the same way as the geometrical space of a map, an imaginary representation of all theoretically possible roads and routes, is opposed to the network of beaten tracks, of paths made ever more practicable by constant use. The genealogical tree constructed by anthropologists, a spatial diagram that can be taken in at a glance, uno intuitu, and scanned indifferently from any point in any direction, causes the complete network of kinship relations over several generations to exist only as theoretical objects exist, that is tota simul, as a totality present in simultaneity." (Bourdieu 1977: 37-38)

In the shantytowns the official kin, as a geometrical space of a map, is a broad category with a quite rigid configuration while the practical kin, defined in contact with the household, as a reciprocity network, is a restrict category with a fluid configuration. This issue will be addressed again later in the comparison with the British groups.

The ethnographic data collected along several years indicates that to study properly issues such as family, household, and space organisation in shantytowns and their relationship with other aspects of life, it is necessary to understand them as dynamic processes, since movement and change are basic elements in the constitution of people's everyday life in the shantytowns. It is in that sense that "inside" and "outside" as fixed explanatory categories are very limited for the understanding of space organisation in shantytowns. The de-construction of them in terms of non-exclusive and dynamic categories, allowing for change from one into another according to the situations families, groups or individuals go through, opens up other categories such as fluidity and flexibility as keys to the understanding of people's life in the studied shantytowns.

The limitations of pairs of opposition as explanatory categories have also been pointed out by Bachelard (1994):

"Outside and inside form a dialectic of division, the obvious geometry of which binds us as soon as we bring it into play in metaphorical domains. It has the sharpness of the dialectics of yes and no, which decides everything. Unless one is careful, it is made into a basis of images that govern all thoughts of positive and negative. Logicians draw circles that overlap or exclude each other, and all their rules immediately become clear. Philosophers when confronted with outside think in terms of being and non-being. Thus profound metaphysics is rooted in an implicit geometry which - whether we will or no - confers spatiality upon thought: if a metaphysician could not draw, what would he think? Open and closed, for him, are thoughts. They are metaphors that he attaches to everything....Simple geometrical opposition becomes tinged with aggressively. Formal opposition is incapable of remaining calm..." (Bachelard 1994:211, 212)

Perhaps this is precisely the difficulty presented by most oppositional categories, that is, as theoretical devices they are not able to account for the lived experience of a nuanced reality where being both - yes and no, open and closed, positive and negative, inside and outside - at the same time, depends just on the perspective looked at. As seen in Bachelard's follow up:

"In any case, inside and outside, as experienced by the imagination, can no longer be taken in their simple reciprocity; consequently, by omitting geometrical references when we speak of the first expressions of being, by choosing more concrete, more phenomenologically exact inception, we shall come to realise that the dialectics of inside and outside multiply with countless nuances." (:216)

In accordance with Bachelard's idea that the phenomenological experience can not be caught in rigid dichotomies I suggest that the dynamics of life in a shantytown needs to be perceived in terms of fluidity. The many examples presented earlier in this chapter about family and household composition illustrate the idea of a fluid space organisation, where everything can change very quickly and people move in and out for unspecified periods of time. This notion of a fluid physical space is also present in the informants' perception of the space inside the body where the reproductive organs are. This topic will be addressed in the following chapters.

Connections between time and space

The above discussion about space organisation in the studied shantytowns is permeated by ideas of time. Time and space, as analytical categories are often intertwined and it is difficult to say whether things change rapidly in the shantytowns because time is organised in what seems to be small sections or the other way round. The fluidity observed in the household

composition is one expression of this connection, since it can only be observed in relation to a certain time period.

In any case, one of the most striking features of the shantytown culture is the speed things change. Looking from the outside it seems that people change houses, jobs, get "married" or "divorced" very quickly.

The way I found to look at the notions of time and duration of events was by asking my informants questions other than "how long ago" something has happened. Previously I would ask questions such as "has it been long" since (something happened) and compare the "yes" or "no" answer for those questions with the answer for subsequent questions concerning the specific amount of time in days, months, years. From that I gathered that a boyfriend and girlfriend who have been going out together for about three months are considered in a serious relationship; a marriage that has been lasting for 6 years is a long term marriage; a woman who has been trying to get pregnant for more than 4 months has been trying for a very long time.

That means that they do not perceive their sequence of life events as rapid (as I did, looking at it from the outside). For them, that is the only way to live life, perhaps it is a way of dealing with the exacerbating uncertainties forced by the everyday life of urban poor. The struggle for money to supply basic needs is constant and fought for on a daily basis. There is hardly any room for planning in advance when immediate needs are overwhelming.

But I believe there is more to it than just the realisation that there is a time inside and a different time outside the shantytown but co-existing notions of time which sometimes operate separately and others simultaneously. This is because we are dealing not with an isolated community but with shantytowns embedded in a complex industrialised society. In fact shantytowns are only viable because they are in-built in modern urban centres. The geographical location of shantytowns offers at the same time possibilities of inclusion and exclusion in the surrounding larger society. In that ambiguous relation there are a number of events that require a shared notion of time with the larger society, for instance, going to work, keeping medical appointments, watching television programs,

going shopping. On the other hand there is also an independent life style peculiar to shantytowns that follows its own rhythm.

One of the clearest examples of these different "times" is the relationship between the studied "communities" and the health centres. One important difficulty observed by the medical staff who work in the shantytowns' health centres, is that the "patients" do not arrive "on time" for the appointments and that they have difficulties in making appointments in advance. During my first field work period in 1990, I used to attend the staff meetings at Vila Divina Providencia Health Centre and one of the "improvements" they had recently introduced was longer hours for pre-set appointments, in an attempt to reduce the queues of the walk-in clinics. However, the measure did not work as expected because the in-advance schedule would have plenty of empty hours while the queues for the walk-in clinics continued as usual. Another problem related to time was that the doctors tried to keep self-help groups' meetings weekly in the Health Centre but they usually did not last because people would often "forget" and did not show up. There was still another problem related to Community Health Agents, who were selected from the community to work as an intermediate person between the shantytown and the health centre, but some of them were rejected because they could not keep the meetings timetables at the Health Centre, among other problems. [18]. There is obviously more to these examples than the different "time" between the communities and the Health Centres but to address them at the moment would divert the debate far too much.

The non-compliance of the group to the health centre timetables, can be seen as a refusal on their part to submit to biomedical time and control. This interpretation follows Frankenberg's (1992) ideas about the "interrelations of biological and social time in the cultural performance of sickness". He points out, among other things, the relationship between the control of time by biomedical staff in medical practice as the basis of power and control over patients, observed especially in hospital admissions. (Frankenberg 1992:35)[19]

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[18] See Victora and Knauth (1991).

[19] Other social scientists such as Foucault, Goffman, Turner and Douglas have also pointed out spatio-temporal constraints in the exercise of power over the body . (Frankenberg, 1992)

The ambiguous position of a shantytown, simultaneously in and out of the city presents thus a peculiar combination between a shared time with the wider society and a specific local time. In many of the everyday situations people who live in shantytowns use the "capitalist" time, for example, to work in regular jobs, for hospital appointments, shopping and to watch specific television programs, such as the extremely popular soap operas which are shown daily, punctually and are never missed. All these activities demand submission of time, apparently without much problem. In that sense it is as if they negotiated their notion of time depending on the situation.

The problem about the idea of a negotiated time is that time seems more like a commodity that can be negotiated than a lived notion that organises life events, as I claim it is.

The distinction presented by Gell (1992) between "time and processes which happen in time" seems helpful to discuss the relationship between the use of time by my informants in the shantytown, despite my reservations to his severe opposition to more traditional anthropological ideas about time as a social construct.[20] For him the experience of time is alike everywhere, "there are only other clocks" (:315). To me, the existence of "other clocks" inevitably projects the issue of time into the social domain, from where it can not be isolated, even if one admits that there exists an abstract category such as time.

To borrow Gell's words, it seems to me that the processes that happen in the shantytown follow different clocks. When I take as my unit of analysis the number of changes in a household during a few months' time, I find that they change much quicker than the same events in a middle class group. But if I focus on the everyday activities of someone who spends most of the time in the shantytown, I see that it follows a much slower pace which can be noticed, among other things, in the difficulties with medical centres described above, for

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[20] One example of that is Durkheim's view that time exists for us because we are social beings, that is time exists because we, as social beings distinguish its different moments. (Durkheim 1965).

example. And there is also a large number of situations - work, shopping, etc. - when the shantytown clock seems very similar to the wider society's. Form this I suggest that the shantytown time consists above all of a flexible clock.

That takes me back to an earlier observation that even though changes in the shantytown households seemed very quick to me, it did not seem so for them. Among the shantytown groups there is hardly any planning in advance. Because there is no planning, events can change very quickly, without causing any damage. And it does not seem quick to them because they have a flexible clock that admits changes more easily than my middle class clock.

Another difficulty I have in dealing with time as an abstract category as proposed by Gell, is that a number of ethnographic events observed in the shantytown life could only be accounted for in a space-temporal dimension. All the examples above regarding the shantytown "clocks" can not be analysed exclusively in terms of notions of time. In other words, in everyday life there is always a combination of a certain "clock" with a certain place which requires the overlapping of time and space as analytical categories. Problems arise when the informants apply the wrong clock to the wrong place, as seen in the examples of the "community" X the health centre.

A less immediate but all the same relevant example of the use of overlapping time and space as analytical categories can be seen in relation to the female life stages where the space occupied by women in the shantytowns are indicative of their life stage. Non-married teenagers have much more mobility and visibility in the shantytowns than married women who are supposed to refrain from *viver na rua*, which literally translates as "live in the streets" but means spend a lot of time outside the house. Presence in certain spaces at certain times are in this case indicative of life stage and consequently, social status. In that respect it seems illustrative to recall a personal experience as an ethnographer in the shantytown who shared a number of experiences, such as being a woman and being a mother, with my informants but who, on the other hand, did not conform to the space and assignments of married women in the shantytown.

When my informants first met me and realised that I used to spend a lot of time in the shantytown, walking around, talking to different people, they invariably used to question me about (1) whether my husband did not mind my going out so much and (2) who did I leave my children with while I was in the shantytown. I used to tell them the truth, that my husband did not mind my going out, that he used to go out a lot himself too, and that I left my children in a crèche. But both answers had serious implications for my image as a respectable woman and therefore as an ethnographer. For them there was obviously a contradiction there because instead of staying home and looking after my children in the time-space of a wife-mother, I went out walking along the *becos* occupying the time-space of teenager girls. (The female life stages and change of status will be discussed further in chapter 4)[21]

The de-construction of time and space as exclusive analytical categories should be overlap is also helpful in understanding ideas of privacy in the shantytowns, especially regarding the visibility or invisibility of sex in overcrowded dwellings. Taken for granted notions that people who live in shantytowns are promiscuos because several member of an extended family may eat, sleep, make love, etc., in a small dwelling is only consistent with the idea that privacy is a matter of space. Instead, I suggest that traditionally private actions such as sexual intercourse are still invisible as long as they are taken as a matter of a time. [22]

To summarise the ideas presented in this section, life in the shantytowns follows a highly structured organisation characterised by a fluid space organisation and a negotiated time.

II. The British study

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[21] Skar (1981) explores a very interesting concept from the Quechua language, pacha, that means simultaneously what we understand as the separate concepts of time and space to discuss the position of Andean women in Peru.

[22] Ronnie Frankenberg, personal communication. For more about the invisibility of sex see Friedl (1994).

In chapter 2 I have described the groups studied and explained my initial intention of interviewing different people, especially in lower social classes, who had different contact with biomedicine. The interviews pointed out some similarities and differences in terms of life experiences which helped me to classify the informants in three groups in relation to certain housing arrangements as follows:

Group 1 - working class informants living in council estate flats;

Group 2 - working class informants living in their own house;

Group 3 - middle class educated informants living in their own house.

To discus my informants' space-temporal experiences - life stages, housing arrangements, years of marriage/partnership, stability of relationship, changes in the family/household - I will concentrate on the similarities leaving the differences to be discussed on chapter 6. I will also focus on the analysis of data about the informants whose age range from 27 to 38 years old, leaving out the ones who are younger or older temporarily.

Most of the informants in that age range recollect their life histories basically in three stages: (1) a stable period living with their parents while still going to school (until 16); (2) an unstable period which may include leaving home, starting work, going away to university, spending a period of several months abroad, living together with a partner or getting married for the first time, etc. (17-18 until mid-twenties); (3) a stable period when they get married and have children.

In relation to what I called "first stage" most of the informants recollect a quite happy and safe time, living with biological parents or mother remarried to step father. I am quite aware of the dangers of making such a generalisation, especially when it involves recollection of childhood times. However the fact that most of my informants lived basically in the same house with parents and siblings for most of their childhood years, went to school locally, recall friends with satisfaction suggests a certain degree of content and stability. In fact, all - except two who I will comment on next - conveyed the idea that those times were just as they were supposed to be. That was even the case of one informant brought up

by a single father after her mother walked out leaving the husband and three children.

There were two different cases though. Two of the informants - both working class living in council estate flats - recall very sad childhoods and one of them especially had a far from stable infancy. This person was put into care when she was 8 and the other was severely beaten by her mother for years. These two cases are very interesting and will be discussed in depth in chapter 6. For the moment I want to concentrate on the fact that in the recall of their life histories they emphasised the "first stage" much more than the others who described that phase quite quickly, taking for granted all the events involved. These two informants took their time to tell details of their childhood and referred back to that stage several times during the interview, making particular connections with problems they have even presently. Interestingly enough they have a much more psychologized discourse than the others demonstrating certain shared views possibly with health agencies and social services, suggesting that the correlation between social background and biomedical influence is a complex one and therefore worth exploring further.

The "second stage", that is before constituting their own nuclear family, the informants recall as a period of relative instability identified by them with being young and inexperienced. In the working class group living in council estates, that period is marked by experiences such as living with unsuitable partners - jealous, physically aggressive - before settling down and having children.

In the middle class, educated group, this intermediate period is spoken as a time they went in search of life experiences. Travelling abroad seems to be a good source of experience and many informants recall extraordinary - positive and negative - experiences which have marked them for a long time afterwards. Three informants had their first sexual intercourse while abroad, two of them reported it as being a rape. Three others came back from abroad to live with former partners devising stable arrangements.

The following table summarises the frequency of the most common aspects related to my middle class informants mobility after finishing school and leaving their parents house.

Events \ Informants	S	A1	H1	C	J	A2	H2
Away to University/College	X	X	X	X	X	X	X
Lived abroad for some time		X	X	X	X	X	X
Lived together with partner in a (rented) flat before buying present house	X	X		X	X	X	X
Bought present house, had child and got married simultaneously		X		X	X	X	X

Table 1 : Middle class informants after they leave parents house

Getting married, buying a house and having the first child are events that usually happen simultaneously, as if one depended on the other two. However, in the middle class, educated group plans for a second child are usually related to the plans of moving to a larger house, while in the other groups it is not. In the working class group who live in council estates, for example, they tend to have more children first and then apply for relocation in a larger council estate house. In fact, they have to prove that the house is overcrowded in order to be eligible to be moved. The working class group who have their own house will fit the new members in the house they have. Most of them mentioned that they bought their houses before the prices went up and the mortgages were still fairly reasonable, indicating that even if they wanted, it would not be possible to move.

In any case, the idea of planning is prevalent. And even if there are changes, which is obviously the case many times, they are seen as changes in previously made plans, the beginning of new plans themselves.

Regarding the household composition all informants interviewed, in all groups, lived with their nuclear families.[23] None of them had hosted any family or friends in the house, or gone themselves to live with family or friends in recent years.

In the working class group who own their own house, the "second stage" was usually brief, marked by job instability. The same is not true for relationships since most informants in this groups have known their partners since they were teenagers. Comparing them with the working class group who lives in council estates and the middle class group, this group reports long term relationships, and have been living together/married for several years. The duration of the present relationship in the three groups is shown on the tables that follow:

Working class with own house:

Event \ Informants	C	J	D	P	K
Present age	27	27	30	29	32
Age when first met husband/partner	09	17	15	07	18
How many years has been together with husband/partner	11	10	16	17	18

Table 2: Working class group living in their own house and present relationship

The same information about the middle class group:

[23] For a sociological approach to family arrangements other than the nuclear family in Britain see Marsh and Arber (1992).

Event \Informants	S	A1	H1	C	J	A2	H2
Present age	38	28	33	29	35	34	33
Age when first met husband	31	23	29	23	25	24	28
How many years has been together with husband	6	5	2	3	8	8	2

Table 3: Middle class group and present relationship

Working class living in council estates:

	I	S	C	S2	H
Present age	30	28	23	35	34
Age when first met husband/partner	24	27	15	25	29
How many years has been together with husband/partner	6	-	5	9	3

Table 4: Working class group living in council estates and present relationship

As commented earlier getting married, buying a house (or being allocated a house by the council) and having children are events that seem to be connected in the three groups. However, there are differences in relation to when in their lives these events happened. The major difference is seen in the working class group who own their houses, which at an average of 29 years of age, have been married or living with their husbands for an average of 14 years. The other two groups, working class who live in council estates and middle class groups have been living with or married for an average of 5 years having an average age of 30 and 32 years of age respectively. (For the purpose of figuring the mean years of marriage I have excluded the non-married working class informant living in council estate.)

Looking at the data in more detail we see that middle class informants have actually postponed their engagement in long term relationships for personal

and professional reasons. Two of the seven informants who are in the 27-38 age range had been married before for 2-3 years but did not have children or bought houses with their previous husbands.

None of the five working class informants who live in council estates had been particularly involved in any professional activity, three had been married before and one had a child with her previous partner. These issues are discussed in more detail in chapter 6.

But in spite of the relevance of these differences in years and stability of relationship between the groups, there is a recent period of at least five years in the life of nearly all of them when they have been living in the same house with their nuclear family. They have also reported a long period of stability while living with their parents before they finished school and an intermediate period sandwiched between two periods of stability when they were "young" and had a variety of experiences, even though the content of the experiences varied in different social classes.

To have the nuclear family as the centre means that there is a limited number of people involved and a relatively small range of variables to contemplate in domestic decisions. One example of this can be seen in my British informants' decisions of pregnancy termination, which are seen by them as matters that concern the couple but whose final word is the woman's. This is certainly not the case among my Brazilian informants, discussed in depth later in this chapter, for whom pregnancy and terminations are family matters, involving the whole household group.

The comparison made by Bourdieu presented in part 1 of this chapter between official kin and practical kin is useful to illustrate how the two types of family are seen in the British groups and in the shantytown groups.

I have argued that in the shantytowns the official kin, as a map, is a broad category that presents a quite rigid configuration. On the other hand the practical kin - living in one household or in the same *beco* - can be defined as having restricted amplitude and fluid configuration. This is what figure 10 presents:

Category	Amplitude	Configuration
Official kin	broad: comprises all the extended family members	quite rigid: only changes with birth, death or marriage of family members
Practical kin	restrict: the number of members is limited by objective means	fluid: changes constantly

Table 5: Amplitude and configuration of official kin and practical kin in shantytown groups

Using a similar approach I suggest that although the official kin and the practical kin are also distinct in the British groups, they both present a quite rigid configuration, as seen on the table below.

Category	Amplitude	Configuration
Official kin	broad: comprises all the extended family members	quite rigid: only changes with birth, death or marriage of family members
Practical kin	restrict: comprises the nuclear family (sometimes the maternal parents too)	quite rigid: only changes with birth, death or marriage of family members

Table 6: Amplitude and configuration of official kin and practical kin in the British groups

It is also a relevant fact that among my British informants, even when they had relatives living nearby who were part of their reciprocity network, they did not

mention them as an integral part of their "family" as it would be the case in the shantytowns, suggesting that in their representations of family the practical kin overlapped the nuclear family.

Discussion

Throughout this chapter I have described several situations regarding household composition, family structure, life stages, in order to demonstrate key concepts of space organisation and notions of time Brazil and Britain.

My purpose was to show that life in the shantytowns is viable because there people conceive space organisation as fluid and time as flexible. Differently the experiences of my British informants point out a much more rigid space organisation and more regular time. This is reflected in the British groups long term planning strategies.

Apart from the specific notions of time, space, family and household composition there are many differences in the objective living conditions in the studied groups. I must acknowledge the role of the Welfare State in Britain. However deficient it may presently be, it gives the minimum security necessary for making plans. That is not to say that the Welfare State does not fail. There is a growing population of homeless people throughout Britain which can not be ignored.

The possibility of making plans may be one of the most striking differences between the groups I studied in Brazil and in Britain. I have argued earlier that in the shantytown groups there is very little room for planning in advance because the objective conditions change very quickly. I used the example of the extremely fluid household composition which is only possible within a flexible notion of time. Besides, people rely on their families for most of their needs, because in a place where there is no social security the practical kin plays the role of the Welfare State.

Studying my informants' reconstruction of their life history, I suggest that the British groups' experiences of space and time organisation follows a more

rigid structure, based on exclusive nuclear family organisation, quite fixed household composition, and a relatively linear sequence of life events, expressed in the equation of the three phases - stability, instability, stability. This is not to say that the British society is homogeneous and that people in different groups or classes live similar events throughout life. There are many relevant variations between the groups studied which will be discussed in chapter 6. However, the British data suggests variations within a structure characterised by a more rigid space - and time - organisation. This is made evident particularly through the little changes in their household composition and their planing strategies.

My claim that time and space are experienced differently in the groups studied in Brazil and in Britain is based in the assumption that we experience time and space through our bodies. The habitus - in this case of the shantytown groups and the British groups - can be defined as an "embodied history, internalised as a second nature and so forgotten as history ". In Bourdieu's terms the habitus, as an immanent law is inscribed in bodies by identical histories. The identical histories means the embodiment of the same objective conditions by a group, or social class. However, the idea of an identical history must not be taken literally. In this context it means that, given a number of shared objective conditions, members of the same group or class are more likely to face the same type of situations throughout life. (Bourdieu 1995)

My point is that the particular embodied space organisation experienced by the British groups and the Brazilian shantytown groups are not isolated facts. The more or less fluid/rigid structure observed in the different groups studied in relation to the lived space is also seen in the way people live their bodily experiences. As I discuss in the next chapters the shantytown groups' experience of a more fluid space organisation in the household is coherent with a more fluid notion of the body organs and systems. This differs from the biomedical image of the body that relies on a much more rigid structure.

This is not to say that the British groups, because they experience a more rigid space organisation, comply with all biomedical procedures. My claim is that the biomedical principle of a fixed body with organs that are organised in isolated

systems is more easily “assimilated” by the British groups than the Brazilian ones because their lived experience of space provides the framework required for such understanding. Differently, for the Brazilian groups who live a more fluid space organisation, the body has a more fluid structure, allowing the possibility of organs that move from place to place or are "awaken" according to the bodily situation, such as the "mother's body" described in chapter 4.

Chapter Four : The Brazilian Study - The Female World

"Mulher e' mulher, homem qualquer cachorro e'. Brazilian popular saying

Studied groups

The data presented in this chapter as well as the interpretation of this data refers to my ethnographic research among working class women in Porto Alegre since 1989, although a large part of what will be presented here belongs to the most recent section of my research, developed between 1992 and 1994. It includes data about 100 women who have been interviewed for a larger research project developed by the Nucleo de Pesquisa em Antropologia do Corpo e da Saude[24]. All these women live in four shantytowns where there is a Community Health Post. For the purpose of differentiation from other groups I call them "shantytown" group. It also includes data about eleven women who live in another shantytown in Porto Alegre where there is not a Community Health Post, which I call the "independent" group, as well as seventeen women who were in a Public Hospital for ante-natal or postnatal reasons which I call the "hospital" group. [25] The researched women's embodied cultural experiences can be seen in a range of aspects in various areas of their lives and are discussed here especially in relation to their perceptions of their bodies and their

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[24] The larger research project which generated most of the information included in this chapter has been described in chapter 2.

[25] The situation of the independents' interviews and the hospital interviews has been specified in chapter 2.

reproductive system. These experiences are clearly related to a working class background and are explored here through their expressed and observed beliefs and practices. The ways their families are organised, the way they relate to other people, the way they raise their children, the way they cook, the way they love, the way they look after the ill, all of these identified primarily as female activities in what is known in the Brazilian anthropological literature as "popular culture".

The "popular culture" general sense of time and space for everyday events and for life in general are given by embodied cultural experiences and have been discussed in the previous chapter. The focus now is on the female views and experiences within this culture.

Representations of marriage: the single body and the married body

I have argued elsewhere [26] that in the studied shantytowns the female change of social status is related to their development as grown up reproductive beings. The female life stages are defined through a cumulative process where specific bodily gender experiences such as the menarche, the first sexual intercourse and the birth of the first child will upgrade the female child to a higher and more respectable status of an adult. The emic stages of *menina* (girl), *mocinha* (young lady), *mulher* (woman) and *mãe* (mother) are cumulative in the sense that a female has to go through them all in that order, in that the experience of the previous one is necessary for the accomplishment of the next one.

In many societies in the past and in the present, the first menstrual period, the first sexual intercourse and the birth of the first child has been the focus of rituals and practices that are meant to celebrate or protect women

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[26] See Victora (1991)

and men and their reproductive functions. According to Delaney, Lupton and Toth (1976):

" In most native cultures in the world over, the first period is accompanied by rites which give formal notice to the menarcheal child that woman's place in society is indeed a special one. The most widespread practice is seclusion of the menstruating girl from the tribe for periods lasting from a few days to a few years. During this seclusion, the girl is taboo. She may be prohibited from seeing the sun or touching the ground; she may not feed, handle food, or eat certain foods considered dangerous to her in this state. the circle of bushes or whatever barrier is placed between her and her people will probably also serve as her isolation hut during later periods. At the end of her seclusion, the girl is considered marriageable." (Delaney, Lupton and Toth 1976)

In the studied shantytowns the female changes are related to a series of bodily changes. And although they are not the reason of rituals when they occur, a number of taboos and seclusive bodily practices are carried out over the women's life especially in relation to the menstrual period. This issue will be discussed in more detail later in this chapter.

In relation to the menarche the designation of an specific phase - *mocinha* - for those girls who have had the menarche may be an indication of the importance of this stage.

Presently my focus is on the female life stages and how they are connected not just to physical experiences of sexual maturity but also to the embodiment of specific attitudes that socially indicate female status. Change of social status can thus be interpreted as above all a bodily centred experience, but can not be defined as biological or social; physical or psychological; individual or social events. That is why, in order to properly understand the female life stages and its consequences for the women's reproductive life it is necessary to collapse the dualities through which the academic thought is used to perform on, and concentrate on the body as not

just the site where the changes take place (object), but as the agent of change (subject).

Changes in bodily attitude referred to as bodily events can be seen in the life stories of three teenagers who are precisely in the process of change:

M. had her first sexual intercourse when she was 13, and after that, her boyfriend proposed she came to live with him. Her mother and brother whom she used to live with before, disapproved her intentions on the grounds that (1) she was under age; (2) her boyfriend was a drug user; and (3) she had not had the menarche. She ran away from home to live at her boyfriend's parents house. Her mother went after her and smacked her; her brother threatened her with the police. She ended up going back home.

M. is now 15 and has lived with her new boyfriend for 9 months. This time her family did not oppose the "marriage" even though she is still under age. Now she has had her first period and was allowed to live with a partner. Since they have been living together she has been trying to get pregnant. She says: "It is the dream of every woman", but she dreads she could have become sterile because of having sexual intercourse before her first menstrual period.

As a "married" woman she does not go to local "discos" any more as she used to do before living with her partner. She spends most of her time watching the telly and looking after her younger sisters while her mother is away at work.

E. is 15 years old. When I first met her she was 8 months pregnant and in due time she gave birth to a baby girl. She had her first sexual intercourse when she was 12 not long after she had had her first menstrual period. She describes her behaviour before getting pregnant as very different from now. Once she told me: "if you had met me before I got pregnant, you would have known another person." Among the things that were different was the use of drugs, specially glue sniffing - a very common practice among teenagers in the shantytown -, dancing at local "discos", mucking about in

small groups. While E. was pregnant, her older sister with whom she used to live , was afraid she would not look after the baby properly considering her previous behaviour. But her fears were swept away after E.'s baby was born and she became a very responsible mother.

A. is 14 and lives with her boyfriend. They both would really like to have a baby. She can not understand why she does not get pregnant. After all "we have been together for 6 months", she tells me. A. has known her "husband" since she was 12, but they had to hide their relationship from her parents since the parents did not approve of it. When she turned 14 she wrote a letter to her parents and ran away from home, staying at relatives' houses in another part of the city. After a few weeks her boyfriend told her to come and live with him in the shantytown. When her parents' learned that she had returned to the shantytown she was already living with her boyfriend.

A. is very proud of her husband. He works as a wall painter and provides for them both. In return he asks her not to muck about with friends in the shantytown because "there is too much gossiping"; he likes her to be clean and wear nice clothes. She says she does that only when she knows he is about to arrive back from work. So, she complies, but not always. When she does not, neighbours tell her: "I don't know how D. [her "husband"] lets you go out so much." but his most important request is still to be seen to: he really wants a child.

Through the stories of the three teenagers I aim to focus on the link between change of status and bodily changes.

In the first story, M. was only allowed to live with a man after she had had the menarche. To become a *mulher* (woman) before she was a *mocinha* (young lady) was not accepted by her family: she was smacked like a child and threatened with the police like an adult. Now that she is "married", she behaves like a married woman - stays home, looking after younger children, does not go to "discos" - and she is very anxious to became a mother.

E.'s story, the second one, is more linear. She had the menarche, she had sexual experiences, she then got pregnant. The fact that she is not "married" does not seem important, as long as she has her older sisters to look after her while she looks after her baby.

Her change of attitude has been very dramatic since she fell pregnant: no more glue sniffing, no more mucking about with friends, no more "discos", because that was not consistent with her upgraded status.

The third story is a mixture of the two previous. A.'s parents did not allow her to have a boyfriend when she was very young. She carried on going out with her boyfriend until she decided to run away and start to live with him. Only then she had her first intercourse. She now says she has a "husband" who provides for her and in exchange asks her to stay home, look nice, and give him a baby. She is looking forward to get pregnant.

Through these examples it is possible to see how their change of status is related not just to physical changes but what female in different life stages are supposed to <u>do</u> with their bodies. There are changes in the physical body, such as the menarche, changes in body shape - enlarged breasts and hips - as well as in bodily attitudes. A female who has not had the menarche is not allowed to "share" her body with a man.

The first intercourse is also seen as a body change. Some informants describe the differences they felt after the first intercourse, in terms of bleeding, pain, walking differently. When girls refer to their first sexual intercourse they say: *quando eu me perdi* that means "when I got lost" which is related to the idea of going out of the regular path.

In terms of bodily attitudes, this stage allows much more freedom with the body. Body movement is the order so going to discos, mucking about, using drugs are seen as the right things to do.

The married women are required to change their body. Although they do not always comply, they are supposed to have the body clean and well dressed, to keep the body at home instead of outside, to get pregnant or look

after the children.[27] As one informant puts it in relation to her understanding of what a "good wife" is:

[A good wife] "is one whose husband is proud of her; who is not dirty, sloppy; who keeps the food and the clothes clean; one who cares for their little child. One who says: "my son, today we only have rice for dinner, but that was all Dad could get." (I. 23 years old)

Their "husbands" status is thus directly related to the way their "wives" act with their bodies. Through their bodies women display their husbands "potency", in terms of (1) their power to provide - so the women can afford to stay at home, keeping their bodies clean and nice looking; (2) their power to keep the women faithful while they are away at work; (3) their sexual power to make them pregnant. In other words, the adult female body is the mirror of male's potency in the shantytown.

Having children is extremely important for women, who desire to conduct themselves and be respected as adults. In the shantytowns a girl of 12 has already dropped out of school either because she was required to stay home and look after younger siblings, or get a "job" as a helper in child minding neighbour's babies and toddlers in exchange for food and second hand clothes. Or just because the education offered at school was far too distant from her everyday needs. At 14, their leisure will be to muck about with peers, go to discos, sniff glue and watch the telly. It is not surprising that their social status is not very high at that stage. Getting married and/or having children comes as a very good opportunity to change their status.

In this light, having children is not just a matter of "choice", as advertised in family planning programmes specially those directed to Third World Countries. There are important economic, social, and symbolic reasons that justify teenage "marriage" and pregnancy.

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[27] Hirschon (1977) observes similar requirements from married women in the study she carried out in Greece and comments that a wife is judged by her proficiency in mantaining cleanliness and order around the house. According to her during the study " a young man divorced his wife after one year of marriage because she was not a good housekeeper, she was dirty." (:82)

To start, there are very limited job opportunities for women in the lower classes. They can only apply for jobs as house maids or cleaners as their educational level is very low. Even in this situation, sometimes their physical appearance - the type of clothes they wear, the presentation of their teeth, their verbal expression, and the fact that they live in a shantytown - is not "acceptable" among the upper classes that would employ them. Apart from that, if they get a regular job, they would have to pay the transport to and from the job place, as well as someone to look after their children, while they are away and the wages paid for house maids are usually not enough to compensate all that.

So, when my informant says that to have children is "the dream of every woman", she might be speaking about the actual act of becoming a mother, but she is also implying all the rest that comes with it. Apart from anything else, having a child is a way to get engaged to a man, where he will be responsible for provision and protection in a place where it is not safe for women to live on their own. Once again I must stress that this is present in the dominant discourse about women which does not mean to say that all women behave in that way. One example of that is that although marriage and children do not appear so frequently in the male discourse, these are not exclusively female goals in the shantytowns. Marriage and parenthood for men are extremely important because these are the only ways they can prove they are socially, economically and sexually potent.[28]

This is not to say that young people will jump at any opportunity to get pregnant and to get "married" with anyone who is available at the moment just because they ran out of better opportunities. It is not a social "obligation" but it is neither a "choice", in the sense implied by a more individualistic ideology. What I am proposing is that becoming a mother and a father for the

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[28] One of most important arguments of Bourdieu's theory is that of the opposition between masculinity and femininity as the fundamental principle of division of the social and symbolic world. This is emphasized by the "twofold meaning of the word *nif* in the Kabile language which means sexual and social potency, which are inseparable. The concept is imposed through a social definition of maleness governing all bodily experiences - not just the sexual ones. (Bourdieu 1977:93)

studied groups should be seen within Bourdieu's concept of habitus, as a "virtue made of necessity". As he puts it:

"The fundamental proposition that the habitus is a virtue made of necessity is never more clearly illustrated that in the case of the working classes, since necessity includes for them all that is usually meant by the word, that is, an inescapable deprivation of necessary goods. Necessity imposes a taste for necessity which implies a form of adaptation to and consequently acceptance of the necessary, a resignation to the inevitable, a deep-seated disposition which is in no way incompatible with the revolutionary intention, although it confers on it a modality which is not that of intellectual or artistic revolts. Social class is not defined solely by a position in the relations of production, but by the class habitus which is "normally" (i.e. with a high statistical probability) associated with that position."(Bourdieu, 1994[1986]:372)

In this working class habitus, the "choice" of a "husband" or a "wife" is also a necessity. And the "taste" for an specific type of "husband" or "wife" reflect the embodiment of necessary qualities by the partner.

"The dual meaning of the word 'taste', which usually serves to justify the illusion of spontaneous generation which this cultivated disposition tends to produce by presenting itself in the guise of an innate disposition, must serve, for once, to remind us that taste in the sense of "the faculty of immediately and intuitively judging aesthetic values" is inseparable from taste in the sense of the capacity to discern the flavours of foods which implies a preference for some of them". (Bourdieu, 1994:99)

In the female "taste" for men, some qualities are specially highlighted. A good man is one that is hard working and maintains the house; one that does not drink or causes disturbance as a result of drinking; one who does

not quarrel and one who is *carinhoso*. One informant summarised her ideal man in four items:

" [A man] who does what you like, does not quarrel, does not drink and does not hit you. "

The category of "carinho"

The most recurrent quality described by women was that a man has to be "*carinhoso*". This quality came up in different parts of the ethnographic interviews, sometimes related to their representations of a good husband, other times in their representations of a good father, and finally in their representations of an ideal sexual partner.

"*Carinho*" which in Portuguese means affection, caring and also a loving physical act such as a caress, summarises the female expectations about their male partners.

The fertile body: contraception and menstruation

When ideas of motherhood and fatherhood seen in terms of working class habitus are compared with biomedical ideas of family planning or with the feminist emphasis on the female rights of choice, some difficulties arise.

In the first case, the idea of planning requires a linear sequence of life events, hardly ever present in the studied context. In other words, planning in advance is an uncommon strategy in that context where the everyday needs are much more urgent than the means to satisfy them. The local notion of stability - a much more short term state - is not compatible with the notion of long term stability required for family planning.

Another aspect of this particular type of sequence of events, is that in the dynamics of the shantytowns everything changes very quickly, the fluidity

of the household composition is an important factor influencing decisions of contraception (This has been discussed in the previous chapter). This is not to say that the decision about having a child is related to the actual physical space available in the house, as shown in the British study presented in Chapter 6. The relationship between the fluidity of the household composition and decisions of contraception regards the extended family's availability to raise another child. [29]

This issue has also been discussed by Leal and Lewgoy (1994) in relation to the studied groups' ideas of abortion. They use Bourdieu's ideas of "rule" and "strategy" to understand the logic underlying ideas of prohibition and toleration of abortion in the studied group. They argue that:

" 'Being pregnant' or 'taking responsibility for a child' is always a process of negotiation of the social reality of the woman, where alliance situation, financial and moral maintenance of the reproductive project (biological and social) become previous conditions and strategy of social recognition of a defined pregnancy." (Leal and Lewgoy, 1994:73)

In other words, a pregnancy is only understood as such if there is someone to take responsibility for the child to be born. Otherwise, the suspension of the menstrual period will be seen as a disorder which will usually be treated through *chapoeiradas*, a combination of abortive herbal teas. The authors point out that the substantialist ontology, as seen in the Judaeo-Christian tradition, as well as the relational ontology, as seen in Kantian ethics, are present in the group's ideas of pregnancy and in the strategic decisions of termination. Both models are negotiated according to the woman's social reality.[30]

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[29] See Victora (1991)

[30] For *chapoeiradas* see Leal (1990)

Issues about motherhood and fatherhood, pregnancy and contraception must also be seen in the light of the studied groups understanding of fertility.

The fertile body: contraception and menstruation

This section aims to discuss the female ideas about contraception and menstruation. The reason why these two issues - contraception and menstruation - have been put together is because apart from both being considered female "problems" in the studied group, there is strong association between them in the female representations or the functioning of the body. (Victora 1991: Leal 1995)

The idea of a supposed female "heath" during menstruation is not a new one or peculiar to the shantytown group, rather it has been traced back thousands of years in the history of the human body. (Laqueur 1987;1990, Martin 1993)

It is not my intention to associate 20th century urban poor's ideas of reproduction with Mediaeval ideas of the functioning of the body, but to show that the biomedical model of the body is just one among several models that may vary historically and geographically. The reasons for the development of changes in the understanding of the body are hard to tell or foresee, but according to Laqueur (1987) and Martin (1993), the "scientific" findings play a limited role among the political and economic factors that motivate change.

According to these authors, for several thousand years women and men were supposed to have the same genitals, except that men's were outside and women's inside. Women did not extrude the organs of reproduction because they did not have enough heat in the body. So, male and female bodies were seen as analogous, but not equals within a logic that associated more heat with more perfection. But although not equals, they were seen as of the same kind because they were basically the same

structure. The amount of heat in each body was the main difference. According to Martin (1993):

"The new liberal claims of Hobbes and Locke in the seventeenth century and the French Revolution were factors that led to a loss of certainty that the social order could be grounded in the natural order. If the social order were merely convention, it could not provide a secure enough basis to hold women and men in their places. But after 1800 the social and biological sciences were brought to the rescue of male superiority. " (:32)

Another common idea associated with the "one sex model" of the body was that orgasm was necessary for conception but by 1800 this view had come under attack, as ideas of "spontaneous ovulation" became more influential. As Laqueur put it:

" The model in which men and women were arrayed according to their vital heat gave way to the biological divergence (...) By the 1840s ovulation at least in dogs could occur without coition and thus presumably without orgasm. So the human female, like the canine bitch was a spontaneous ovulator producing an egg during the periodic heat that in women was known as their menses." (Laqueur, 1987:3)

Based on that assumption, until much later in our century medical advice books stated that in order to avoid pregnancy intercourse should take place during the middle of the hormonal cycle.

As stated earlier, I do not assume that the shantytown groups widespread belief that the menstrual and the fertile periods coincide are related to ancients medical beliefs. In fact, even if there is a correlation, it is impossible to trace the origin of beliefs successfully and "compose" a homogeneous belief system in a multi-ethnic-complex-urban society such as the one in case. What is possible to do is to understand present images of the body through the study of bodily practices and beliefs.

According to Leal's (1995) thorough account of the same shantytown group's ideas about blood, fertility and contraceptive practice:

"Pregnancy is always seen as a *risk*, an event that may or may not happen and is always subject to a number of random possibilities. In relation to this idea of *risk*, it is not accidental the term *pegar filho* (literally: to *catch* a child in the sense of fall pregnant), that is the same expression used to be contaminated by a disease or be submitted to an affliction: to *catch* a disease. Conception is a means of contagion where fluids meet. The *par excellence* female fluid is blood, in direct analogy with the fertile masculine fluid that is semen. One of our informants even used the term *woman's semen* when referring to "substances produced in the fallopian tubes". Sexual intercourse is represented as the moment when the exchange of bodily fluids happen. It is essentially a social relation where there is an exchange. Bodily fluids are transmitting substances, of either pollution, or life, or emotions, or moral substances..." (Leal 1995:20-21)

This is evident not just in the female and male informants' understanding of menstruation but also in their accounts of the use of contraceptive methods as well. According to Leal (1995):

" The number of statements of people who state they have got pregnant during menstruation ("I got pregnant during the pills interval") or using the coil is massive. This data can only be understood in reference to the idea that it is meaningless to take contraceptive pills if one should interrupt its taking "exactly" during the menstrual period." (Leal 1995:29)

The avoidance of sexual intercourse during the female menstrual period even under oral contraceptives is consistent with a recurrent form of reinterpretation of the biomedical message that states that the pill will only be successful if taken daily. The idea that the pill has to be taken daily seems to

be translated into the idea that "there is risk to get pregnant when you do not take the pill" which is a recurrent statement in the interviews. This results in two types of reasoning:

(1) that in order to avoid pregnancy a woman must take the pill when she has sexual intercourse. That means on the days she has intercourse. This is also consistent with the widespread representation of the contraceptive pill as a barrier method, emphasising its use only when necessary.[31] According to one informant:

"During menstruation the womb is bleeding, everything is humid, the pill does not cling around the womb. The male fluid goes up more easily. It does not meet any barrier." (C. 23 years old).

(2) If women are at risk when they are not taking the pill, it means they can get pregnant in the interval days between two pill sets, if they have sexual intercourse.[32] As one informant puts it:

"Yesterday I had the last pill on the strip. Until the end of my period I must not have sex because I am at risk of getting pregnant." (I. 27 years old)

The contraceptive pill: "Contraceptive pills don't work for everybody"

Although the contraceptive pill is the most commonly used method among the female studied population [33] its side effects are often mentioned

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[31] The idea that the pill and all other contraceptive methods are seen as barrier methods is developed further on Chapter 5.

[32] For a detailed interpretation of the data see Leal 1995 and Victora 1991.

[33] The use of the contraceptive pill in the area has been rated as 39% according to an epidemiological research developed in the shantytowns by Hospital Conceocao and the Who-Body research. For further analysis on the contraceptive methods used by the

by women. Many report feeling "unwell" but still use it because they feel it is better than other methods. This imprecise "feeling unwell" account for a number of bodily negative experiences such as, headaches, nausea, sickness as well as difficulties in remembering to take it daily. Apart from those sensations, changes in the body shape caused by the use of the pill are also seen as inconvenient by some informants:

" The pill makes me put on weight". (A. 22 years old)

"One make of pill has made me put on weight, the other made me lose weight". (M. 31 years old)

Difficulties are also seen in the presence of specific conditions, such as lactation:

"I haven't taken pills after the birth of my baby because they make her very nervous. Only after weaning the baby or it might pass to the child through breast milk." (T., 24 years old)

Besides, some women get distressed when they perceive difficulties in getting pregnant and relate it to the prolonged use of the pill. That was the experience of V., 28 years old who
stated:

"The pill damages you, dries your womb".

It is important to observe here that there is no reference to hormones as the content of pills, as there are hardly any references to hormones in the interviews in general. But whatever the content of the pill is, it is seen as not

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population see Leal 1995. For a comparative analysis of the use of medical contraceptive methods (pill, coil and injections) between Brazil and France see Scavone, Bretin and Thebaud-Mony (1994).

proper for children as it might cause damage to a baby or to women themselves as seen in the above examples. This is specially true if the pill is seen as something that "clings" around the womb as shown in an earlier statement.

Another idea that is present among the Brazilian informants in general is that it is necessary to discontinue the use of oral contraceptives for some months within a year, or even once a month, otherwise the body may get addicted (*viciado*). This notion is consistent with their notion of medications in general. In fact the popular name for contraceptive pills is *remedio* that means "medication". Women classify the different types of pill as "strong" and "weak". The "weak" pills are the ones that, even if you take them regularly you might get pregnant. In a large number of cases where there has been a pregnancy while taking the pill (these accounts may include either the informant's personal experiences and comments on friends or relatives' experiences), it was seen to have been caused by a "weak" pill. " I got pregnant because the pill wasn't strong enough" is a recurrent story. But, at the same time, a "strong" pill as any other strong medications should not be taken uninterruptedly. Strong medications must be used only in cases of serious manifest diseases, otherwise the body might get used to it and not be able to benefit from it when it is really necessary.[34] This view seems to be related to the idea of "limited goods", that is also present in other parts of the interviews where there informants express that there is a limited number of goods available, and if they are used indiscriminately, they might lack when really needed.

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[34] Knauth (personal communication) has also observed the avoidance of strong medications in a similar group in southern Brazil. Her study, about women and AIDS points out, among many other things, that HIV+ mothers do had HIV+ babies are very reluctant to give AZT to their non symptomatic babies because they consider it a very strong medication. The mothers argue th at if the babies take the medication while they do not present symptoms - which is often seen as not having any health problem. - what will be left for when they actually start to have symptoms?

The coil: inside the lived body

When the informants were asked to describe how the different contraceptive methods work, they usually employed personal experiences as well as experiences of friends and relatives to make sense of the method.

That is especially the case when they describe the coil pointing it out as the most problematic method. In the female discourse about the coil it is not criticised because it is an abortive method, taking on the Catholic Church discourse about it, since it is clearly not thought as an abortive method, rather as a barrier method. Neither is it criticised because it is less reliable than the contraceptive pill, which is an argument present in the medical discourse about it. The major problem of the coil is that it may cause harm to the baby in case of pregnancy. The following statement expresses both, the coil as a barrier method and the coil as an efficient method:

"The coil is efficient because it does not allow the sperm to go through." (M., 16 years old)

Whatever the contraceptive method there is always a risk of pregnancy, as shown by Leal (1995). So, in the case of the coil, it is less problematic because it might allow a pregnancy to happen but because the baby might be harmed. The following accounts are examples of how a baby can get harmed by the coil:

G., 24 years old, had a neighbour who had the coil in and got pregnant. The baby was born with the coil on his head and died one month later.

J., 27 years old had a friend who got pregnant and lost the baby at 4 months of pregnancy because of the coil. Another of her friend managed to have the coil taken out without losing the foetus.

The fear of seeing the coil attached to the baby's body was also expressed even where there was no loss of children. Other informants indicate friends' negative experience with the coil relating infection, rejection, pain, discharge and cancer. As a strange object, it can break or be misplaced. And as an object exposed to the humidity of the internal body it can also rust. As shown by some informants:

"The coil broke inside my friend's body." (E., 25 years old)

"It might get out of the place." (S., 37 years old)

"My cousin died because of the coil: they didn't know how to insert it and it rusted inside." (F., 18 years old)

The coil is also feared because of its location, somewhere inside the body:

"It's not good to have something inside; it hurts inside." (V., 28 years old)

"I am afraid of a strange object inside." (E., 27 years old)

"I didn't like the idea of having something inside." (C., 31 years old)

This understanding that the coil is an alien object inside the body left to its own luck (it can break, get out of place or rust), shows that, in the lived body imagery, the "inside" is a hidden but dynamic place where many things can happen.

Apart from the dangers offered by the coil to the woman's "inside" the body or to the foetus, in case of pregnancy, another reason why the coil is not popular among the informants can be the lack of control that it imposes.

Women can not interrupt its use as they wish, or according to changes in their personal lives.

"Sex using a condom is like eating a sweet in its wrapping paper"

The powerful metaphor of a sweet in its wrapping paper is the most popular image of the use of condom in Brazil. Condoms are called *camisinhas* in Portuguese, which mean "little shirts", suggesting quite literally a piece of clothing over part of the body - the penis.

Many informants, male and female, mentioned that the condom is the best method to protect against sexually transmitted diseases, especially AIDS, but very few actually use it for different reasons that will be explored in this section. As one female informant puts it:

"The ideal method is the condom because it doesn't harm the body. But it is very difficult to get a man to use one." (C., 26 years old)

Actually, acceptance on the part of partners seems to be a major problem when men's ideas of condoms are mainly as a method that is "not natural" and "not comfortable". Besides, women find it very problematic to ask a partner to use the condom as this can be interpreted as offensive for him or for herself. As one informant puts it:

"I never thought of using a condom because I trusted my partners. And if I asked them to use it they would be suspicious of me." (C., 23 years old)

In C.'s case, the request could indicate that she had caught a sexually transmitted disease from another man and did not want her partner to know that. So the condom would be the evidence of her betrayal. But not all the "evidence" promoted by the condom is negative. Teenager informants, for

example, showed how the condom can be employed by teenager boys to indicate that they are sexually active. In this case the boys show the girls condoms they carry in a propositional fashion, saying words such as: *"Shall we?"*. Other boys are less direct, as shown by one female informant:

" I know some boys carry condoms in their pockets, but I have never used one." (M., 15 years old)

So, even though the condom is not popular as a contraceptive method among the studied population, it is still a recognised method which has important symbolic connotations.

Still regarding the condom's symbolic aspects, it raises two important cultural issues:

(1) As a method that has to be used by men, the condom indicates an attempt to reverse the widespread understanding that contraception is a female issue. But several informants made it very clear throughout the interviews that contraception is seen as a female only responsibility.[35] As one male informant puts it:

"This is the woman's problem, it is she who gets pregnant, not me." (P., 29 years old)

(2) As a device to be used during intercourse, it clashes with the local meaning of sexual intercourse as an exchange of fluids and as a thoroughly sensorial experience. Many men expressed their lack of interest in the condom in terms of: *"it is not the same", "you can't do it properly"* or *"it is not natural"*. As one male informant stated:

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[35] The female equivalence method - the female condom - is not available in Brazil, so none of the informants mentioned it. In very few interviews the cap - diaphragm - was referred to as the female condom (*camisinha da mulher*), but none of the women had ever used it.

"Condom is not natural. It [sex] has got to be the male body with the female body." (J., 38 years old)

Finally, some informants stated that the condom was not completely safe because it could tear, based on personal or friends' experiences of pregnancy as a result of such accidents. As a male informant puts it:

"We get in with a "little shirt" (camisinha) and get out with a little tie (gravatinha)." (C., 32 years old)

Tubal ligation

"The only method that works is the tubal ligation. Now-a-days not even the TV helps. In fact, the soaps operas even stimulate more sex. The soap opera starts and you take your wife to the bedroom." (A., 38 years old, male informant)

Tubal ligation as a way of preventing pregnancies accounts for around 10% of the women's choice of contraceptive methods, being the chosen method of nearly 50% of women over 30 years of age in the studied context. It is a common method in Brazil, widely accepted although not available free of charge through the Brazilian national health service (INAMPS), unless demanded by health reasons. But a few other social services, some sponsored by international agencies, offer the possibility of buying a private tubal ligation at reasonable prices. Even in this cases it is not recommended by the doctors for women under 35, or without the agreement of the woman's partner. The only way women can have a tubal ligation through the national health service is if they go into hospital for a caesarean section and combine the two surgeries. This is a very common practice and has been responsible,

among other factors, for the increase in the number of caesarean sections throughout Brazil in the last 10 years.[36]

Tubal ligation performed during a caesarean section operation is seen by the female informants as the only method absolutely guaranteed. Another type of tubal ligation performed through the navel has been identified as not as guaranteed, since a few women have got pregnant afterwards.

In terms of body image, the tubal ligation is seen as a disconnection of the tubes. In the emic vocabulary to tie up the tubes - *ligar as trompas* - is expressed in terms of a disconnection or interruption - *desligar as trompas* - in an allusion to the fact that the tubes get disconnected and interrupt the flow. The word *desligar* is the same word used for turn off (i.e. lights, appliances) which seems a vivid image of what happens inside the body when tubal ligation has been performed; it represents that the reproductive system has been "turned off".

Apart from that, the word "tubes" (that are translated as *trompas* in Portuguese) are called *trombas* which means "trunks", the same word used for the elephants' nose maybe in association with its shape or just because of the phonetic similarity. So instead of *ligar as trompas* - "tie up the tubes" - the emic expression for tubal ligation, is actually *desligar as trombas*, which literally means "turn off the trunks".

As a part of the body that can be disconnected, the fallopian tubes are pictured as a passage way that conducts either eggs or semen to the womb. In this last case, as if spatially it were situated before the womb. Looking just at the female explanations of how conception takes place solely from their drawings, the idea is that the trajectory of semen is: penis-vagina-tubes-womb. As some informants put it:

"There is the womb, the ovary and the vagina where the sperm comes in through the tubes." (S., 45 years old)

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[36] For more about the practice of Caesarean section in Brazil see: Faundes and Cecatti (1993); Souza (1994).

"The woman has the tube (tromba) that is linked with the womb. Then, when the man comes (goza) it [semen] arrives through the tubes and gets to the womb." (A., 16 years old)

In any case, whether the tubes conduct eggs or semen, the womb is seen as the meeting place of egg and semen. Only two of the Brazilian informants said that the conception happens in the tubes and that later the fertilised egg attaches itself to the womb.

In terms of graphic images of the reproductive system, the tubes represent an important element in the female pictures of the body. This is not surprising considering that tubal ligations are recognised by the female population as the most efficient contraceptive method, representing the reality of 10% of the interviewed women over 30 and perhaps a later choice for women under 24 years who presented favourable views about it. Among the younger group, 1/3 of the women said they were against tubal ligations, while the other 2/3 were either openly favourable or stated that they would have a tubal ligation if they "had more than three children", if they "had financial difficulties", or if they "had become ill". All women interviewed were aware that tubal ligation is a permanent method. The ones who said they would never have a tubal ligation were against it on the grounds of its irreversibility, expressing the possibility of having other partners who would like to have children.

In comparison with the images made by male informants, the absence of the "tubes" constitutes one relevant difference between male and female drawings. Very few men actually represented the tubes in the graphic images and hardly any acknowledged their existence at all. Comparing tubal ligation with the equivalent surgery on men, vasectomy, the latter was either unknown by the informants or not considered a good choice, usually on the grounds of its extremely difficult reversibility and a general feeling that would not be the proper thing to do. Only one male informant had it done a few months previous to the interview and another one had considered it as a future possibility.

The absence of "tubes" in the male drawings and explanations about the reproductive system as well as the greater acceptability of surgical sterilisation for women in relation to men, point out, among other things, gender differences in the understanding of the body and its functions. Both points reinforce the idea that contraception is seen exclusively as a female issue and stress the assumption that embodied gender experiences give shape and meaning to bodily practices.

Body image and non-medical contraceptive methods/practices

Apart from the pill, the coil, the condom, and the tubal ligation, other contraceptive practices are also employed by the group. These are used by a very small number of people and will be briefly discussed in this session. Coitus interruptus, "home recipes", "the rhythm", oral sex and anal sex are "non-medical" methods or practices in the sense that they are carried out by men and women without interference of health professionals.

Coitus interruptus is a well known and widespread practice which, according to the studied group, presents advantages and disadvantages. Among the advantages it is seen as a choice that does not depend on any external device, avoiding the problem of side effects. It does not involve any monetary costs as it relies exclusively on the couple at the moment of the intercourse. The emic name for this practice is *se cuidar* which means "to be careful", and this is all it is in their view. But exactly because it depends on the couple, especially on the man who has to withdraw the penis from the vagina before ejaculation, it is seen as dependent on self control and will to accomplish the practice properly. Male informants rarely mentioned this practice and when they did, they referred to it in negative ways. Female informants claimed that they had used it temporarily, some more, others less successfully. The following example is of a not very successful one:

" We used to 'be careful' (se cuidava). He used to withdraw before, but it depended on whether he wanted to be careful. It is difficult for them [men] to want to be careful. On the best moment, that's exactly when they don't want." (C., 31 years old)

Similarly to the condom it is a method that depends on the male partner's commitment to the contraceptive project. A few informants suspected that this method was not "good for your health" because it interrupts the natural course of the sexual act.

A few informants when explicitly asked about home recipes to avoid pregnancy mentioned procedures usually based in ideas of fluid flow in and out the body, such as water and urine. As some informants put it:

"To avoid getting pregnant drink three sips of water and pass water after intercourse." (I., 44 years old)

"Have a glass of water; wash the vagina with soap and water after intercourse." (T., 42 years old)

"I don't believe that a douche after intercourse prevents pregnancy. It is like having three sips of water and passing water [it doesn't work]. After it [semen] gets in, there is no way." (C., 31 years old)

The ideas that drinking water and passing water could prevent a pregnancy, even if not very effectively as suggested by the last statement, point out an important aspect about the understanding of the body by the informants. Their statements indicate that drinking water through the highest body orifice - the mouth - will dilute the semen inside the body, which is expelled in the urine through the lowest orifice - the urinary canal. That points out a connection between organs significantly different from the biomedical model that understands the reproductive system, the digestive system and

the urinary system as three separate functions, even though the digestive feeds into the urinary system.

The rhythm has also been mentioned as a contraceptive practice. According to this practice sexual intercourse should be avoided at specific days when there is an increased risk of falling pregnant, which is understood by the majority of the informants as the days near the menstrual period. This is consistent with the widespread notion that the fertile period is immediately before, after or during the menstrual period. This topic has been discussed earlier in the present chapter, and will be discussed further later in the group's representations of the fertile period.

Finally, oral sex and anal sex, although explicitly asked about by the interviewers, have not been associated with contraception at all among the informants. Female informants tend to have a very negative view of these practices but state that their male partners do not. In the next chapter I discuss some aspects of these practices according to the male informants' views. According to the female informants these were not considered healthy either because they were dangerous, or because they were against nature:

"Coitus interruptus, anal sex and oral sex are against nature." (J., 47 years old)

"I've heard of someone who practised anal sex who torn inside and had cancer as a result of that." (A., 14 years old)

But mostly women refer to anal and oral sex as inappropriate for respectful "family women" like them. These practices are often described as "repulsive" (*nojentas*) in the same terms as having sex while menstruating. Although in the hierarchy of the sexual practices one informant stated that she would rather have intercourse during her menstrual period than having to have anal sex as an alternative.

"It is better to allow that [sex during menstruation] than having to have anal sex." (A., 22 year old)

Menstruation and pollution

"And if a woman have an issue, and her issue in her flesh be blood, she shall be put apart from seven days: and whosoever toucheth her shall be unclean until the even." (Leviticus 15:19)

The pollution represented by menstruation is not peculiar to the studied group. Extensive anthropological literature point out different taboos observed during the menstrual period by men and women on the grounds that menstrual blood as a polluted fluid may cause personal, social or environmental damage. (Douglas 1986; Davis and Whitten 1987) As mentioned earlier in this chapter seclusion of the menstruating women was frequently required in order to avoid misfortune.

According to Delaney, Lupton and Toth (1976) the rule against intercourse with a menstruating woman in Judeo-Christian scriptures appears first in the Leviticus (as quoted in the beginning of this section). They also point out the ambiguity sometimes represented in certain religious views as seen in the Koran, where it reads:

"They will also question thee as to the courses of women. SAY: They are a pollution. Separate yourselves therefore from women and approach them not, until they be cleansed. But when they are cleansed, go unto them as God thath ordained you."

Yet, in the Islamic account of the Creation, blood is seen, not as a source of pollution, but as the substance of creation:

"Recite, though, in the name of thy Lord who created;-/Created man from CLOTS OF BLOOD:-/ Recite though" (3). According to the authors then, "blood like the menstruating woman, is *sacra*, both sacred and accursed." (Delaney, Lupton and Toth 1976:15)

In the present session I will present the views of the studied groups about menstruation, especially in relation to taboos of sexual intercourse during that time as they disclose my informants understanding of such bodily processes.

In the first part of this ethnographic research, developed in 1990, my informants were asked to tell me about their first menstrual period. The great majority of them recalled the experience in terms of surprise, embarrassment and shame. As one of my informants puts it:

"When I had my first period, I didn't know, I cried like mad: "I've cut myself!" I didn't know what it was. But then, later, when my mum arrived at night, she explained to me. I was embarrassed. My godmother used to live with us and she asked me what was my problem, and I just cried." (Z., 25 years old)

This type of feeling in relation to the menarche, that the menarcheal blood comes from a wound in the body, has also been described by some of my British informants and will be presented on chapter 6.

Similar accounts of fear caused by the first period have also been described by MacCormack and Draper (1987) in their study about reproductive health in Jamaica. Their finding in Jamaica are quite similar to my data from Brazil where informants who were initially distressed about the inset of menstruation, re-interpret it later as a sign of health and strength (MacCormack 1987; Sobo, 1993). But while menstruation as a process is seen as necessary for a healthy female life, the actual menstrual blood is described as "repulsive", "a mess", "a hassle", in short, a source of pollution. (Furth and Shu-yueh 1992)

Other anthropologists have discussed positive and negative aspects related to menstrual blood and amenorrhoea pointing out the importance of an adequate blood flow to maintain health balance. (Douglas 1986, Duarte, 1986; Martin, 1987; Victora, 1991; Sobo, 1993; Leal, 1994).[37]

According to Leal (1995) on the same shantytown group menstrual blood is seen as the substance that makes the foetus, and is thus seen as blood of a different type. As she puts it:

" This [blood] is not the same blood that flows in the body. Expressions of disgust and repulsion are displayed by a woman in relation to her own blood, at the same time that blood from a wound does not cause any distinctive reaction. There is a strangeness regarding this blood's smell and the state that is identified as "strong", "repulsive", "thick", "pasty"."

This, however, is not a perception exclusive of this Brazilian group since there are other similar references in the Anthropological literature. For example, menstrual blood as blood of a different type refered to with a different name has been described by Rasmussen (1991) as a be lief of the Kel Ewey where different terms distinguish ordinary blood from menstrual blood.

Martin (1987) observes that although her American female informants' discourse about menstruation differs according to women's social class, general cultural views of menstruation as "hassle" and as a mark of womanhood stretch across all interviews, other aspects differ markedly by class. Definitions and experiences of menstruation are seen by her as related to access to the forces and means of production:

"...Where access to the forces and means of production in the society are severely limited, reproduction can be a way of acting in the world,

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[37] For a discussion about the medicalization of menstruation see Bransen 1992. For an account about female views on the relationship between health, food and female reproductive cycle in a multi-ethnic group attending a public clinic in Michigan see Snow and Johnson (1978).

changing one's life, producing a "resource" to be shared or cherished." (Martin 1987:104)

In terms of their views of menstruation, Martin's middle class informants explained in terms of "a waste product of an effort that failed" similar to the biomedical failed reproduction view of menstruation while working class women didn't. The latter accounted for a phenomenological experience or in terms of a life change.

Together with the idea of a "repulsive mess", the Brazilian informants also avoided intercourse during menstruation on the grounds of health. In the words of one informant:

" The woman runs the risk of getting a sexually transmitted disease, because the body is open, bleeding." (S., 45 years old)

"...something might happen, either pregnancy or damage. You can't put anything in when it is coming out." (V., 28 years old)

These ideas are consistent with the widespread image of an "alive", moving body, that opens and closes. (Leal 1995) This opening and closing is seen also in the case of miscarriages. The most common reason for miscarriages according to the informants was carrying heavy weight. In an analogy with a balloon that bursts if heavy weight is applied to it.

According to Delaney, Lupton and Toth (1976) avoidance of sexual intercourse during menstruation on the grounds that "it is bad for his health" and "that it is bad for her health " is a widespread historical phenomenon. From the Mae Enga's beliefs that "contact with a menstruating woman can make a man vomit, can "kill" his blood, waste his flesh, darken his skin, ruin his "vital juices" and "dull his wits" to the twentieth century believe that it can cause urethritis. As for the female health fears of "haemorrhage, injury or infection" are cited as the most common pseudoscientific taboos in the twentieth century. They also point out that the Roman attributed the deformity

of the god Vulcan to menstrual intercourse between Juno and Jupiter, and the same belief relating conception during the female menses as the cause of horrible diseases in this century. (Delaney, Lupton and Toth 1976: 17,18,19)

But if in the studied population menstrual blood is polluted, it does not mean that menstruation as a process is seen in negative terms. Rather it is seen as a beneficial and necessary cleaning process of the body. As put by one informant:

[Menstruation in beneficial] "because it cleans, takes away impurities. It cleans and avoids disease." (E.,30 years old)

Menstruation and "the failed production view"

"Menstruation is like the red flag outside an auction sale; it shows that something is going on inside" (Mathews Duncan, British gynaecologist quoted by Laqueur 1987:28)

"Menstruation is the weeping of a disapointed uterus" (Sir Norman Jeffcoate, Principles of Gynaecology 1975)

The above quotations, account for two different views of the functioning of the reproductive system. In the present session I will demonstrate that the shantytown group's view of the body is related to the first one while the biomedical view to the second.

Emily Martin argues that the biomedical negative view of menstruation as a failure to produce a baby contributes to our negative view of it. She compares the way in which medical texts describe the female and male reproductive functions, in terms of production of eggs and sperms, pointing out that while the production of eggs and endometrial lining and their release through menstruation is seen as a failure to produce, the production and

release of sperm when conception does not take place is seen as "remarkable".

She presents several extracts from medical books. One of the books cited describes the male and female reproduction process in the following way:

Male:

"The mechanisms which guide the *remarkable* cellular transformation from spermatid to mature sperm remain uncertain...Perhaps the most *amazing* characteristic of spermatogenesis is its *sheer magnitude*: the normal human male may manufacture several hundred million sperm per day (emphasis added)." (quoted by Martin 1987:48)

Female:

"The fall in blood progesterone and oestrogen, which results from *regression* of the corpus luteum, *deprives* the highly developed endometrium lining of its hormonal support; the immediate result is *profound constriction* of the uterine blood vessels due to production of vasoconstrictor prostaglandins, which leads to *diminished* supply of oxygen and nutrients. *Disintegration* starts, and the entire lining (except for a thin, deep layer which will regenerate the endometrium in the next cycle) begins to slough...The endometrial arterioles dilate, resulting in *haemorrhage* through the weakened capillary walls; the menstrual flow consists of this blood mixed with endometrial *debris*...The menstrual flow ceases as the endometrium *repairs* itself and then grows under the influence of rising blood oestrogen concentration. [Emphasis added.]" (quoted by Martin 1987:49)

In a similar fashion ovulation is also described in terms of loss and degeneration as women are born with about one million of follicles from which

only 400 should reach maturity, while men's massive sperm production is seen as positive (Martin 1987:49)

Martin's protest against the way menstruation is described is also based in the fact that even if menstrual discharge is actually a process of breakdown and deterioration, why are not other analogous bodily processes - such as the lining of the stomach that is shed and replaced regularly - described in similar terms? .

Among the shantytown groups who have an understanding that menstruation is a necessary cleaning process, menstruation is not seen in terms of "failed reproduction", as suggested by biomedicine. It may be a blood loss, but not the loss of a potential foetus. Menstruation is seen as necessary, it is beneficial. Precisely because menstrual blood is considered "bad blood", "dirty blood" that has to be released, is that it is seen "a mess". So, although a woman loses blood, her body is renewed after each menstrual period. The blood loss is explained by one informant as follows:

"During menstruation the woman loses blood, gets weak, gets tired. (T., 51 years old)

The female body is cleaned during menstruation, "bad blood" is released, menstrual periods are described as "red flag indicating that something is going on inside the body" rather than "the uterus crying for lack of a baby". It is seen as a dangerous period and as such requires seclusion. In an analogy with the seclusion in a menstrual hut as performed by several tribal groups described by anthropologists, I suggest the withdrawal from sexual intercourse during the menstrual period among the shantytown women is a also a seclusion, as put by an informant:

"You can rest for a few days." (V., 30 years old)

Another reason why "seclusion" is recommended is because the reproductive system is not seen as a separate system but as part of a whole

bodily system. "Bad blood" should not stay "inside" the body because if it does it may cause damage to other parts of the whole if it gets in contact with:

"My aunt has washed her hair during menstruation. The menstrual blood went up to her head and she's gone a bit crazy since. (M., 27 years old)

Leal observes that in the emic symbology that complies with humoral theories, blood is hot and water is cold.[38] The cold water is thought to cut off the menstrual flow and consequently cause harm to the woman. (Leal 1995; Victora 1991)

According to Martin's view "working class women are less exposed to scientific vocabulary, less familiar with the kind of written materials that schools use to disseminate the scientific model. Or they have been more able to resist one aspect of the hegemonic scientific view of women's bodies because it is not meaningful to them or because it is downright offensive..." (Martin 1987:110).

Although I believe it is true what Martin observes, that the contact with biomedicine influences the way women understand their bodies, her arguments that women may resist the biomedical explanation because it is offensive or meaningless seem to explain women's views better. The reason working class women do not describe menstruation as failed reproduction is because they do not experience the body as a reproductive machine, rather as a pulsing lived phenomenological experience. And this is true even in the studied shantytown groups which have been invaded by biomedical knowledge through the community health centres located there as explained in chapter 2.

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[38] In this case, as in humoral principles in general "hot" and "cold" are not necessarily related to thermal temperature, rather they indicate humoral values within a principle of opposites. For a thorough discussion about humoral theory in Spanish-American therapeutics see Foster (1986).

The pregnant body and the "emic" organ: the body's mother

Perhaps the most vivid example of the lay model of the body can be found during and immediately after pregnancy, in other words, in the way women perceive their pregnant and post-natal bodies and how they make sense of their sensations.

Pregnancy is a very "public" state in the shantytowns in the sense that many people get involved, give opinions, advice, and make predicaments to pregnant women. Pregnant women are seen as suffering significant influence from the immediate social environment and from direct actions performed by them. This is shown in the following statements:

"Everything that happens to you during pregnancy, the baby gets it too. I had problems with my family, and when I went to the doctor, the baby was across the belly. Because of that I needed a Caesarean section." (F., 27 years old)

"I had to do all sorts of heavy work during my pregnancy, carry bricks, cement; the belly was often wet from washing clothes. The baby was born weak, with low birth weight. (C., 25 years old)

In these types of account the women are usually implying that they have not been treated properly according to their distinctive state of pregnancy. The implications of the external/social environment can be seen in the internal/pregnant state. Perhaps the division between an external and internal environment is not so clear cut and the boundaries between the natural body and the social body or the environment are much more complex then this dualistic model allows. In the examples above, problems with the family and a wet belly penetrate the pregnant body and influence the development of the foetus.

The Brazilian group that has been interviewed in Conceicao Hospital as well as the independent informants stated the existence of an organ called the "body's mother". This "emic" organ they describe as an organ that is always inside the body and that accompanies the baby during pregnancy. After the baby is born, it looks for the baby, because it misses it. That is why there is movement in the women's belly after birth. Here are some of their accounts about the "body's mother":

"The "body's mother" is like a baby, it jumps up and down. But it is always inside the body, it remains inside after the baby is born." (I., 43 years old)

"The "body's mother" helps the baby to grow; after the baby is born it looks for the baby, you have to massage it to calm it down. [And what do you think about it?, I asked] I don't think, I feel it." (J., 25 years old)

The body's mother as a phenomenological experience, is an organ that moves inside the body - it jumps up and down, it needs to be calmed down. It is alive on its own because "it looks for the baby". But at the same time it is a bodily organ like any other that "is always inside the body". The reason it is there is to "help the baby to grow" or just to keep company to the baby while in the belly, as it has been told me recurrently.

It is a friendly organ, like a mother, that gets so attached to the baby that keeps looking for it after it is born, but not for very long. As some informants put it:

"I felt it yesterday, it was bothering me. It looks for the baby. It misses it. It was not painful, it just moved and then stopped." (C., 17 years old)

"The "body's mother" moves in the body after the baby is born, but not for very long." (T., 36 years old)

I asked a few informants to point or draw the "body's mother" in the graphic images of the body and they pictured a small circle in one of the sides of the womb and indicated with lines the movements performed by the organ. But the idea of making a drawing of the "body's mother" in the silhouette was not very adequate because it was clear that the body's mother belonged to distinct type of knowledge, an experiential knowledge. I asked my informants how did they first learn about the body's mother and they told me that their mother had told them about it, as follows:

"My Mum has always told me: it beats like a heart." (C., 26 years old)

"The "body's mother" is like a little baby inside, it moves. But it is not. I had felt it before and I thought I was pregnant. I told my Mum and she said I wasn't, it was just the "body's mother". I did a pregnancy test and it was negative." (V., 28 years old)

But, even though women state they have learned about it from an older female relative, several informants said that doctors had confirmed that the movements they felt in the abdomen after giving birth was the "body's mother".I suspect that doctors and patients are speaking about ` movements inside a post-natal body, contractions and rearrangement of internal organs after birth. But although they are actually speaking of the same general phenomena, they imply different meanings. The doctors, so I have been told by some of them, are actually talking about the contracting womb and assume that the womb is the "mother of the body", an organ that commands the female being. On the other hand, the women speak of an "emic" organ. As in Portuguese both expressions ("the mother of the body" and the "body's mother") are the same ("*mae do corpo*") it is hard to confirm.

Two informants also used the term "womb" to translate what the "body's mother" is, but kept the meaning they had learned "at home".

"The "body's mother" is the womb, it misses the sac, looks for it after the baby is born. (R., 23 years old)

"If the "body's mother" is weak, the woman does not get pregnant. It is the womb. I have felt it, it moves side to side, makes noises, have cramps. We feel it after delivering a baby. It is as if you still have a baby in. Every woman knows that." (M., 44 years old)

The idea that this knowledge is common to all women is also a recurrent one since this type of information is clearly part of the female gender experience. I can understand their surprise at my ignorance, when they realised that I, even being a woman with children, had never felt the "body's mother", as for them "every woman knows that".

As a distinct organ the body's mother accounts for another bodily event, the psychological pregnancy. As one informant explains:

"I know it moves like a baby in the womb. Sometimes, when a woman cannot get pregnant, she has a psychological pregnancy. It is the "body's mother" that grows." (F., 27 years old)

In a similar way that doctors use the emic expression *mae do corpo* to speak about the contracting womb, the women use the "medical" word, womb, implying the emic organ. My understanding is that doctors and patients are not just using different words, they are actually using different models of the body. The same can be said in relation to the "psychological pregnancy" which in a lay model of the body is seen as growth of the "body's mother". Being the "body's mother" a quite autonomous organ that mirrors the mother's behaviour: it desperately wants a baby, likes the baby, looks after the baby and searches for the baby when it is gone.

Graphic images of the body

The body maps made by the female informants were in general quite similar to the biomedical model, especially if compared with the pictures made by male informants shown in the next chapter. Very few informants - 3% - refused to make the drawing and some of them recollect having done this type of exercise or seen it done before in women's group meetings with the local health post staff. But even though a significant number of pictures were similar to the biomedical model, the meanings conveyed to the organs were not necessarily the biomedical ones. This demonstrates one of the points of this dissertation regarding the constitution of knowledge about the body in the sense that there are different ways of knowing the body.

The experience of making a drawing was never an indifferent one. Some women found it very difficult and complained, others found it a lot of fun and laughed. My evaluation is that it was stimulating as I heard them comment about the interview like "that interview that you are asked to make a drawing of the body."

In general when the women were asked to "fill out" the empty silhouette, they attempted to recall the biomedical model. This indicates that they have been exposed to the picture of the internal body but at the same time they presented a certain detachment as if that was a body, but not necessarily their body. On the other hand, when they spoke about the functioning of the reproductive system, they recalled their bodily experiences.

I have classified the maps of the body according to the type of organ they include or exclude, as follows:

F1A presence of face; presence of breasts, vagina and other organs

F1D presence of face; absence of any sexual organs

F2A absence of face; presence of breasts and vagina

F2B absence of face; presence of reproductive organs (very similar to the biomedical model)

F2C absence of face; baby in the belly or womb

F2D absence of face; presence of diffused organs in forms of circles, scribbles

FNO refusal to draw

The most common picture was the one which presents the reproductive organs as the biomedical model and no face. Thirty five per cent of the women basically pictured Fallopian tubes, ovaries and womb. Some included the vagina others did not. The following are examples of this type:

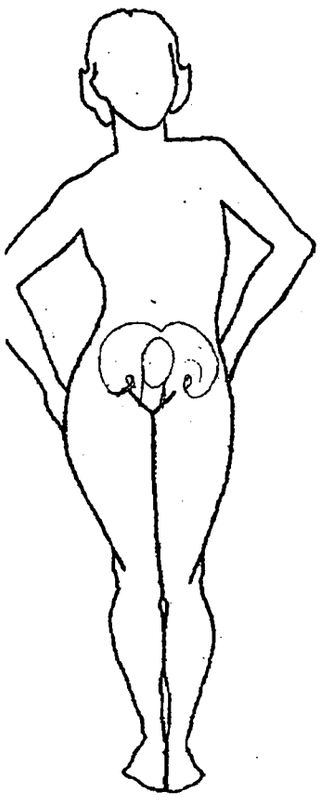

Figure 11: Brazilian informant's drawing - similar to the biomedical model (A)

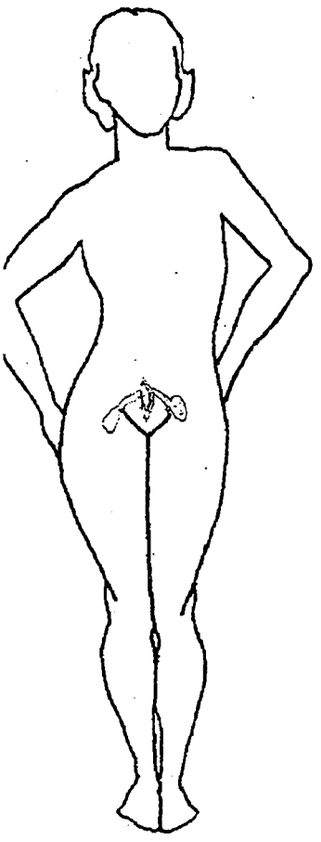

Figure 12: Brazilian informant's drawing - similar to the biomedical model (B)

As mentioned earlier it is not surprising that the women who have in general been exposed to the biomedical body kept a visual record of it. What is striking is that although picturing the body according to the biomedical model, the overall understanding recalled an experiential domain. This is evident in several interviews. One example of that is the case of C., 23 years old, whose drawing included fairly well shaped womb, Fallopian tubes, ovaries and vagina. She identified the fertile period as being 10 to 12 days after menstruation because during that time the womb is more humid and can absorb better the male fluids. This informant takes the contraceptive pill and explained that the pill taken spins around the womb, preventing the sperm to meet the eggs. The pills immobilise the sperm. She also thinks that there is a risk of getting pregnant during the menstrual period because the area is very wet and the pill cannot remain around the womb.

The second most common type was one that presents a number of what I called "diffused organs" because they do resemble organs, but not the ones present in the biomedical model. Here are some examples:

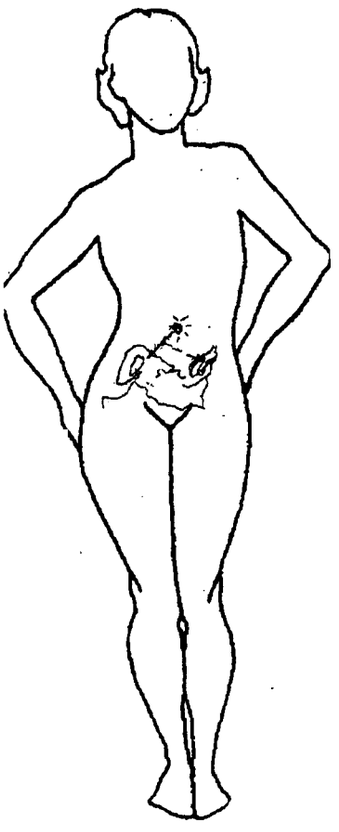

Figure 13: Brazilian informant's drawing - difused organs model (A)

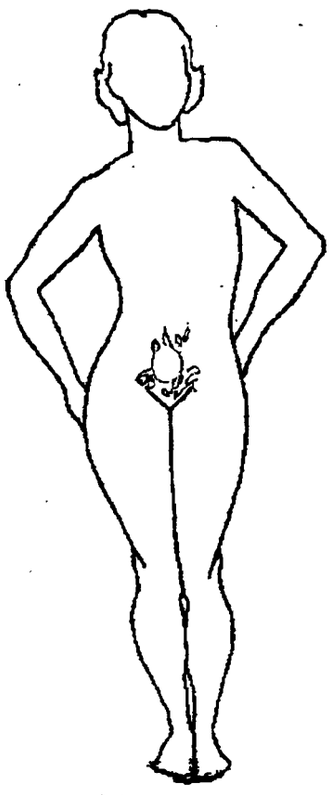

Figure 14: Brazilian informant's drawing - difused organs model(B)

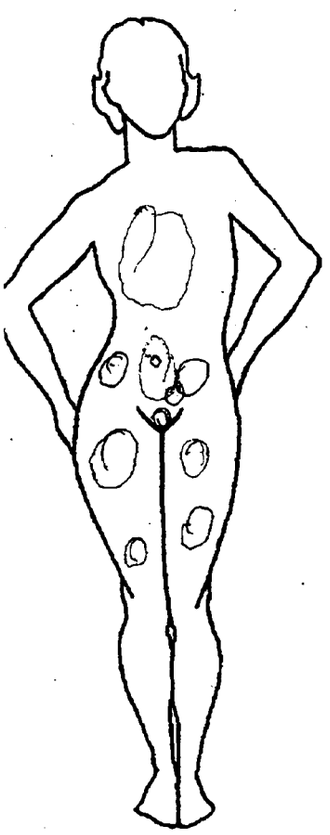

Figure 15: Brazilian informant's drawing - diffused organs model(C)

The above pictures represent 27% of all the female pictures. I see them as an attempt to make a biomedical model. They do not portray a face as happens in nearly 80% of the female drawings.

Among the 20% of drawings that portray a face is the third most common type of drawing. Fourteen percent of women made what I considered a very expressive drawing that shows a face, breast, vagina as well as other organs, which can be seen in the following examples:

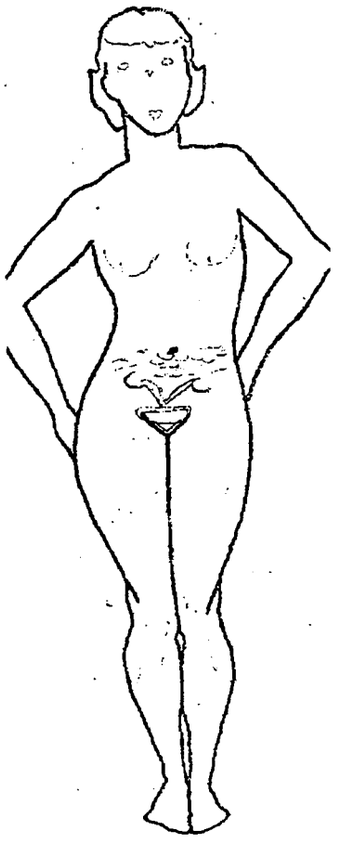

Figure 16: Brazilian informant's drawing - face and multiple organs model (A)

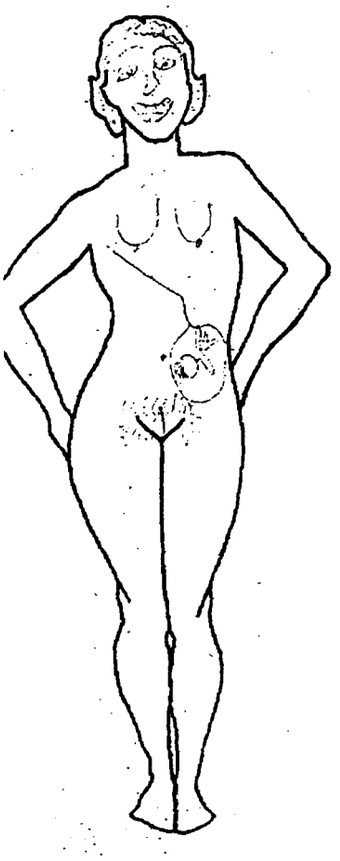

Figure 17: Brazilian informant's drawing - face and multiple organs model (B)

The fourth most common type of drawing is one that presents either and empty circle or a baby in a circle. Eleven per cent of the women pictured the reproductive system in this way. Here are some examples:

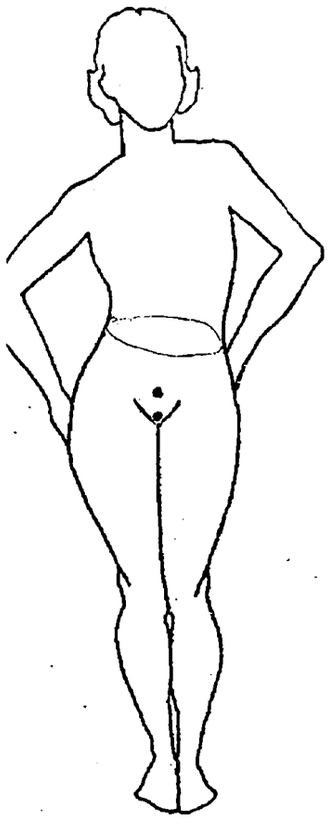

Figure 18: Brazilian informant's drawing- baby/empty space model (A)

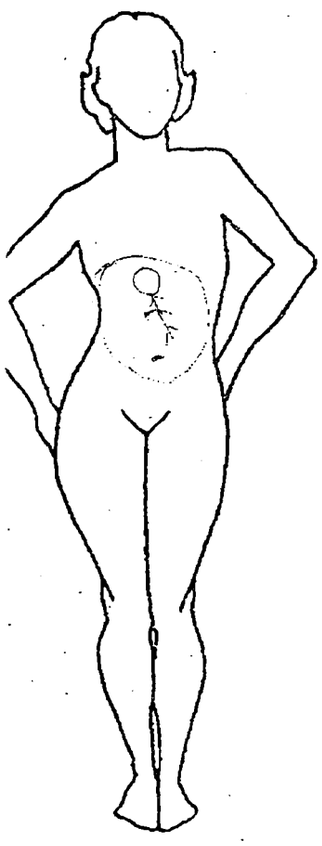

Figure 19: Brazilian informant's drawing - baby/empty space model (B)

The type made by 11% of the women does not try to represent the biomedical organs, rather it concentrates on the function of the reproductive system. It accounts for a more phenomenological experience of pregnancy, when there is a baby in the sac, or indicates the space where the pregnancy takes place. Some women who have made a biomedical picture of the reproductive system in their oral account referred to that space in the body. That was the case of one informant who after making a fairly accurate biomedical drawing I asked what she felt was in the body, and she replied: "I don't feel anything. I feel I am empty." (E., 15 years old)

The least common types of drawings are F2A and F1D. F2A pictured by 5% of the women shows no face, breasts and vagina and F1D picture by only one woman shows face and breasts. I also relate them to the above mentioned "space" in the body, or even to difficulties in picturing what is inside the body.

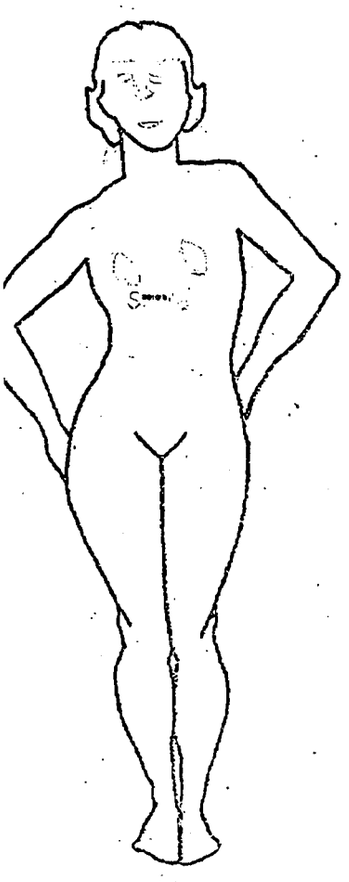

Figure 20: Brazilian informant's drawing - least common model (A)

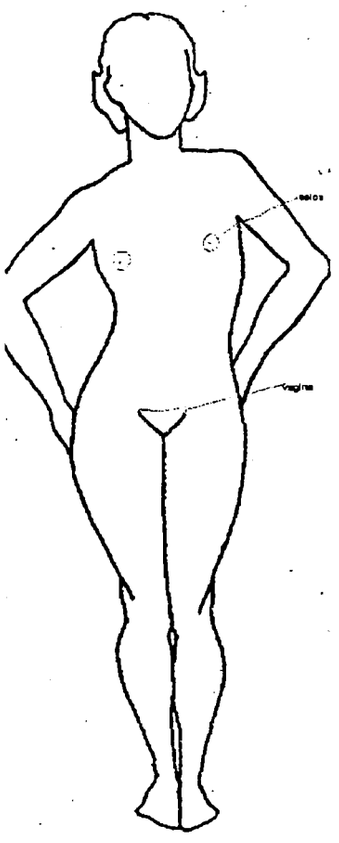

Figure 21: Brazilian informant's drawing - least common model (B)

In my attempt to understand women's ideas of the reproductive system it has been very helpful to look at the period women said they were more likely to conceive. As discussed earlier, large groups of women (and men) related the fertile period with the menstrual one, pointing out that immediately before, immediately after and/or during menstruation there is an increased "risk" of conception. But there is also a significant number of women who pointed out what I called "other" periods, in the sense that they are not related either to menstruation or to the mid-cycle (as in the biomedical model). Those refer to certain times, spaces or conditions, and are basically associated with personal or social experiences, such as having or not had an orgasm, or in certain months of the year ("In August, because all my pregnancies happened in that month" or "in May, because its is mother's month) or related to the weather (" When it is raining that it is more humid).

Discussion

In this chapter I have focused on how women in the shantytowns experience their bodies in general and their reproductive systems in particular. I started by pointing out that the female changes in status are related to bodily changes as seen in the embodiments of attributes of single women and married women. Getting married and having children represents a very important ring in a chain that runs from childhood to old age. But, as a ring in a chain, it can not be analysed separately from the whole context where it exists. The way women experience their sexuality, or the way they understand and use contraception needs to be looked at as part of a wider social process since this is where it belongs.

Grounded on neo-Darwinian ideas, family planning ideologies towards Third World countries go only as far as the promotion of birth control based on medical methods or sterilization procedures that are often problematic for the users.[39] This is because they ususally require planning strategies and a certain degree of stability that are hardly ever present in the studied shantytowns. Decisions of contraception often rely on the everyday arrangements of the household composition which is, as shown in the previous chapter, extremely fluid. Kinship and social network play an important role in the very definition of a pregnancy that is seen as a bodily process defined in a negotiation between members of a social network, rather than a biological process that occurs in the female body.

The use of contraceptives also needs to be seen as part of a social context, and therefore can not be restricted by biomedical ideas. In the shantytowns, the recurrent notion that there is always risk of getting pregnant is consistent with an overwhelming experience of risk embedded in the shantytown reality. (This topic is developed further in the next chapter) Besides, the female bodily experiences of contraceptive methods also reflect ideas of what is appropriate for the female body. The contraceptive pills for

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[39] For a demographic analysis of the use of contraceptives and sterilization procedures in Latina America see Berquó (1991)

example classified as "strong" or "weak" - there is no intermediate classification - are not always appropriate. The coil, as a strange object inside the body is bound to move, get out of place, break or rust, inside a body that has a dynamic nature.

Consonant with this notion of the body as a dynamic space is the experience of the emic organ, "body's mother". The "body's mother" is described as "something" that keeps the "baby" company and searches for the baby after birth.

In relation to the graphic images of the body it is evident that women have been exposed to the biomedical model and that they can reproduce the basic biomedical model in a drawing. But this model does not seem to make sense in my informants' embodied experiences of sexuality and reproduction. This is clear in their explanations about the functioning of the body that refer to cultural experiences such as the notion that it is necessary to mingle male and female fluids - semen and menstrual blood - for conception to take place.

Also the idea that menstruation is a vital cleaning process indicate a distinct view from the biomedical "failed reproduction view". The integration of the reproductive organs in a much less sub-divided body (in contrast with the biomedical model of the body divided in several different systems) may also account for avoidance taboos during the menstrual period, since they believe that anything that could cut off the menstrual flow (cold water, for example) should be avoided. Otherwise, the blood kept inside the body - as a holistic system - may bring about hazardous consequences.

To summarise: consistent with the social context of the female world in the shantytowns, the female informants understand their bodies and their reproductive system as a dynamic phenomenological experience. They are able to reproduce graphically the biomedical model because they have had numerous contacts with biomedical agents, but their practices regarding their own bodies reflect a much wider social experience, the cultural embodied experience of being a woman in a shantytown.

Chapter Five :The Brazilian Study - the male world

"... Estimulada por el entusiasmo con que Jose Arcadio disfrutaba de su compania, equivoco la forma y la ocasion, y de un solo golpe le echo el mundo encima. "Ahora si eres um hombre", le dijo. Y como el no entendio lo que ella queria decirle, se lo explico letra por letra:

- Vas a tener un hijo." Gabriel Garcia Marquez - Cien anos de soledad

Female ethnographer X male informants

My experience as an ethnographer has always focused on the female world. The main reason for this stems not only from a personal interest but can also be attributed to the problems of access to the male world. My ethnographic experience in two of the researched shantytowns proved that having access to the male world is a rather difficult thing for a female ethnographer in that setting. I used to visit and interview my woman informants in their homes when their men were out. And in case I was visiting someone and a man came in, I was immediately hinted by my informants to change to "milder" subjects. If their men were unemployed and therefore home all the time, they would not take part in the women's chat. And if I knocked at an informant's door and the husband opened it he would barely greet me and call his wife. Depending on the situation, I would be warned that my informant's male partner was at home and we should go somewhere else to talk, or I would offer to come back some other time which was promptly accepted.

In fact it would be virtually impossible for a woman to interview a man about matters of the body, sexuality and reproduction in the context studied. It would be seen as a threat in different ways. The wives and partners would be very suspicious of a woman who interviews men about those subjects. The men would be very reticent and not willing to talk to a woman about anything that goes

out of the usual script for male/female chat. In some cases the topic of conversation proposed could also be misinterpreted by the informant and lead to embarrassing situations for the researcher, or the other way round. This is an integral problem of the ethnographic method. The way anthropologists aim to present themselves as "equals" to their subjects in order to establish rapport with them can at the same time be a barrier to certain research topics, as the usual gender relations tend to be reproduced in the interview situation.

To overcome this problem the research group I was of in Brazil [40] decided to have male interviewers speaking to male informants and female interviewers to female informants. [41]

Reflections over my fieldwork experience as a female ethnographer led me into the understanding of separate gender perspectives. The female perspective, that I could learn through my female informants' eyes and through my own eyes; and the male perspective that I had to learn partly through my female informants' eyes, looking at the representations they have about the male world, but mostly through the data gathered by my male colleagues among male informants.

According to previous ethnographies developed in working class groups in that area, [42] as well as other research developed in similar social stratum in different cultures, the body and its reproductive functions are very much seen as a part of the female world: women look after the ill, women take the children to the doctor, women get pregnant and deliver babies, women look after babies, women feed the family. But it would be false to say that "bodies" are a female issue since essential aspects of the construction of the male identity rely on the body, or on the male's embodied gender experiences. Apart from that, sexuality and reproduction are concepts that are embedded in gender relations and if I

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[40] As explained earlier in chapter 2 the research group is NUPACS-UFRGS - Nucleo de Pesquisa em Antropologia do Corpo e da Saude, Departamento de Antropologia, Universidade Federal do Rio Grande do Sul.

[41] That does not mean to say that it is impossible for women to research male subjects. In fact two members of the research group had done this before but in different contexts. They wrote two brilliant anthropological accounts of the construction of male identity in southern Brazil, which motivated several of the present research issues. See Leal (1990) and Jardim (1991).

[42] Knauth (1991) and Victora (1991).

want to understand the context where concepts like body, sexuality and reproduction acquire meaning, I have to look at both male and female perspectives. In many situations I have found that a multiplicity of aspects in the male discourse about the studied themes appear related to the female discourse, and vice-versa, showing that although it is reasonable to speak of the female and the male world as separated worlds, I could not treat them as isolated units. For this reason themes that are dominant in the male discourse will appear in this chapter and include briefly a comparative female view. While the ones that are more relevant in the female discourse have been presented on chapter 4, where I present a comparative male view.

Men's studies: A new field of research?

It is clear to me that the present research is not supposed to be a study about men, but the fact that it includes one chapter about male's views of the body and the reproductive system, has driven me into the literature about the so called field of "men's studies".

For over a decade now, different academics in Sociology and Anthropology, have been debating the need of demarcation of a new field of men's studies that would examine men's lives and experiences, not simply as normative assumptions, but as gendered and socially and historically variable. (Kimmel 1987) The underlying idea is that little attention has been given to the heterosexual male world, while the female and the gay perspectives have been unravelled in academic studies, specially generated within the feminist academic wave of the last decades. So, the interest in the study of men and masculinity is put in terms of a "response to the challenges of feminism." (Cornwall and Lindisfarne 1994)

What is interesting to note is that most of the feminist literature that has provoked the new field of men's studies is said to be developed in response to male biased knowledge. One of the feminist criticisms of classical ethnographies done by male ethnographers, is that the presented native groups' views was in

fact the native men's views; this has also generated criticism towards itself. It seems that the problems are not so much of not presenting the native women's views, but that the female ethnographers who helped to gather data and understand the female perspectives for the well known male anthropologists, were never mentioned in the ethnographic accounts.[43] This refers to an epistemological problem, pointed out by Hearn and Morgan (1990) that the invisibility of men in sociological research is in fact "an invisibility constructed through and within a wider framework of male dominance." (:7)

I do not intend to get into this complex debate any further[44], except to show that whatever theoretical approach to social life is taken gender exists everywhere and that the real problem is how to speak of female and male social life, without sounding normative, as if maleness and femaleness were reified concepts, the result of the "acquisition of normative sex roles, the internalization of the rules through which children came to behave as adult men and women." (Harvey and Gow 1994) So, when I claim that the female and the male world are quite separate in the studied context it does not mean to say either that there are static gender roles or that the female and male roles have been previously defined by "nature". The ethnographic data shows that there is one dominant discourse about maleness, femaleness and gender relations at one level and a number of arrangements of different types and lengths of time that will constitute the lived reality. So, my aim is to understand the different levels in which reality is constituted, taking gender relations as a permanent negotiation process.

The understanding of gender relations as negotiated realities has also been represented in the field of anthropological studies of men and masculinities. As Cornwall and Lindisfarne put it:

"Essentialist interpretations of male/female dichotomy are a major problem in comparative studies of gender. In any given setting, gender differences are often presented and perceived as absolute and dichotomous. Moreover, such

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[43] Ronnie Frankenberg, personal communication.

[44] For further discussion and theoretical approaches to men and masculinities see Hearn and Morgan (1990).

gender differences, when viewed from a historical or cross-cultural perspective, often appear stable or repeat themselves as variations on a single theme. However, essentialist explanations cannot explain variation and the fact that cultural forms are never replicated exactly. An essentialist male/female dichotomy cannot account for the ways people are gendered in different places at different times. Once comparative studies expose a diversity of meanings, the idea of being a man can no longer be treated as fixed or universal.

If notions of masculinity, like the notions of gender itself, are fluid and situational, we must consider the various ways people understand masculinity in any particular setting. And we must explore how various masculinities are defined and redefined in social interaction..." (Cornwall and Lindisfarne 1994)

In the following pages I will describe and discuss the male world as it has been shown in the ethnographic interviews, in terms of who are these men, what they do for a living and what are their perceptions and representations about the body and the reproductive system.

The 70 men who took part in the research all live in the four studied shanty towns in Porto Alegre. As mentioned earlier the masculine world is in many ways separated from the female's one. But there are points of intersection and there are shared ideas about the nature of the human body that will also be explored in this chapter.

Men in search of better chances

Most of the families who live in the four shantytowns are first or second generation immigrants from other parts of Rio Grande do Sul state or from the neighbour state in the north, Santa Catarina, who have moved to Porto Alegre in search of better work and wage opportunities.

Migrants came mainly from rural areas of extensive cattle or sheep breeding where manual work has been replaced by modern equipment and the

work force made redundant. They are part of a very significant social phenomenon of rural exodus seen all throughout Brazil.

Others are manual workers that moved away from small towns which did not offer enough work possibilities. Some of them have large families and when the children start to grow up they move to the State capital seeking education, health care or even just food for the children.

There is also a significant number of families, specially in Vila Dique, that come from the areas of the state known as "colonies", which are places of the most recent immigration to Southern Brazil. In that case, they are descendants of German or Italian families who immigrated to Rio Grande do Sul in the beginning of this century, inhabiting lots assigned to immigrants by the government. The immigration as a whole has been a very successful enterprise, the immigrants' areas are now some of the richest in the State. But not all the immigrants had the same opportunities, nor the same kind of land to cultivate. In either case, the immigrants' families had children who had the right to inherit their parents' land. In a system of bilateral inheritance to every child, in time the shares became smaller, to the point that it was not possible to divide them any more. Later, in the 1950's, land reform was enforced but the government used original Indian reservations or other disputed land to re-settle the immigrants' descendants. Those lands have later been claimed back by the original owners who expelled the immigrants, creating an important dispute that remains to be solved. In this process many families moved from rural areas to the state capital in search of better opportunities.

Apart from people who moved from rural areas of extensive cattle or sheep breeding, or manual workers that moved away from small towns, or "migrant" ex-immigrants from the colonies, there are a few families who come from other shanty towns in the city; together all these make up an extensive heterogeneous group known as “the urban poor”.

According to the data gathered the main reason why the people moved to the shanty town was to move close to family relations and to find a better job. Although they have not always managed to do so, they do not complain or regret their decisions, especially because the ones who originally squat in the area, are

now parents or grandparents of children who have grown up there. It is now their home, and they will, if necessary, struggle to remain.[45]

Among the male informants there are few regular factory workers, wall painters, truck drivers, bricklayers. Others work as helpers in shops, supermarkets or petrol stations. There is a large number of formally unemployed men who do any kind of manual work that does not require formal training such as gardening, washing cars, loading and unloading trucks, picking up recyclable rubbish. This type of work is called "biscate" and the one who performs it is known as "biscateiro". Although the work of a "biscateiro" does not have the same status or the regular salary of more formal work as, for example, a helper in a pizza shop, it is not considered a bad job, as the worker will have much more freedom to work flexible hours and he will also be able to take his children with him to help. Especially if they are picking up recyclable rubbish along the streets, they are frequently seen with one or two children who help to push the trolley where the newspapers, cardboard, plastic bags, packing materials, bottles, etc, gathered from the rubbish are put to sell later.

Some of the informants are less precise when talking about their present occupation, especially if they work as drug dealers or burglars.

The reason I started to describe the men's world by the kind of work they do is because the ability to work is one of the main components of the male identity in that group. It is possible to see this in both male and female discourse. In the male informants' discourse, ideas such as the age of starting and the hardship of the job are often cited to demonstrate the value of someone. The association between male identity and working capacity has long been observed in several studies which take the body as the connecting point between the two.

In the local sexual division of labour the role assigned to men includes the tasks of providing and protecting the family, both duties that require an extensive use of the physical body.[46] In female discourse about men, ability to support the

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[45] Dos Anjos (1993).

[46] The problem of the relationship between the male body and the "providing" and "protection" role has also been discussed in anthropological accounts of cases of physical disability in families. An interesting account can be seen in French (1994).

family is a basic condition. In their recurrent discourse about men's duties of supporting the family appear in terms of: "work", "have a job", "support the family", don't be lazy", "have a house", "have something financially", "have 'means' [of supporting the family]" (condicoes), "take on the house, the food". When such duties are not performed, women will think about other alternatives, such as separation, as shown in the statement that follows:

" I want to separate [from partner], but the house rent agreement goes for one more year. He has been drinking, sometimes doesn't go to work. I am thinking of getting a job, putting the children in a creche, to have the security he is not giving me." (C., 23 years old)

The security mentioned by C. most of the time goes beyond the need of support to children in terms of housing and food. It is also related to physical safety in an environment that is not always safe. A woman with her children is seen as a vulnerable entity who needs the protection of a man in the house. This is a shared discourse among men and young women, as shown in the following account.

J. is 39 years old and lives with his wife and 6 year old step daughter. When he and his wife first met, she had been widowed about 4 months before. They started to live together 2 months after they met. He comments that the common law marriage was "kind of quick" because his partner did not want to lose him to other women in the neighbourhood, so she brought him to live with her. He considers that was the right decision because now when he gets home his clothes have been washed and his wife has cooked dinner for him to take to work. He adds:

"It is also good for her because it is dangerous for a woman on her own. It is dangerous...people may take advantage. They may even break into her house."

Older women are not seen as so vulnerable, and are much more likely to be "accepted" as living with grand children "on their own". In this case living on their own means living in their own house, but usually having relatives - children, nieces, sisters -nearby.

Although most of the women informants did not work outside the house, female work is not forbidden, and an extra income will be welcome as long as it does not interfere with the women's main duties of looking after the children and the house.

That is because in contexts where low income is the rule, even if the father has the major responsibilities for providing for the family, every member of the family from an early age is likely to help the family to survive. School opportunities are not necessarily seen as a necessity for children after they have learned basic reading and writing skills. And although nobody will deny the fact that ideally to have an education is important for your life, I have never seen any parent express annoyance because one, or all, of their children has dropped out of school. In other words, education is a value but its benefits are far too distant to be worth pursuing. Apart from that, starting to work at an early age, is seen as a reason for pride among men. They also take pride in working very hard, and complementing the family income with small extra jobs. The usual male discourse about work starts with a reference to a time in the past when they were young:

A., 30 years old, is presently a delivery truck driver. He started to drive when he was 12 helping his father who delivered bricks, sand, cement for the building industry. At the present time, as a driver he also works loading and unloading the truck. Although it is regular work, he does not have a formal working contract. Often he works late hours to increase his income. Apart from that he also works on a scrap heap selecting and classifying recyclable material.

I., 50 years old, is the father of 8 children, 6 of whom still live with him. He used to have a regular job until 4 years ago, but had to leave it since he hurt his leg. Since then he started to collect and select rubbish for recycling at his own

garden. After selecting the different recyclable items he sells them to a dealer. His wife does a similar thing in an organized community recycling centre run by a Catholic grassroots movement in the squatter settlement. His daughter helps the mother in the centre. A teenage son does some informal work in a nearby vegetable market and "always gets some potatoes as reward". The younger children beg and get some food in the local industries.

N. is 21, a bricklayer who lives with his parents. He started to work at 13 helping his father out with whom he learned the trade. At 18, apart from helping his father, he started to do some "biscates" on his own and with friends. Now at 21, he works for a building construction firm. He does not always have work. Sometimes he works for 3 or 4 months and when the job is complete he remains several weeks off work, until another job comes on.

J., 25, started to work at around 12 years old in a shoes factory. After that he worked for 2 years in a construction firm as a helper, then he worked for 4 years in two different supermarkets. Recently he has been working in a battery factory. He thinks his present job is fine, although he does not make much money. But he mentions that this is not a problem at the moment because he does not have to pay rent as he has lived with his wife at her parents' house since he got married 7 months ago.

Basically the informants started work as apprentices, although the word "aprendiz" has never been mentioned in the interviews, maybe because it is limited to a work training. The idea that comes across is that in the position of an apprentice young men are learning more than a skill. They are also learning how to be men and hard working, respectable persons, where these features - being a men, hard working and respectable - can hardly be separated.

This aspect of adult male identity has been discussed in other ethnographic accounts, such as the following:

"Apprentices in factory cultures are given a variety of trivial duties to perform. The older men define themselves as doing 'real work' and the apprentices are seen as their junior. However, this is an area of contest and negotiation: seniors compel apprentices to inhabit a feminized position while apprentices strive to transcend it. Apprentice is about becoming not merely a qualified worker but also a qualified man." (Back, 1994:173)

There are quite a few formally unemployed men among the informants, who call themselves "biscateiros". As explained earlier they will take any job that does not require formal training. As most of them had never had a regular job in their lives, they are not eligible for unemployment benefit, which in any case, in Brazil is extremely low and hardly compensates the effort and the expenses it takes to claim it. The "biscateiro" will manage to raise some money for the support of his family, usually with the help of his wife and children.

The men who are regularly unemployed are the ones who have health problems like those associated with heavy drinking. There is also a number of men who even declaring themselves unemployed display in their houses objects of reasonable value, such as video and audio equipment. They are usually very vague about their occupation. But while three of the informants have declared to the ethnographer that they "sometimes" deal drugs, none has ever declared being a burglar, even though there is clear evidence about it, no one says it openly. It is a known practice, but rarely spoken about. Stolen goods are bought and sold in the shantytowns and although I have never observed this sort of transaction taking place I have seen extremely poor houses where there is barely any other furniture, keeping expensive equipment, obviously beyond the tenant's purchase capacity. While drug dealing seems to be a much more open activity as I have during my visits to informants' houses seen drug dealing taking place in daylight several times.

This is because, even if in the eyes of the law they are both illegal activities, in the shanty towns the illegitimacy of the two practices are hierarchically different.

To understand why the two illegal practices are hierarchically different in the emic perspective we have to look at what are their effects on the broader social life of the shantytown.

The several faces of violence: Relative concepts of "the goodies" and "the baddies"

The problem with stolen goods and drug dealing is a complex one. It comprises of several variables and different levels of police involvement.

Police raids in shanty towns are fairly common events. Often police officers can find out the place of residence of men who have previously been arrested in connection with a certain types of offence and can easily trace them when similar offenses are committed. Apart from that, stolen goods are much more visible than drugs. When an upper class family house has been robbed - this happens virtually everyday - and there is a known, sometimes named suspect, the police may come down to his house in an attempt to recover some of the stolen goods. What happens is that they usually do not find the stolen goods, but they may search in the surrounding dwellings and find stolen products that have been bought very cheap by neighbours. Drug dealing, on the other hand, tends to be a more self limited practice, as the usual mode of dealing in the shanty towns is small quantities of drugs, especially joints (cannabis), bought by people from the shantytown on the door step of the dealer's house.

If the drug dealing is mostly a self contained practice in the sense that it does not spill over the boundaries of the shantytown, it is not considered a real threat by the dwellers as the police tend not to interfere. That does not mean to say that there is no dealing between the shantytowns and the outside world. When this does happen other related problems arise, such as extreme violence by armed gangs, murders, and police investigations. This is especially the case in one of the four shantytowns studied where one of the male researchers was compelled to watch a Russian roulette and cocaine sniffing session.

Such extreme acts of violence are not shared by the majority of the shantytown male population, who although they know about violence induced by robberies and drug dealing, still pretend that they have not seen them. As one informant told me once about someone who had been shot in front of his house:

"I heard three gun shots but I didn't even look. On the next day the murdered man's sister called in to know what had happened, but I did not see anything (...) If you look, you may get shot on the spot and if you see something, you may get shot later. I pretend I don't see."

In this case the informant made clear that it is wise for those who do not get involved with illegal activities to withhold comments. Several situations have indicated that they do not seem to hold a judgemental view of criminal activity. My hypothesis is that moral aspects usually connected to illegal practices do not arise from the practice itself. The problem lies in making them public. Taking up a social interactionist perspective, my ethnographic experience shows that the more visible the practice, the less "legal" it is considered, because it may bring consequences not just to the men directly involved in such actions, but to his family as well.

One of my female informants, who has been married to a drug dealer for 7 years gave me an interesting account of a situation she had lived through. As her husband had been in prison in connection with burglary several years earlier, he is often considered a suspect by the police who come to their house to search for stolen goods frequently. On one such occasion she was pregnant with one of her five children and during the raid a policeman pushed her to the floor with extreme violence, so that she fell flat on her back. She said she was lucky that nothing happened to the baby she was expecting.

In her statement she makes it clear that she did not see the police as "offensive" for invading their property in the middle of the night without a warrant. This was a recurrent event which was not unexpected and was even in a certain way, accepted. The policeman's real offence was to push a pregnant woman to the floor. When she told me that, the other women who were also taking part in

our conversation in the room were also very emphatic about the policeman's wrongdoing, and felt justified when my informant's husband who, overcoming all hierarchical barriers, presented a complaint at the police station when he was taken there for interrogation.

In the behaviour code between the so called "suspects" and policemen, invading a suspect's house is not necessarily a violation, or perhaps it is an accepted violation. What happened in this case is that the policemen violated a gender boundary which is ruled by a different code of conduct - a gender relations code -which he failed to recognize. In this code, a man is not allowed to beat up someone else's wife, whether pregnant or not in the same way that he is not allowed to have sex with someone else's wife.

The specific social context of emic social codes is important. The same man who got angry with the policeman for pushing his wife, has himself beaten his wife on other occasions.

Not all men act in this way, but all understand the rules of the game, having to deal with it on a daily basis, either passively - pretending that they do not see - or more actively, having to prove their innocence when accused of taking part in "illegal" activities.

A. is 28 years old and lives with his wife and children near his wife's parents and sisters. He is presently unemployed and states that he takes any kind of informal job in order to bring home some money. He says:

"I will do anything. What is important is to bring food into the house. But even unemployed, I never steal. Although tempted. When I was a bus conductor, I never took any of that heap of money."

He adds that once he was accused by his in-laws of being a burglar when he bought himself a radio/cassette and record player while he was unemployed. His account states that he has always loved music and that after leaving a job he received some extra money on the grounds of a social security bonus. His in-laws did not believe him even when he showed them the actual receipt of the

transaction. He then went to a police station with his in-laws and from there phoned the shop from where he had purchased the appliance and had his story confirmed. He said he also did that to show his in- laws that he had friendly relations with the police since in his job as a conductor, he used to give those policemen a lift on the bus without charging them.

Looking at the above account, it is not difficult to identify what was in fact the problem with A.'s in-laws. It was not so much that he could have stolen the appliance, but more because he used his extra money to buy something for himself and not for his wife and children, as he should have done especially when he had become unemployed. If the problem was really proving he had bought the appliance, they would have accepted the transaction receipt as proof of his innocence. The point was that he broke the basic rule regarding married men: namely that, no matter what a man does, he has to provide means for his family.

Women and violence: "I have already seen one brother killed, might as well see the other one too"

Women participate in this violent world in a different way. They may be the motive for violence between men, as in the case of a woman whose partner had recently been shot dead by her ex-partner inside her house. The murderer has not been caught, and my informants said that the police has been around searching for him, but that he was hiding in an unknown place. As the story is told by different people in the shantytown, very little is said about the murderer, who is a well known person there, but a lot is said about the violent police who invades the place trying to catch him and about the wicked woman who caused the tragedy. This woman is said to be teasing the murdered man's brother now, inviting him to go over to her house and when admonished by others, replied: "I have already seen one brother killed, might as well see the other one too."

The idea that specific qualities, such as violence, are related differently to different genders, does not mean to say that there are qualities that are

exclusively male and others exclusively female. The ethnographic data show that there are different socially legitimate characteristics lived differently, hierarchically, by men and women in a processual way. A multiplicity of discourses make sense of the gender assignment in specific situations. As Moore (1994) puts it:

"...The existence of multiple gender discourses means that in many situations, a discourse that emphasizes the oppositional and mutually exclusive nature of gender categories can exist alongside other discourses which emphasize the processual, mutable and temporary nature of gender assignment. The co-existence of multiple discourses, however, produces a situation, in which the different discourses on gender are hierarchically ordered. This ordering may be both contextually and autobiographically variable, as well as being subject to historical change. The result is that some discourses overdetermine others, and various sub-dominant discourses develop in opposition to dominant ones." (Moore, 1994:144)

In the present study characteristics of the male world, such as physical violence, drinking, drug dealing, as well as the position of head of the household as provider and protector, although central in the dominant discourse about masculinity, are far from being exclusively masculine characteristics. What they seem to be is hierarchically less relevant in the discourse about femininity. And I suggest, they are lived as different experiences by men and women.

In relation to predominantly male characteristics, the ethnographic data shows that adult women can also fight for rivalry, they can also be extremely aggressive verbally, they may sell drugs at their door step, they may be the sole bread winners. But the situations in which that occurs are qualitatively different. The women's fights I have heard of, for example, were usually related to disputes about male partners, but they will not fight the man, only the "other" woman with whom their man has been involved. As for being verbally abusive, they can direct very harsh words towards children but hardly ever towards other adult woman or

man. In relation to drug dealing, I have seen them selling drugs without any constraint but always on behalf of a temporarily absent partner/drug dealer.

So, although in the cultural repertoire of legitimate procedures, characteristics such as violent behaviour, drinking, etc, will be associated with male gender discourse, they also appear in female accounts, but in a hierarchically subordinate position.

Where work for maintenance of the family and house is concerned, they are usually seen as an additional help to the husband's income.

Perceptions of a gendered time: "A single man gets home and it looks like a desert"

I said earlier that there is a recurrent discourse about the male role, both by male and female informants, based on the idea that a man has to be able to support his family. In their words, a man has to "have a job", be "hard working", "not depend on anyone for financial support", "not be lazy", "provide for his children". In that sense a man is considered ready to get married, when he "is mature enough to take the responsibility of a family". This idea is linked to the idea that a man "should have enjoyed his life with his friends", he should have "acquired [sexual] experience", he must have "lived a lot" (vivido bastante) before getting married. In everyday experience the idea of enjoying life is closely related to social activities such as drinking with friends (specially getting drunk) in botecos[47], going out to play football with friends for long hours on week-ends afternoons, not having to be back home at any specific time, being able to have casual relationships with female partners.

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[47] Botecos are cheap pubs very popular among lower class men that sell specially cachaca, a strong brazilian liquor made of sugar cane, bottled beer and refreshments. Botecos in general are very unsophisticated wine shops, where you can either drink or buy drinks to take away. Some botecos may sell food as well in the form of simple meals made of rice, black beans, egg and meat. In the shantytowns, botecos are often small rooms usually made of irregular wood boards built for that purpose or the front rooms of shantytown houses adapted specially for that purpose. In these cases they are usually family businesses, and are served in by the husband, the wife and their older children as well. There is frequently a black and white television permanently turned on in the premises.

The idea that a man must have "enjoyed himself" and "lived a lot" before committing himself to a family project does not mean that married life is not seen as enjoyable. It means that marriage is proper to a certain time of life and may be enjoyable in different ways. Because, if on the one hand, the code of behaviour with regard to marriage imposes limitations in terms of the amount of freedom one has, on the other hand it removes away other limitations related to the life of a single men. The ideal time to get married thus, is not so young that a man has not "enjoyed life", nor too late, as shown in the following statement:

" A man while he is single, won't build anything. One should marry around 20-22 years old. If he enjoys life up to when he is 22, then that's it. I have a friend from Erechim who is quite well off. He got married at 52 with a woman of 25. What is his future? He is now around 62 and has a young wife. He will leave a child for another man to raise; his capital, for another man. Because probably when he dies, she will find another one. And he didn't enjoy that life [of a single man]. It was he, alone, eating poorly, getting home, having to cook for himself, eating cold food, or warmed food from lunch time.

If he had a woman with him, and both had made some money together, had a child, enjoyed a child together, raised a child together. When you get old you don't get to raise your child. Now his daughter is 6, when she is 16, he will probably be dead...

...A single man gets home and it looks like a desert. I know, I stayed alone for some time..." (A., male informant, 38 years old)

In most of the men's interviews they do not present a specific age as ideal for getting married, as long as they display qualities that are proper to adult men. This is not always what happens though. In fact several informants got married at very young age (17-18 years old) as a result of an accidental pregnancy, many young couples will have to share their parents' houses for months or years to come because they can not afford to rent their own house. They negotiate the embodiment of "adult qualities" in contact with the cultural repertoire of possibilities.

If we compare the male informants' ideas of the right time for men to get married with the right time for women, we will find that the requirements for such commitment are quite different. In other words, the embodied gender experiences are different for men and women, for example, having "lived a lot", having had sexual experience, are not seen as relevant or even recommended experiences for women. Women should to be able to cook, to look after the house and children, and they need to know how to behave as a married woman, that means not go about as a teenager hanging around with friends on the streets.

In the statement above, the sad image of the single men's house as a desert translates the experience of someone who has probably embodied the qualities of an adult man, and the culturally constructed needs of wife, children, a clean house, warm food on time, but whose social experience of being alone does not match with it.

The "right" time is thus a "gendered" time, a position in the ongoing embodiment of male identity where categories such as married and single relate to different attitudes in general but specially attitudes towards women. In relation to that, marriage imposes rules and obligations that are sometimes seen as positive and sometimes as negative.

The split ethic: the "wife" and the "others"

Two culturally constructed categories, the "wife" and the "others" organise the embodiment of male experience. In relation to his wife, a man has to have "respect". On the other hand, with the "others" they can do anything they fancy. This is specially true when it concerns sexual practices with the "others" with whom, they do not feel they have any responsibilities. For example, if by any chance, "the other" falls pregnant as a result of casual intercourse, the men can easily deny the claim that the child is theirs. And although the women in general are aware that there are means of proving a child's fatherhood, this is not the type of action anyone would pursue.

This dual standard is also present in the men's ideas about contraception, specially in terms of to whom it applies:

"If you have sex with someone you know, it is better if she uses the pill. If you have sex with others, it is better the condom, because you protect yourself from AIDS." (male informant, married, 30 years old)

The same informant when asked how he decided whether he should use a condom or not, replied:

- *"By the girl's looks. If she looks clean and is not wearing extravagant clothes, or if you have known her before [you do not need a condom]. On the other hand if it is someone you met for the first time, and seems to be the type who sleeps with everybody, you got to wear a condom. But it is the last resource."*

As shown in the statement above, the classification as one of the "others" relies very much on embodied ideas of aesthetics, but can also rely on ideas space/distance, ethnicity, sexual orientation or sometimes marital status. This was presented to me in terms of different sexual practices, such as oral and anal sex, which is allowed with one type of person but not with other.

(1) *"I think it [anal sex] is beautiful. But the black girls don't like it very much. On the other hand, the blondes ... live for that!"* (male informant, black, single, 18 years old)

(2) *"I used to have fun with the gay prostitutes and transvestites that stay at D'Paschoal. " He was asked about his sexual orientation he said: "I am not a homosexual, but I ended up enjoying myself with what they did", referring to anal sex and oral sex practised with them.* (male informant, single, 18 years old)

(3) *"I don't do that with my wife. Only with street women who like that."* (male informant, married, 32 years old)

(4) *"I used to have oral sex with another woman before my marriage".*

(5) *"One may have anal sex when searching for more pleasure, something different, not recommended for married men like myself."* (male informant, married, 40 years old)

The above statements demonstrate the contrast presented by the "others". In example (1), "the blondes" are referred to by a black man, in a clear ethnic distinction. In (2), he presents as acceptable the practice of a different form of sex with a different kind of people, "the gay prostitutes", who he differentiates from himself since he although, having homosexual intercourse, does not consider himself as a homosexual.[48] In example (3), the "street women", is the other in relation to the informant's wife. In examples (2) and (3) it is also possible to understand the spacial relation of the "other": the gays stand by 'D'Paschoal', which is the name of a shop which sells car parts and accessories in the northern part of the city, and the "street women", as female prostitutes are called, due to the fact that they "work" in the streets, and also as an allusion to the fact that they do not have a house or family, therefore they fit the category of "the others".

Examples (4) and (5) stress the different conduct for before and after marriage. The women they have chosen for wives they owe "respect" which is a category built in relation to the wives' qualities. Their representations about a good wife can be seen in the following recurrent statements:

"A good wife is one who stays at home, looks after the children, has the food ready and does not argue with her husband".

or:

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[48] For more about homosexuality in Brazil see Parker (199); Silva (1993);Cornwall (1994).

"A good wife is one who looks after the house and does not deceive her husband."

In both statements the men refer to the female role in two ways. One is in clear association with the ability to nurture: the house, the children, the food. Several other statements have also mentioned washing clothes as a primary female function.

The second aspect defines the female role in relation to her husband/partner: one who does not argue with her husband; one who does not deceive her husband. Fidelity is often pointed out as one of the required female qualities.

Male informants also use the same two ways to describe their role: nurture and in relation to partners. So the good husband is one who supports the house, someone who goes home after work, someone who does not drink, does not beat his wife up, respects, someone who "does not go out with any bitch, threatening to bring a disease home". Many informants, though, admitted openly that they did not conform to this model.

Sexuality and contraception: the shifting values

Categories such as single men and married men, and the wife and the "other" are also behind men's choices of contraceptive practices.

The ethnographic interviews with men show that the pill is seen as a safe and easy contraceptive method. For them, those single women who are sexually active but do not take the pill are probably planning to catch a man through pregnancy. In any case, that is not something that greatly concerns men because in their opinion contraception is a female problem. In the case of single men, it is especially true. Married men will be aware of the problem of contraception, and will frequently know what contraceptive method his wife/partner uses. But if they have extra-marital relations, they will not worry about contraception at all. If a pregnancy occurs as a result of a casual relationship, it is seen not just as a

problem, but as a problem to be solved via abortion. The evaluation of such conditions however may vary according to who is the person who got pregnant, as seen in the following account:

One informant who is young and single told the interviewer that when he was told that a girl with whom he had had sex had fallen pregnant, he had beaten her up until she had a miscarriage. He said that she had planned it in order to trap him. But later he admitted that the same thing happened to his sister who got pregnant by her new boyfriend, but in her case it was different, it was an accidental pregnancy. It ended up that her sister and her boyfriend started to live together as a result of that "accident".

Among the 69 men interviewed about this issue, 13, mostly single men with irregular sexual partners said they did not know, did not care or did not use any contraceptive method; 5 of the same group of singles with irregular partners used a condom; 29 said that their wives used the contraceptive pill; 3 said their wives were pregnant; 6 said their wives used the coil, and 13 stated that they or their wives are sterile either naturally of surgically.

Contrary to women's view of the contraceptive pill, that it may be inappropriate because of the side effects, some men referred to the contraceptive pill as better then surgical sterilization "because it doesn't change the woman's body like the tubal ligation." [49] The idea of change here is related to interference of "unnatural" procedures, on the "natural" body, even though the great majority of informants recognise the tubal ligation as the only method that is completely efficient. The use of condoms and coil is also objected on similar grounds. All of them - the condom, the coil and the pill - are frequently described in terms of barrier: the condom, restricts the free flow of sperm; the coil, obstructs the entrance of the sperm in the egg; and the pill, destroys the sperm on the spot.

Their idea is that the coil and the pill are seen as working in a similar mode as barrier methods. The coil, for example, is not seen as an abortive

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[49] It is worth noting that in the female discourse about contraception, the contraceptive pill is rejected exactly because it is seen as causing change in the body, such as changes in menstrual pattern, weight changes, mood changes. For the female discourse about contraception see chapter 4.

method, because all it does is to obstruct the entrance of the sperm. Following from that many people who stand strongly as anti-abortion, will not object to the coil in those grounds, as seen in chapter 4.

A similar rationale can be seen in their understanding of the contraceptive pill. The fact that it is seen as acting like a barrier that destroys the sperm has important consequences in terms of its way of use and efficacy. In an analogy to actual barrier methods it is thought to rely on the principle that it has to be used only when the couple has sexual intercourse. This explains in part interruptions in its use and consequent pregnancy among users.

But even if the pill is understood as a barrier method, it is still seen as a medication. One informant strongly advised his wife not to take the pill everyday because "too much medication can not be good for her". It is clear that in his view, the pill, as any medication, should only be used when necessary, in that case on the days a woman has sexual intercourse.

The definition of oral contraceptives in terms of a barrier to the sperm is consonant with the complete absence of the idea of hormones as agents in the body. The only reference to hormones by male informants was in relation to their influence on female sexuality. In his words:

"Sexuality is different for each person. It depends on the hormones. Women who have more hormones, make more and better sex. I am a straight man (homem serio): I don't like much foreplay (arreto), or too much chatting (balaca). I am a bit quick because I have too much acid in my body, that is like an energy." (Í., 35 years old)

I.'s statement tackles several points of the males' discourse about sexuality and masculinity. The idea that sexuality is different for each person will be explored further in the concept of singularization of bodily experience and the contrastive "universal" biomedical body. It also expresses gender differences in conceptualizing sexuality, such as the presence of "hormones" in the female body, and "acid" in the male body. Although his ideas of "hormones" and "acid" may not correspond to the biochemical definitions of those substances (for

example, in his words acid means energy), he points out the qualitatively different constitution of male and female bodily fluids. It also give us a glimpse into his concept of a "straight" man, as someone who does not like "foreplay" or "too much chatting".

Sexuality and the constitution of the body

The male body as an energetic body is a powerful image of masculinity, related to concepts of work previously discussed. This image is evident in the men's description of sickness. Except for those who have a specific health condition, such as back problem or heart problem, most of the interviewed men only consider themselves ill when they are unable to go to work. And even those who have an specific condition will blame it on previous hazardous working conditions.

Other ideas of the strong male body are also present in the recurrent statement that men are always ready to have sexual intercourse, and need more sex than women. That justifies the fairly common practice of extra-marital relationships with other women. This idea is also present in the female discourse about male sexuality. In general it is much more acceptable for men to have extra-marital relationships than for women. Although the great majority of informants - male and female - state that they regard fidelity important for a marriage to work, they very often consider that it is in the male's nature "pular a cerca", that means literally "jump over the fence" in the sense that marriage is like a fenced area and men go out of marriage in search of extra-marital sex. In their lived experience of infidelity the few men who declared they had the experience of an unfaithful wife, had separated from them, while the same did not happen with the women who had an unfaithful husband. The women seem to be much more flexible in relation to the limits of tolerance.

Another example of the strong male body can be seen in relation to the failure of the contraceptive pill, as experienced by an informant whose wife got pregnant while on the pill. His explanation for his wife getting pregnant has a

different focus from the female accounts about the "weak" pills. He says: "maybe I was "too strong". (V. 30 years old).

A similar account of male potency and its relationship with their "need" for sex is shown in another informant's explanation about how semen is produced in his body:

"The man has a gland that produces sperm, sort of, it varies, depending on the man. I had to have a gland operation in my breast because it was too big, it was accumulated semen. The doctors said I have overproduction of sperm and that I should have sex every time I feel like, otherwise it will accumulate again." (E. 40 years old)

In E.'s account his sexuality is so overwhelming that it had effects over his body. The mixture of a biomedical discourse - "the gland that produces sperm" - with his personal experience of having to have a "gland" operation, in this case is an indication that there is a biomedical reason for him to have as much sex as he feels like. And according to him, this is confirmed by the doctor's words and advice.

The understanding that men are always ready to have sex could be connected to the idea that men are able to conceive at any time, while women are subject to specific times when they are fertile. But although in the male interviews they see themselves as very potent, full of energy for sex, the domains of sex and reproduction are not interrelated in their discourse. Sex is very closely related to the masculine world, although women are not seen as passive objects. In fact several men stress in their discourse that the ideal female sexual partner is one who is not passive. At the same time they see reproduction as basically a female domain. And so is contraception. This is clear in the explanations men gave about the reproductive organs. The ethnographic data indicated that 54 % of the interviewed men said they did not know how to explain the functioning of the male or female reproductive system. This in itself is a highly important data. The domains of reproduction and contraception in the male informants' words are "coisas de mulher", that is, "female issues". The remaining 46% gave what I

called (1) lay explanations - 25% ; (2) mixed explanations - 11%; (3) biomedical explanations - 4%. (6% of the explanations are missing).

(1) Lay explanations

Male lay explanations about the functioning of the reproductive system tend to connect several parts of the body. It bears little, if any, resemblance with the biomedical model. It also speaks of fluids and moods. Regarding the female body, their explanations tend to singularize the experience of conception to each woman. Several male explanations close with the idea that each woman is different. Two examples of lay explanation follow:

" A man generates about 3500 eggs and the woman, 1. Inside her body if the eggs like each other, they couple together. If not, they are discharged in the urine. The female eggs come down on the moment[of the sexual act], because of the emotion . To conceive, both [man and woman] have to finish at the same time. But I don't think it happens like this, because while the man has one orgasm, the woman has 100, 200. Seven days before menstruation and during menstruation the eggs are more exposed for coupling. That is for us [him and his wife]. I don't know how it is for others." (C., 55 years old)

"*There must be a head in the body [map], because we think to make the reproductive system work."* (G., 39 years old)

"[The reproductive system] has ovary, vagina, two kidneys, the heart. Without a heart she can not reproduce." (N., 20 years old)

Several issues that are addressed in the above statements indicate the presence of interdependent domains, such as physical, emotional, stated rules and the lived experiences of sexuality and conception. The ideas that there are eggs that couple together; that head, kidneys and heart are involved in the process; also the emotion of the sexual act as generating the process of liberating eggs, the need to "think" to conceive, all point to non-separation of

systems as thought by biomedicine. In C.'s statement he presents a conflict between what is seen as the right explanation, that is that women and men have to finish intercourse at the same time to conceive, and his questioning the idea based on his personal experience: how can that be possible if women may have multiple orgasms? Finally, he "solves" the problem stressing that each couple is different.

The connection/dependence of body parts is also seen in the men's explanations about the male "contribution" to conception. Several men describe the trajectory of the sperm through "tubes", once it is produced in other parts of the body.[50]

" *Sperm comes from the brain. It is produced by the spinal cord. There is a tube that brings it through the back."* (J., 37 years old)

"There is a tube where the blood flux goes, that the brain sends to the penis. That makes it erect." (O. 46 years old)

"Semen is made in the back part of the neck." (L., 39 years old)

Accompanying his statement L. indicated in his drawing of the male reproductive organs, the trajectory of the semen from the neck to the penis, as shown in a copy of his drawing that follows:

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[50] Heritier-Auge (1989) presents a consistent account of ancients theories concerning the genesis and relationship between semen and blood, many of them linking food, bones, marrow, blood, semen and milk.

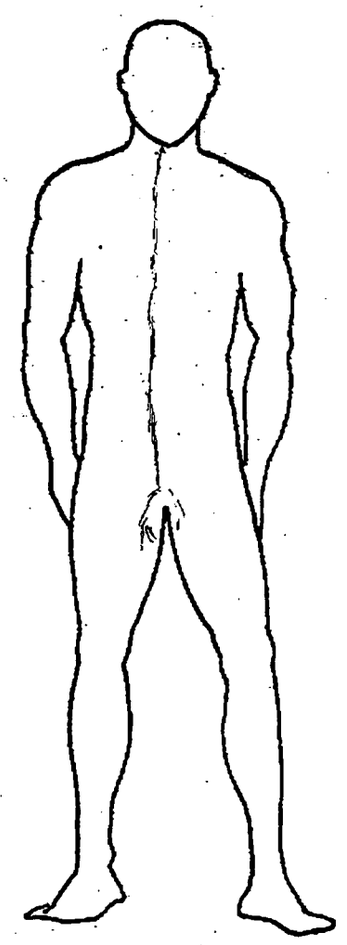

Figure 22: Brazilian informant's drawing - trajectory of semen in the body

The "tubes" cited in the male's discourse are an important vehicle of connection between interrelated body parts, and may supply different contents - blood, semen. They are not equivalent of female "tubes" - the Fallopian tubes - which were never mentioned in male discourse about the reproductive system, except in one case where an informant related his girl friend's infertility to problems in the "tubes", or when they were explicitly asked about tubal ligation.

(2) Mixed explanations

Mixed explanations are those which are loosely biomedical in the sense that they are based on biomedical principles, or use biomedical terms, but do see body functions as universal, rather they make each experience unique. For example:

" The fertile period is from the 8th to the 16th day after menstruation. But that is my wife's. It is not the same with everybody." (C., 32 years old)

"There is the erection, then the sperm that will meet the egg gets out and conception starts. But only in the fertile period is it like that: each month women are fertile for 24 hours, in a specific day. But it varies according to the woman. The books say that the fertile period is 7 days before, and 7 days after menstruation, but I don't believe it. My wife got pregnant during her menses." (J., 45 years old)

In both statements there is a mixture of biomedical information especially related to the principle that conception can only take place when sperm and egg meet in an specific moment, showing a certain degree of exposure to the biomedical principle. But immediately after, they state that the period varies for different women. In the second statement, the informant contests "books", meaning formal knowledge, that deny the menstrual period as the fertile period, since his wife got pregnant during her menses.

Beauty and the beast: representations of the female reproductive organs and menstruation

As suggested earlier in this chapter, the apparent neglect of men for the functioning of the reproductive process, can be seen as another aspect of the separation between female and male domains. The fact that nearly 60% of the men who made a drawing of the reproductive system (42% of the total) included exclusively the vagina or the vagina and breasts, indicates that sexuality has priority over conception in their views of the interdependent systems. The presence of breasts in 50% of the male drawings (25% of the total), in comparison with 20% of the female drawings indicates gender differences in envisaging the reproductive organs.

This information, if taken together with some informants' comments about general views of the women's body parts and functions, suggests the presence of an ambiguity related to the same body in terms of attraction and repulsion at different moments. The attraction is expressed in terms of difficulty in resisting female appeal, often related to female body shape, curves and sensuality. But sometimes also related to specific parts, as put by N., 23 years old, commenting on his admiration for the vagina. He says:

"Suddenly you see that beautiful thing..." (N., 23 years old)

The extreme contrast between the pleasure produced by the female organs and the repulsion provoked by a menstruation, conveys an understanding of a changing body that is seen simultaneously as the "beauty" and the "beast".

Menstruation is often expressed by men in terms of something "repulsive" (nojento). The main idea conveyed by men is that menstruation is the release of bad blood with the purpose of cleaning the body or the ovaries.

Some informants' comments point out the possibility of having sex with a woman in her menses as an outrageous act:

"I don't have sex with a woman in her period. Are you crazy? It's too much blood." (L., 18 years old)

"I don't go with a woman menstruating. Not even with a condom." (L., 18 years old)

Sexual intercourse during menstruation is not just considered repulsive, but also dangerous, either because it may cause impotence, or harm a man's health, or because it may result in pregnancy. This last topic has been more extensively discussed in the previous chapter.

In a similar fashion, men and women in the studied groups in Brazil strongly associate fertility with menstrual blood, and avoid sex during menstruation either on the grounds of it being repellent or on the grounds of

danger of pregnancy or of disease. Although the difference lies in the fact that men consider themselves at risk of catching a disease or getting impotent and women think themselves in danger of getting a sexually transmitted disease, because during menstruation "everything is open".

Of all interviewed men, 34% stated that women are fertile during menstruation, 23% before or after menstruation and 11% gave other explanations.

A few informants have explicitly related the menstruating woman with religious ideas of pollution. Such as an informant, who stated:

"During her menses the woman is dirty, so says the Bible." (J., 38 years old)

" I asked my wife why there was menstruation. She said that when Eve tempted Adam with the forbidden fruit, God sent menstruation as a punishment. And I believed her." (A., 41 years old)

The sense of disgust for menstrual blood, fear of catching a disease or getting impotent if they have sex with a menstruating woman, changes its focus when men declare that they expressed the avoidance of intercourse during menstruation in terms of "respect" for the woman when she is menstruating.

Men and the embodied category of respect

One of the key features of the embodied male gender experience is the category of respect. Respect is connected to different types of experience in the basic domains of male identity that have been discussed in this chapter.[51]

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[51] Duarte (1986) has also observed the importance of the category of respect for the adult male identity in working classes in Brazil.

To have respect in the domain of work means to be hard working. It is also related to the way men are seen by work mates and superiors. It is a cause of pride to be invited to stay longer in a job that was supposed to be temporary or to be able to go back to the same position after a leave period.

In marriage, to respect means not betraying the wife with other, not beating up the wife, not spending the money drinking and above all providing for the family.

In sexual activity it means not doing practices such as anal or oral sex, not having sex during the woman's menstrual period, and not being careless about the way the partner experiences intercourse.

Respect as shown above is used constantly as a descriptive category relating to several aspects of men's life. It refers to the acquisition and performance of bodily actions in such a way that respect is embodied in the very forging of male identity.

The graphic images of the female body

The first information that stands out from the drawings of the reproductive system is that 28% of the men interviewed refused to do one (type MNO). This contrast with less than 3% of refusals among female informants.

Nevertheless more men agreed to make drawings than agreed to explain the functioning of the body. Male drawings are significantly different from female ones, suggesting gender differences in the representation of the reproductive organs. Drawings of bodies with face, breasts and/or vagina, without any internal organ (M1B), for example, which account for 25% of the male drawings (35% of all male drawings if refusals are excluded) do not have an equivalent in the female's. This could be classified as the typical ale graphic representation. Here are some examples:

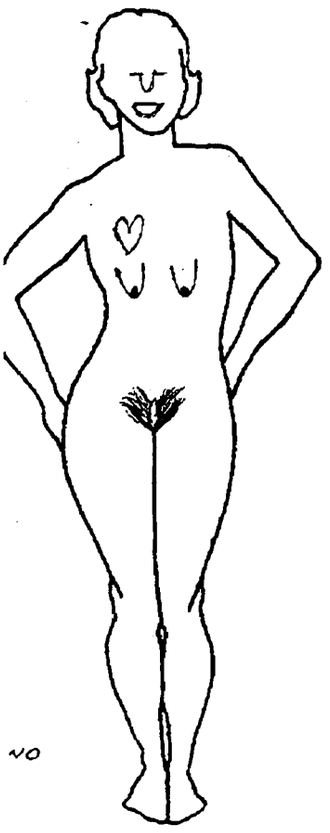

Figure 23: Brazilian informant's drawing- most common model by men (A)

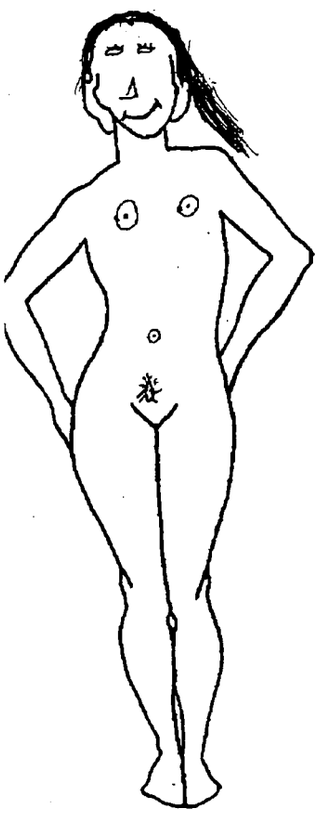

Figure 24:Brazilian informant's drawing- most common model by men (B)

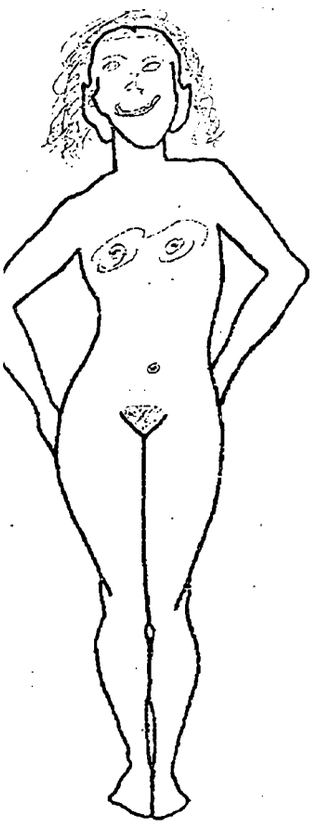

Figure 25: Brazilian informant's drawing - most common model by men (C)

Another common type of drawing is a body which includes only a vagina, without face or any other organs. This type was made by 17% of all men interviewed (type M2A). Here are two examples.

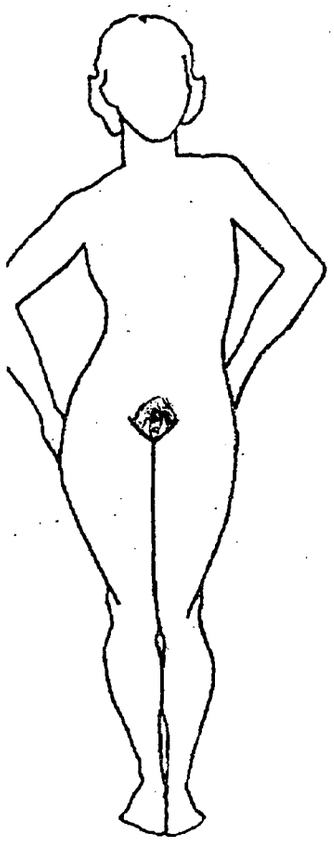

Figure 26: Brazilian informant's drawing - no face and vagina model(A)

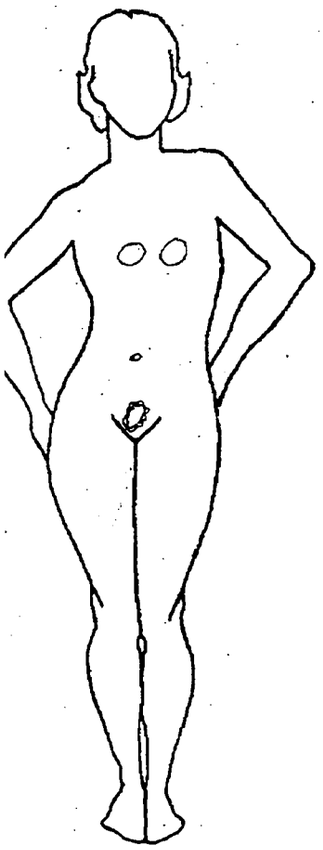

Figure 27: Brazilian informant's drawing - no face and vagina model (B)

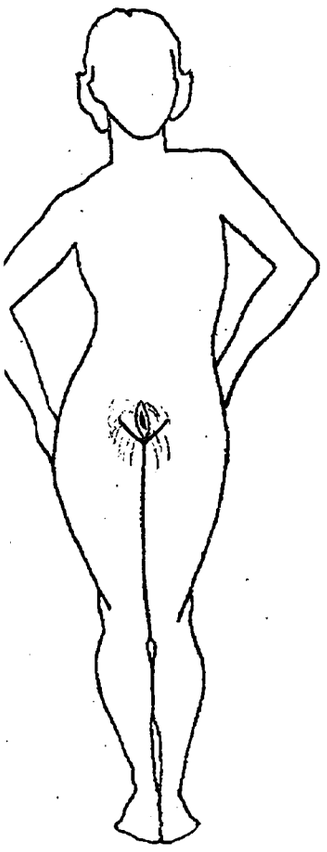

Figure 28: Brazilian informant's drawing - no face and vagina model (C)

The two types exposed above (M1B and M2A) as suggested earlier, indicate a specific way of thinking of the female body where the body parts that are graphically represented account for the more "external" parts, in contrast with the more "hidden" nature of the internal body parts. It is interesting to note that in the female drawings the vagina is mainly seen as part of the "internal" body, the vaginal canal as a continuation of the internal reproductive organs, while in the men's drawings the vagina is pictured as an isolated part, facing "out".

The fourth most common type was that which I classified as similar to the biomedical model (type M2B) which was made by 9% of the whole group. This is considered a model similar to the biomedical one, although only two drawings can be considered very similar. The others were simplified versions of the biomedical model. Examples M2B follow:

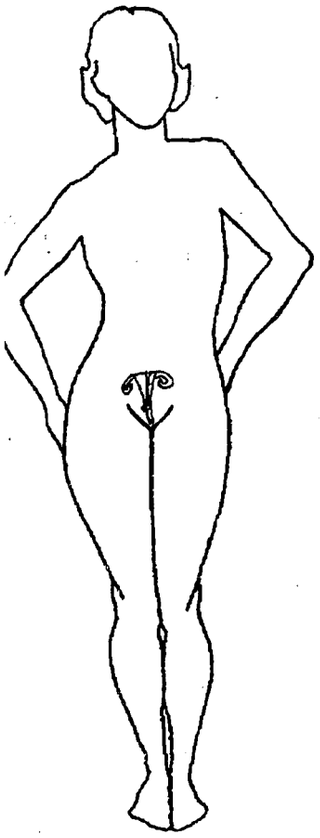

Figure 29: Brazilian informant's drawing - similar to the biomedical model (A)

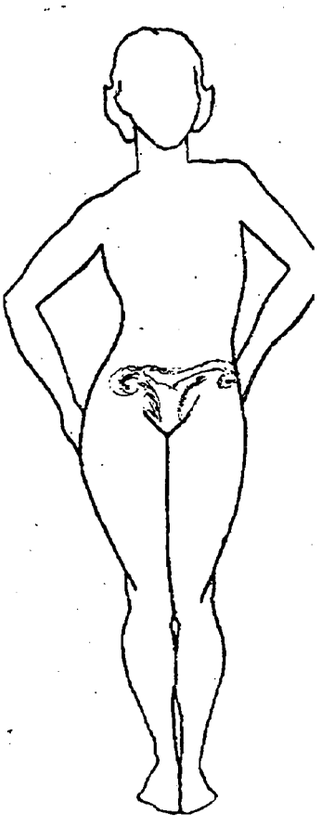

Figure 30: Brazilian informant's drawing - similar to the biomedical model (B)

All informants whose drawings were classified as M2B, except one, are not "typical" informants. They tend to have had more contact with other sources of information, such as the army (two of them have served in the army) or a political party (two are involved with local politics). They were also atypical in the sense that they have regular contact with biomedicine, since one who is a homosexual has had regular HIV tests in specialized clinics, and another had recently had a vasectomy. In other words, the biomedical representation is an atypical representation made by atypical inhabitants of the shantytown.

The other four types - M1A, M2D, M1C and M1D account for a very small number of drawings. They were made by 7%, 5.6%, 2.8% and 1.4% respectively.

Type M1A, is in fact similar to M1B, the "typical" model among the male informants, and could be classified as a variation of it. Their drawings include the presence of face and vagina as M1B, but also include a circle in the abdomen representing the womb. It is a lay representation, in the sense that it does not bear any similarity to the biomedical one. Examples:

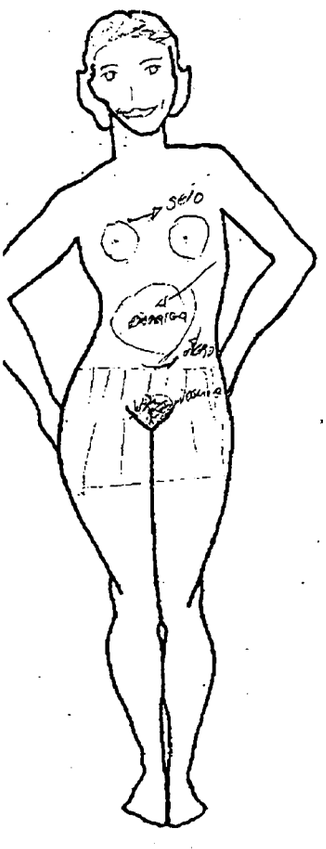

Figure 31: Brazilian informant's drawing - variation of most common model by men (A)

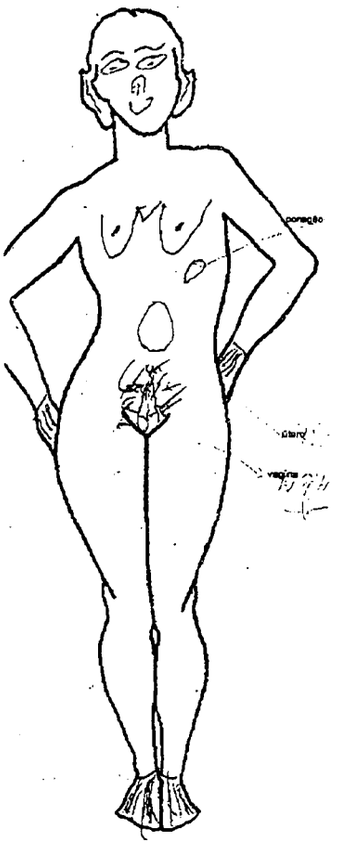

Figure 32: Brazilian informant's drawing - variation of the most common model by men (B)

The type classified as M2D is an attempted biomedical model, which includes some "organs" and no face. But the organs do not resemble the biomedical model.

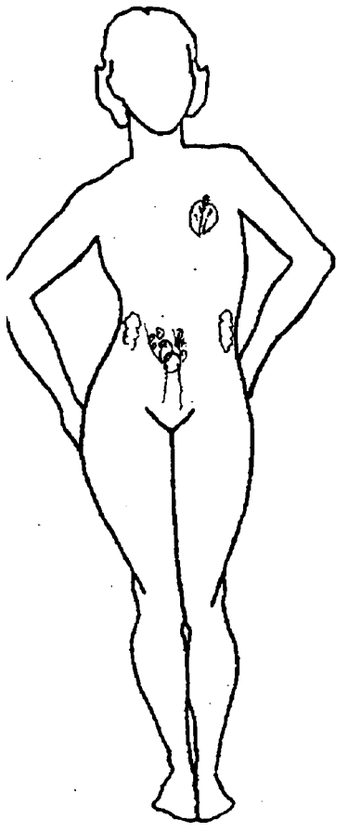

Figure 33: Brazilian informant's drawing - some organs and no face model (A)

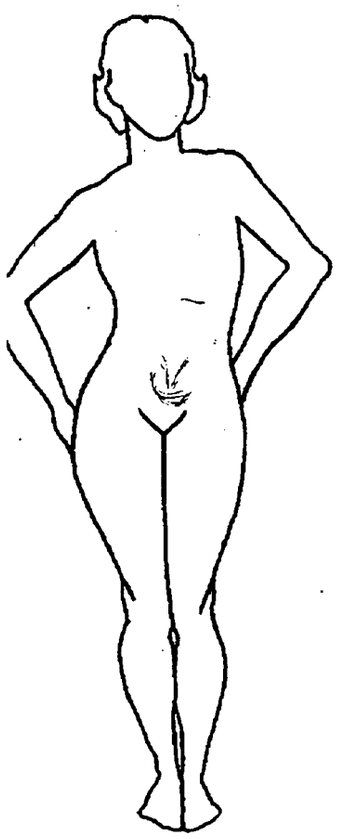

Figure 34: Brazilian informant's drawing - some organs amd no face model (B)

Type M1C is a different model which represents graphically the connection between organs that has often been represented in male discourse about the functioning of the body. Only two very young male informants represented the reproductive system like that.

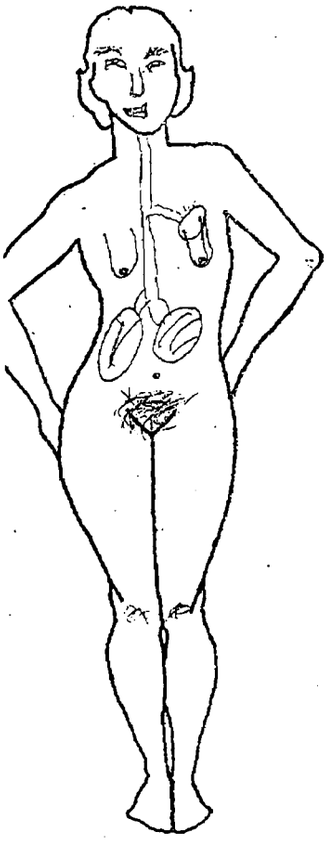

Figure 35: Brazilian informant's drawing - Connected organs model (A)

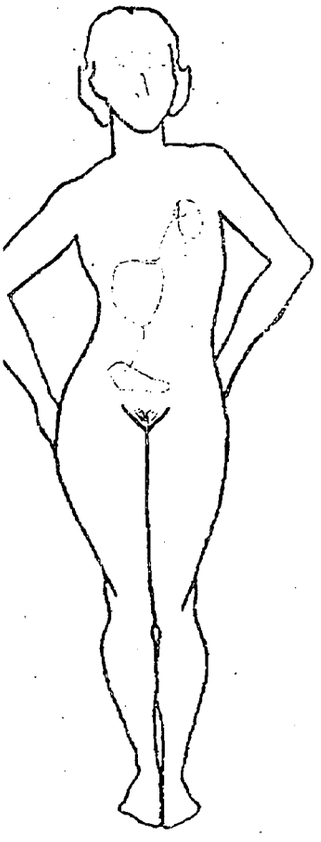

Figure 36: Brazilian informant's drawing - connected organs model (B)

Finally , type M1D, made by only one informant who although asked to make a drawing of the organs involved in reproduction, does not include sexual organs.

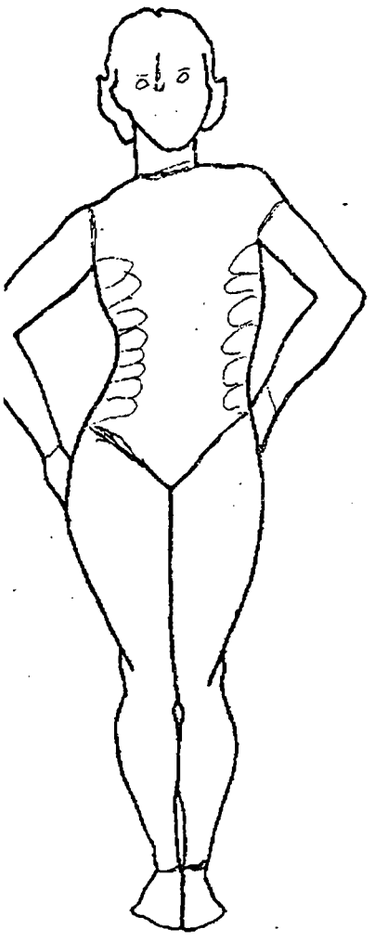

Figure 37: Brazilian informant's drawing - no sexual organs

Discussion

The basic idea of this chapter was to present an ethnographic account of aspects of the embodiment of male identity in the studied contexts in Brazil in order to understand the images the researched men have of the reproductive organs. Underlying this suggested correlation, - between context and images of the body -is the idea that embodied gender experiences give shape and meaning to bodily representations and practices.

The fact that men in many cases did not feel that they could make a drawing or explain the functioning of the reproductive system is related to the way they experience the embodiment of gender in this context.

I suggest that the graphic image is an image "learned" in contact with biomedicine. In different parts of the interviews it is shown that the researched men do not have much contact with health services. One of the reasons for this is the cultural understanding that men have strong bodies which hardly ever get ill. Besides the domains of health and sickness are, to a greater extent feminine issues. As shown earlier, in the hegemonic discourse about male and female assignments, the men are responsible for working and providing for the family while women look after the house and the children. In such contexts, health problems are seen as domestic problems. And although most diseases are seen as being caught in contact with the outside world, they are treated at home. The women are the ones who take the children to the doctors and therefore have much more contact with biomedicine.

However more or less contact with biomedicine does not account for these men's knowledge about reproduction. The point is that biomedical knowledge constitutes just a faint reference for the male informants' knowledge of the body. This is because men's embodied gender experience of sexuality and reproduction do not conform with the medical model of the body.

Apart from those informants who refused to make a drawing and to give an oral account of the reproductive system, the majority of drawings made by men portrayed basically the "external" parts of the body (M1B and M2A), pointing out the primacy of sexuality in the reproductive system. In biomedicine, the reproductive system comprises the domain of sexuality. But in the men's view it would be reasonable to speak of the "sexual system", composed by interrelated domains where reproduction would play a subsidiary role.

This is also evident in their difficulty to speak about a universal body, as pictured by biomedicine. The idea that all women, or all men, have reproductive systems that are identical, is an alien one. As seen in the ethnographic data male and female lay accounts tend to singularize the body based on personal and social experiences. This indicates that the lived body as the site of knowledge production encompasses other domains, such as the social and the biomedical.

Chapter Six :The British Study

" But as for the numerous and varied possibilities of that instrument which is the human body, we are as ignorant as ever, even though the body is universal and is at everyone's disposition; we only know of those possibilities of body use - always partialand limited - which come within the requirements of our particular culture. However any ethnologist who has worked in the field knows that those possibilities are surprisingly variable from group to group. The threshold of excitability, the limits of resistance are different in every culture. 'Impossible' effort, 'intolerable' pain, 'unheard-of' pleasure are not so much a function of individual peculiarities as of criteria retified by collective approval or disaproval. Every technique, every mode of behaviour, learned and transmited by tradition, is found on certain nervous or muscular synergies which constitute veritable systems, bound up with the whole sociological context." Claude Levi-Strauss - Introduction to the work of Marcel Mauss

Studied groups

I have described the British groups studied in Chapters 2 and 3 as a heterogeneous group of 20 women who have been interviewed during the year 1995. In the first part of the present chapter I will very briefly summarise that description, adding some more information based on my informant's life histories that will guide the discussion that follows concerning their images of the body and the reproductive system.

The informants lived in two areas of London, the South East and the North West. Six women interviewed were recruited through the South East London Midwifery Group Practice - SELMGP -, six through the Gynaecology and Infertility clinics of Hillingdon Hospital and eight were independent informants, in the sense that they were not directly associated with any

group, although I met the majority of them through a GP friend. As explained earlier my intention in selecting these three groups was to look at people who had different levels of contact with biomedicine. In my initial approach I associated Hillingdon Hospital patients with more contact with biomedicine, the independents with occasional contact , and the SELMGP patients with opt-outs from biomedical care. My aim was to check whether these different types of influence were associated with different images of the body. However another classification arose later when I was studying the interviews that relies much more on general life experiences. They do not correspond to my initial division, rather they overlapped with socio- economic aspects.

There are a range of reasons why my first classification ideas did not work as expected. The main one is the fact that even though the association of my informants with a specific group at the moment of the interviews indicated an inclination towards a certain type of medical practice - more or less biomedical - was not the result of a commitment at any level. Their choice of medical care was related to many different aspects.

For example, the women who went to the SELMGP because they wanted to have a home birth, did not necessarily opt-out of biomedical practice. They decided for a home birth experience for a variety of reasons. Some had previously had an unsatisfactory hospital birth experience. These tended to stress the lack of control over the birth experience and over the body in labour imposed by the hospitals and their wish to try a different experience with their subsequent birth.[52] However, as I only interviewed them after they had been in contact with the SELMGP for several months, it is difficult to say how much of that reasoning had been learned in the very contact with the group whose general discourse supported feminist ideas of empowerment and control over the body.

Another indication that the choice of a home birth did not suggest an opt-out situation was seen when quite a few of the informants, especially

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[52] For a discussion of ideas of control in hospital birth and home birth experiences in America see Davis-Floyd (1994). For lay peoples's ideas of control and responsibility for the body and health in relation to illness causation in Britain see Helman (1978) and Pill and Stott (1982).

primiparas, although looking forward to a more comfortable time at home during birth, could not in the event have the anticipated home birth because of emergencies that had to be dealt with in hospital. Their hospital birth experience was, according to them, surprisingly positive, and none of them mentioned problems with lack of control, etc. The key issue for them was that they had their own midwives, someone who they had known since the beginning of the pregnancy. Especially for those who had not had any previous hospital experience, it did not seem to make much difference as long as they were accompanied by their trusted midwife. (I will come back to the relationship between the SELMGP patient and their midewives later.)

There was perhaps a feeling among the informants that when chosing a home birth they were doing something extraordinary and that this decision could bring about unpleasant situations. All my SELMGP's informants recalled the day they went to tell their G.P.s of their decision to have a home birth and their surprise in most of the cases when the G.P. did not make any unpleasant remarks. One of the informants had a double concern in that situation because apart from having to tell the GP that she had booked in for a home birth with the SELMGP, she also had to mention that her pregnancy was the result of Artificial Insemination by Donor since she is a lesbian. In fact the decision to have a home birth was also linked to the fact that she had a female partner, who would also like to participate in the process of labour and birth. In choosing to deliver the baby at home they were hoping to avoid extra anxieties and questionings because they were lesbians. To their amazement neither the GP or the hospital staff where my informant ended up giving birth presented any objections. In other words, there was a an anticipation of the biomedical staff reaction which they later admitted did not correspond to reality.

Only one of my informants in this group had what I considered an actual problem with more traditional biomedical practice, namely her GP, who disapproved and accused her of putting her and her baby's life in danger if she pursued her plans of a home birth. In this case, his intimidation contributed even further to her deliberate opt-out condition that seemed

coherent with her general position of disapproval of and protest against the whole Establishment.

So, except for this particular informant, all the other women whom I met through the SELMGP, through Hillingdon Hospital, as well as the independent ones were not particularly committed to any type of medical care. Some of the independent informants had previously had a home birth through their local health services and several informants from all sources had used alternative treatments such as acupuncture, osteopathy, homeopathy, etc., at one time or another for specific purposes indicating that (1) influence of biomedicine is very difficult to assess and (2) it was not possible to correlate more or less contact with biomedicine and certain images of the body in the researched setting. However other interesting correlations arouse. As explained in chapter 3, I observed that certain clusters of life experience could be convened in what I roughly interpreted as three groups:

I) Middle class, educated women living in their own houses
II) Working class women living in their own houses
III) Working class women living in council estates

At first sight, it appeared to me that this kind of classification was much more difficult to make in First World Countries where class boundaries seem less explicit than in Third World Countries where the social class segmentation is much more clear cut. Even though they exist and their distinction has been helpful to the present analyisis.

Regarding the British study, I have argued in chapter 3 that a minimum level of stability, expressed among other aspects, in fewer changes in the household composition, allows people to make plans for the future and is consistent with a more strict embodied notion of space and a more linear notion of time. This is not to say that the British informants were a homogeneous group. It just indicates that, in contrast with the shantytown groups, all the British groups studied have in common a minimum level of

stability. It is from this point that I commence my analysis on different groups that designed the British case study.

When I argue that there are inter-group differences and intra-group similarities I am taking Bourdieu's view that each member of the same class is more likely than any member of another class to have been confronted with the situations most frequent for members of that class. That refers to the distinction he makes between class habitus and individual habitus. As he puts it:

"(...) the singular habitus of members of the same class are united in a relationship of homology, that is, of diversity within homogeneity reflecting the diversity within homogeneity characteristic of their social conditions of production. Each individual system of dispositions is a structural variant of the others, expressing the singularity of its position within the class and its trajectory. 'Personal' style, the particular stamp marking all the products of the same habitus, whether practices or works, is never more than a deviation in relation to the style of a period or a class, so that it relates back to the common style not only by its conformity - like Phidias, who, for Hegel, had no 'manner' - but also by the difference that makes the 'manner'." (Bourdieu 1995:60)

Following Bourdieu's reasoning, in the individual social trajectory of my informants, new experiences modify past experiences but only within the limits defined by their power of selection , which is a function of the group habitus. Group habitus, is not the sum of individual habitus, but the principle of a selective perception (...) a realistic relation to what is possible, founded on and therefore limited by power. (Bourdieu 1995:64,65) This explains, at least in part, the fact observed in chapter 2 that although the SELMGP was meant to attend a wide range of groups, it ended up being sought mostly by middle class educated women, for whom a home birth experience was associated with ideas of control and empowerment, widespread in that group.

I will introduce a brief life history - a sample of their individual habitus - of two informants of each of the three groups to familiarize the reader with my view of the three groups. After that I will discuss pertinent aspects of their group habitus, identifying their views of the body and the reproductive system.

It was very difficult to select the six personal histories for this first section since all of them seemed relevant examples. However since I have selected them and I am selectively re-telling their histories it is perhaps more appropriate to call them their "stories ".

Navigating in individual habitus

I. Middle class educated group : the stories of S. and C.

1) The story of S.:

S. is 38 and was born in the northern part of England. She lived there with her parents until the age of 18 when she went to College in the Midlands to get a degree in nursing. She moved to London when she was 27, did an M.A. degree and now teaches in a college in London. She has two sisters and had one brother who was killed at 21. Her parents are both retired psychiatric nurses. Except for her brother and herself, no one in her family went to university.

S. describes her college time as a very political time of her life. She took part in feminist groups, women's support groups, etc, which she thinks have given her more independence, identity and helped to explore her potential. She says that before going to college and becoming more political, she thought that women were victims of men.

Those times belong to the past now that S. lives with her boyfriend and her baby in a house that they have bought in Lewisham 1 1/2 years ago. The house has three floors, the lower one where there is a kitchen and a small paved garden, the second floor, where the living room is, and the third where

there are two bedrooms. She mentioned that eventually they would have to move from there, implying that the house would get too small for the family.

S.'s boyfriend is a free-lance publisher. They met about 9 years ago at college and have been partners for 6 years.

Last year they decided to have a baby. She recalled no problem in getting pregnant because she knows when she is ovulating. But she was tense and worried during the pregnancy because of her age (38) and because she had previously experienced a miscarriage. However, she thinks it was the right time for her to be a mother. It wouldn't be so good if she were younger, she stresses.

A few years earlier she got pregnant (accidentally, she says, although she was not using contraceptives) and had a miscarriage. She recalls it as a terrible experience. She was critical of the quality of services provided by the NHS. This next pregnancy, she said, she wanted to be looked after from the very beginning stressing the fact that in the NHS a woman is only considered pregnant after 12 weeks. She wanted more individual care and that is the reason she chose the SELMGP.

At the time of the interview S. was on maternity leave from her teaching job and would be going back to work soon. The college where she has a full time job has a creche where she will be able to leave the baby while she is working.

2) The story of C.:

C. is 29 years old. She was born near Sussex, the youngest of two children. She has a brother who is 14 months older than her. Her parents are English, her grand-parents (father's parents) were Italian. Her primary school was a Church of England School, and secondary school was a comprehensive school.

At 17 C. went to study Art at an Art Foundation while still living at her parents' home. At 18 she decided it was time to leave home and went travelling. C. spent one year in a kibbutz in Israel.

When she came back she went to college in Wales to study Graphic Design for 3 years. After that she had two jobs in two different magazines, one as a designer, the other as an art editor. This last one was interrupted by a hand injury.

C. has known her husband for 6 years, and has been married for 2. They met in a bar where he was playing the piano - he is a pianist - and she was a customer. About their marriage, she thought it was not really necessary to get married, but it was a way of showing people that they were together. Besides, there was the party, the presents... The decision to get married came about after her husband had a car accident. She told me he was very lucky to have just minor injuries. "The way the law is at the moment...", she said, implying that if anything happened to one of the partners and they were not married, they do not count as related for many legal purposes.

C. thought she never wanted to get married and have children. She didn't really like kids. When she was 26, she held a baby for the first time. Three years earlier she got pregnant but had a termination. It wasn't the moment, she said. At that time she lived in a small flat, had a steady job and she did not want to leave.

But her later decision to have children was partially influenced by the abortion she had. She felt she had missed something.

Although when I interviewed C. she was living very much the life of a housewife, busy with the house and the baby, she stressed she was looking for another career chance, by studying for another degree since her hand injury cut short her career as a designer.

II. Working class with own house: the stories of P. and J.

I) The story of P.

P. is 29 years old. She lives in her own house, a two bedroom maisonette, with her own garden with her husband and children.

P. has two children, M. who is 4 and E. who is 2. When I interviewed her she was pregnant for the third time. She volunteers the information that the first two pregnancies had been planned, but the third one "just happened".

P. is twin with another woman and has got another sister who is one year younger. Her mother left them when she was just 3 years old. They have been brought up by their father. He used to be a gardener but stopped working to look after them, after their mother left. Her grandfather was also around in her early years first living with them until she was 6 and after he got married for the second time in a nearby house. She said she was so young when her mother went away that she doesn't even remember her. But after so much time, it doesn't really matter anyway. Her father got custody of them all.

P. has known her husband since they were 7 years old. They used to be neighbours. They have been boyfriend and girlfriend since she was 12. They have lived together for 11 years. They wanted to be sure that life together would work before getting married. Five years ago her husband said: " let's get married and start a family."

The wedding was a formal one. There are pictures of the wedding on the living room wall. Three months after she got pregnant with her first child, M.

She worked as a cleaner at the local pub before she had M. and went back to work 6 months after she had him. She stopped working for the second time when she had the second child. She has not been back to work since. She says her husband has got a good job. He is a milkman, and is soon going to have a better position, helping to run the dairy company.

She considers herself a very active housewife.

2) The story of K.

K. is 32. She is married, has one 3 1/2 year old child and is pregnant with the second one. She lives with them in the same house she was brought

up in, since they bought it from her mother a few years ago just after K. had her first child. She has a sister who is 15 months older than she is. Her father died when she was very young. She grew up with her mother and sister. Her mother remarried when she was 50.

K. went to a local primary school and later to an all girls secondary school.

After she finished school she had a number of short term jobs and a longer term one - 3 years - in a hospital as a Health Care Assistant, chaperoning around the hospital, handing out exam results, etc. She pointed out the advantages of her job: it was never the same, she found her colleagues very friendly, she had Fridays off, and it paid well.

When she got pregnant, she went on maternity leave 6 weeks before the birth. She went back 12 weeks later to do the same job, but little by little she reduced her working hours. First she had the Fridays off, later also had the Thursdays, to a point where she found it wasn't worth it anymore.

When she went back to work she used to leave her child with a child minder. As her working hours decreased a child minder became too expensive and she ended up giving up the job completely.

She then found herself a job in the evenings, as a doctor's receptionist, but it didn't work out very well because on the way to the child minder's house her baby used to fall asleep, and wake up later distressed and crying and not knowing where he was.

More recently she started work at a cleaning firm where her husband works, but has stopped now that she is pregnant for the second time.

K. has known her husband for 14 years and have been together since she was 18. On and off in the beginning but steady later. They have been living together for 6 years and married for 2 years. They decided on the marriage after her first child was born. She stressed she wanted to have the same name as her children.

III) Working class living in council estate : The stories of S. and C.

1) The story of S.:

S. is 35 years old. She lives in a two bedroom council flat in south east London with her husband and three children, B. (9 years old), L. (6 years old) and C.(3 1/2 years old). She was born in London, and has two brothers, one younger and one older than she is. Her father was a milkman and her mother used to work at a greengrocer's.

She went to school locally, first to a mixed school and later when she was 14, to an all girls school. She recalls that all the children from the neighbourhood used to go to school together.

After she finished school she started working, first in a shop, then in a factory and later in a shoe shop. She lived at home (her mother's house) until she got married for the first time at 21. She had met him when she was 18. He husband was a road worker and they stayed married for 2 years. During that time she tried to fall pregnant but did not succeed.

After separating from him she lived on her own for a while until she met her second - present - husband. They have lived in this large council estate for 8 years. Before that they lived in temporary accommodation nearby. She says it took a while to settle, but now they don't want to leave the estate. They are waiting for a three bedroom flat because they have three children, but hope it is around the same area. She thinks there are many advantages in living there: the children go to karate classes at the local community centre, among other things.

S.'s husband is the caretaker at the local school, where her two older children go. He has to open the school at 6 and works until 11.30. Then goes back at 3 until 6. Before working there her husband did building jobs, for small building firms or independently. He has never had a formal training. He learned on the job..

She met her husband in a pub where he used to work. She was positively surprised when she got pregnant a few months after they met, because, since she could not get pregnant before, she thought there was

something wrong with her. They got married when she was pregnant with her second child.

2) The story of C.

C. is 23. She lives on a ground floor flat with her partner and their two daughters: E (3 1/2 years old) and R. (10 months old). E. goes to playschool in the afternoons while R. stays home with C.

C.'s father used to be a postman and is now retired. Her parents separated when she was 12/13 years old.

C. went to school locally, but she told me that she never liked school. In fact she did not finish school. She left when she was 15 and did not take the exams. She went straight from school into employment. The school found her a job in a small private printing firm. She started doing general things like making coffee and cleaning, and ended up learning the job.

She met her boyfriend there. He had worked there for several years.

Her boyfriend left college and was an apprentice at the printing firm. "He has become part of the furniture", she told me.

When she was 18 they started to go out together. In 5 months she got pregnant and he moved in with her to her mother's place. Her mother is very close to her: "I know she is there when I need her", C. said.

C. has two children, but has been pregnant three times. Her middle child was born with malformations and heart problems and died a few days after birth. That was a very traumatic experience for C.. When she got pregnant for the third time she had the choice of a home birth and decided that would be a way of overcoming the nasty previous experience. In fact, she told me this was a totally different experience, much more positive.

C. would like to put her older daughter in a nice church school nearby, but the head of the school does not want to accept her unless C. and her partner get married. She is reluctant because for her marriage is a lifelong commitment. "I don't believe in divorce", she said.

As I retell part of my informants' histories, I have deliberately focused on my informants' experiences of education, work, relationship with family, marriages and pregnancies. The reason I did so, was because, as mentioned earlier in Chapter 3, they seem to be relevant differences between the three groups. The sections that follow analyse these differences in relation to the way they experience their bodies.

(Un-)Professional bodies: captivity or liberation?

One of the most striking differences between the groups regards education and work. The informants in the middle class, educated group spend several years in the process of getting an education. During this time they are exposed to a number of situations that are said to contribute to their future life - trips abroad, involvement with political groups. To support their higher education years they either have help from their parents, or have a scholarship, or do temporary work during breaks and holidays. For most of my informants in this group a university degree is just the beginning of their higher education. H.'s situation illustrates that:

" My parents paid my first year of University because my sister was still in public education. But after my sister also went to University I lived on a government grant (...) After I finished University I was unemployed for three months. I took a translation work in ..., but it was poorly paid and not interesting (...) I then realised my degree wasn't enough and decided to do a secretarial training (...)" (H. , 33 years old)

There is a permanent emphasis on their professional life and in how much the "captivity" imposed by motherhood can be detrimental for their mental health. In fact having children is described as something they thought they would never do, and when they did, it had to fit into their career plans,

which include the possibility of having maternity leave and going back to the same job after the baby was born. Having children thus is delayed until the late twenties or thirties when other areas of their lives are fully organised. The interruption to have children is meant to be a brief one. And although they were, financially speaking, better off than the informants in the other groups they were the only ones who mentioned the need to go back to work after having children (1) because of money and (2) because working is important to one's mind. In the words of one informant:

"The baby sleeps from mid-night to 8. Then I feed him and sometimes put him back for one more hour. I get up, have a bath, wash my hair - take time to myself. I make breakfast, do some house cleaning. But because I am not working or thinking of anything serious I have my head full of crap." (S., 39 years old)

The proper time to have children is also related to finding the right partner, which also seems to be delayed if compared with the other groups. My middle class informants recall different hetero- or homosexual boyfriends/girlfriends before settling down in a more steady job with a steady relationship, as seen in the story of H. which I summarise next:

H. got married for the first time when she was 20 but the marriage did not work out . She split from her husband and went away to Hong Kong where one of her sisters used to live. Her husband rang her and asked her to come back. She agreed but it still did not work. Not long after that she got married for the second time but the second marriage did not last very long either. She had an affair towards the end of her second marriage which she saw as a "liberation". During the years of her first two marriages she was also involved in a variety of casual jobs. More recently she did a University degree in Social Sciences and Technology at the Open University and a training in Social Work. After her second marriage she spent 5 years period on her own, the last two as a celibate, until she met P. . Presently, H. is 33, has a steady

and satisfactory job, and lives in her own house with P. and their new-born daughter.

These aspects are very different in the other two groups. Working-class informants who had their own house, tend to have a number of short term jobs after they finish school but a steady heterosexual relationship with someone they have known for many years. Besides, work becomes peripheral after they have children. The ones who attempt to go back to work soon after having children, do it for a short time, just until they realise that: 1) it is anti-economic; 2) it is not healthy for the child; 3) it is not necessary because the husband is providing. As one informant puts it:

"I don't want the children to be looked after by other people. The first years are so important. L. (her daughter) is more important than getting money." (C., 23 years old)

Some working class informants try to go back to work after the last child reaches school age. Those often find it very difficult since they need to engage in special training.

"I have started further education to get a diploma in nursery nursing. I already help out 3 days a week at the nursery. I am also attending a first aid course. I need all qualifications possible to get a job."
(S., 35 years old)

Several informants mentioned difficulties in working outside the house while the children are small and especially those in the working class with their own house have an agreement with their husbands who become the sole provider.[53] This is seen as a positive arrangement and they see

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[53] For a discussion of sexual division of labour and household division of labour in contemporary Britain see Edgell (1980).

themselves as lucky to have a husband who provides. In my informant's words:

"I think I am very lucky because my husband has a good salary. When I need money I just take it from the drawer. He is the one who worries about things. I might get a bit worried for a short time, but the next day I have already forgotten it." (P. 29 years old- husband is a milkman)

For those women going out of the house to compete in the professional world has a different value than for my middle class informants. The analysis of their differences makes me relativize the negativity associated with the female deprivation of the public/professional world seen by my middle class informants. [54] For my working class informants not having to go to work and staying home instead of being seen as a deprivation from the public/male world, is seen positively as a liberation . (Sciama 1981)

The boundaries of the sexual body I: first sexual intercourse and rape

The distinction between the first sexual experience and the first sexual intercourse made by my informants immediately presented an important difference between the Brazilian stories and the British ones. In the shantytowns in Brazil the intentionally broad question ("*What about your first intercourse?"* in English and *"E a tua primeira transa?"* in Portuguese) has always elicited descriptive answers referring exclusively to the strict event when they ceased to be a virgin. In contrast several of my British informants answered this question in reference to sexual games played when they were young. Or sometimes they asked me to be more specific indicating that there could be more than one answer to the question. This may well be related to

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[54] For a more complete sociological approach to women and emplyement in Western societies see Goldthorpe (1987).

differences between the two languages, and the fact that in Brazil the interviews were conducted in my native language while in Britain where the questions were formulated in my second one. In this case the rather formal words sexual intercourse could have a broader meaning than "*transa*", a slang word widely used for sex intercourse in Brazil. But it can also indicate a distinction in the way the interviewees in Brazil and in Britain think of the beginning of sexual activity, as expressed by one of my British informants:

"When I was 16, I had a boyfriend with whom I had lots of sex but not intercourse. There was something wrong with his penis which I never understood completely what it was. My first actual intercourse happened when I was 18." (the middle class, educated group)

Particularly for those informants who had their first intercourse with a casual boyfriend the first sexual intercourse was described as not a memorable experience and sometimes even regrettable . This way differs from the comments made by informants who had their first intercourse with boyfriends who eventually became their husbands, like those in the working class who have their own house.

"*I had sex for the first time at 15 with a boy from school, much because of pressure. It was not a memorable experience."* (middle class educated group)

"*My first time was when I was 18, with a friend of a boyfriend. It was in the garden. It was disappointing.*" (middle class educated group)

However the working class informants who have their own house, and have known their husbands since a young age, tended not to evaluate their first sexual intercourse as good , bad , memorable or regrettable , rather

they describe it as part of a process of being together for sometime before they decided to have sex.

"It was with my boyfriend, now my husband. We had been together for one year (...) It was also his first experience. We had attempted 2 or 3 times before, but didn't go ahead. We were both insecure. When it actually happened I took the leading role." (D. 30 years old)

These differences in the reconstruction of past experiences are seen in the light of further experiences with the same partner, and recorded within a spectrum of experiences in such a way that what had been described as "*not memorable*" by one informant in the middle class educated group is described as something she "*does not remember very well*" by one informant in the working class group.

"My first intercourse was with my husband. I was 16. It happened in the bathroom at a party in his brother's house. I don't remember very well. But I didn't feel any pain. I remember afterwards I asked my friends if I was walking different." (working class with their own house)

Another striking difference that may also be connected to the way my Brazilian informants and my British informants perceive their bodies is with regard to the description of sexual violence. In over 150 women interviewed in Brazil by myself or collaborators there was only one mention of rape. While in the 20 interviews carried out in Britain, there were at least 4 women who spontaneously told me they had been raped. For three of them that was their first intercourse. Here are their reports:

"My first sexual experience was a rape. I was 17 and I was in Germany. I went to a disco and on the way back the fellow who offered to take me home, broke into a house and forced me to have sex with him (...)

For many years I denied it was a rape (...) feeling guilty and thinking that it had been my fault (...)."(middle class educated)

"(...) I had been in the kibbutz for 10 days. I was very drunk and I met this English guy. I was so drunk that I though he was trying to kill me. I remember sitting at the doorstep feeling sick (...) I thought I was taken advantage of. But I pretended he wasn't the first one..." (middle class educated)

"My uncle used to come to my house quite often. One day on my way to work he offered me a lift, but he had to stop at a friend's house and needed a hand to get some boxes down. When we got in, his friend went out and the door was locked. I didn't return to work or home that day. I went to my sister's work . I was battered and had a black eye (...)" (working class living in a council estate)

"I was raped by two Asians when I was 13. I had run away from home. They kept me in a room for days. They injected me with heroin. I was found by the police, after a friend spotted the coat I was wearing when I disappeared in the shop downstairs. I had to have an internal and everything(...)" (working class living in a council estate)

Needless to say that I am not implying that because the Brazilian informants did not mention the word rape (*estupro*) and the British did that there is more rape in Britain than in Brazil. Perhaps in the shantytowns a *estupro* is seen as one violence among others and as such it is not spoken about. As I explained in chapter 5 violence is a recurrent problem in the shantytown but they are usually part of the male discourse. Besides I suggest the difference is also related to the cultural interpretation of the violent sexual act based on specific notion of body boundaries.

There was no specific question about rape or sexual violence in the interviews guideline. Even though, a number of informants brought up the issue. The interview question about the first sexual intercourse was intentionally broad leaving the informants free to say as much or as little as they wished. Two of the British informants referred to rape as their first sexual experience and the other two spontaneously approached the topic when they commented on a number of unfortunate events in their lives.

The first report about rape presented above clearly stated that it took the informant some time to interpret the experience as a rape. In other parts of her interview she mentioned that only through sex therapy had she managed to understand and overcome the problems the rape had caused her.

In the second report the informant did not use the word rape, even though she describes it as an extreme act of violence when she thought she was being killed, she only goes as far as saying she was taken advantage of. In the third and the fourth reports the women presented their rape reports as part of a number of tragic situations that had happened to them, such as being put into care since 7 years of age, or attempting suicide, among many others.

Regarding the observed difference between the Brazilian shantytown informants and the British informants in relation to rape, I must point out the fact that rape as an issue in general is more openly spoken about in Britain than in Brazil. Only recently some special police units, in the larger cities, have been opened to deal with violence towards women in Brazil. Since then the number of reported rape cases have increased constantly. But in my view lack or presence of special police facilities to denounce the occurence of rape alone does not explain the differences. The key issue relies on the interpretation of a [violent] sexual experience as a rape or, in a more phenomenological fashion, to experience such sexual intercourse as a rape. In other words, women can only report a rape if they understood an experienced sexual act as such. My claim is that this depends on the way they perceive the boundaries of their bodies, and in which circumstances

women think they should, or are supposed to, share their bodies with men and in which way.

If this is true, one possible way of looking at the recovery of a rape experience is through the restoration of body boundaries. In that sense the violation of the body boundaries through non-consensual and violent sexual intercourse goes much further than the immediate objective physical body experience. It initiates a trauma by forcefully penetrating victims physically, sexually, emotionally and mentally. (Winkler 1994). The British informants who mentioned being raped in the past implied in different ways that only when they met the present partner had they managed to overcome the problems caused by those as well as other unfortunate experiences.[55] This is what some informants report:

"I never had a proper relationship after that. Only after I met T.. I am not being cynical ." (C. 29 years old)

"My husband is different [from previous violent partner] . He never raises his voice. He rings home three times a day to see how everything is. " (I. 30 years old)

This is not to say that as in a fairy tale "they lived happily ever after". As I see it, the feeling of integration reported by my informants refers to the re-organization of previous experiences enabled by a present stable relationship.

Another issue is that, all four informants who reported having been raped mentioned the fact that they were away from home. Two of them were raped abroad - Germany and Israel. The third one was raped in a locked house and did not return to work or home that day and the last one had run away from home . A symbolic analysis of that fact could indicate that there is a consistent correspondence between the house and the body (discussed in chapter 3) expressed in the statements about rape as a rupture - a disruption

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[55] For an anthropological account of rape trauma, see Winckler 1994.

- of the body, in a state of rupture - a separation - from home. The idea of rupture is emphasized in Winkler's argument that

"Rapists who traumatize the victim's body objectify the body, and this objectification results in the victim feeling as if there is a separation between the body and the mind." (Winkler 1995:250)

The perception of a body-mind split forced by the rape situation, as reported by many rape victims reinforces the feelings of re-integration expressed by my informants when they met their present partners.

The boundaries of the sexual body II: breast feeding

In a different way, the issue of body boundaries could also be observed in women's reports about breast feeding. Even though I do not have a large number of reports on this topic since not all my informants had children, I have observed that among those who did, breast feeding was a problem, except for those involved in a home birth experience who had overcome this "problem" through the remarkable influence of their individual midwives. This roughly coincides with the previous class stratification since working class women who owned their houses had their children in hospital and were the group who did not breast feed their babies.

The issue that most interested me in their reports were the reasons why they did not breast feed. Their discourse usually presented a main reason related either to an uncertainty about the amount of milk the baby was taking or to the impossibility of the father participating in the process of feeding the baby if breast feeding was carried out. And a secondary reason related to practical difficulties such as breast feeding in public and being restricted by the need to be near the baby at fixed times for breast feeding. Here are some of their main reasons:

My husband wanted to help to bottle feed the baby. But I hadn't made up my mind until she was born. I thought I would give it a try. But since the first time I thought it wouldn't work out. (D., 30 years old)

You don't know how much the baby is taking. (P., 29 years old)

Regarding what was said to be the main reason, the contrast between working-class and the middle-class informants is quite remarkable since the latter did not mention the relevance of the father's participation in the process of feeding the baby at any point. Neither did they show any specific concern with the amount of milk the baby was taking, which seemed a major concern for my working class informants. A contrasting example may be helpful to illustrate this point regarding two informants, one in the middle class group and the other in the working class group, in relation to their small and premature babies.

The middle class informant who had a new-born baby considered very small and with feeding difficulties decided that there were two things to be done about improving the baby's feeding ability: (1) spend as much time as possible with the baby on the breast so that the baby could feed according to her (the baby's) own timing, and (2) take the baby to an osteopath who manipulated a possibly dislocated neck muscle that was interfering with the baby's feeding ability making gulping painful.

In contrast, a working class informant who also had a slightly premature baby reported she did not breast feed because the baby was too small and was put on the bottle straight away. She said she was very worried and anxious because she did not know how much the baby was getting from the breast.

The father's participation was an issue that came up in several interviews in the working class groups. The basic idea is that if the woman breast feeds the baby she denies the father the right to help feeding his child. So, the couple agrees that bottle feeding would be more appropriate for all of them: the father would have more contact with the child, and vice versa, and

the mother would be spared difficult tasks such as getting up in the middle of the night to breast feed. Yet, in other parts of the interviews the same informants made it very clear that the father's participation in such tasks was irrelevant or non-existent.

My point is that the father's participation was an acceptable reason related to progressive positions of equal gender rights and duties. But it could also be covering what I called secondary reasons presented by them especially when it was obvious that the policy of equal gender duties were not valid in other domains of their lives.

The interviews showed that the alleged secondary reasons for not breast feeding were clearly related to body boundaries in the sense that the bodily connection established between the woman's body and the baby's body was a disturbing experience. The exposure of private parts in public places for example, was the cause of tremendous embarrassment. The act of breast feeding in public places was, in some cases, unthinkable for them. In some interviews I mentioned how common it was to see such scenes in the streets, parks or in public transport in Brazil and this generated a debate among us on how they would feel invaded by other people possibly staring at their breasts.[56]

They were also concerned with the fact that if they breast fed, they would be physically connected with the baby and this could limit their general mobility. In that case they would not be able to go out leaving the baby with someone else. But again, looking at their accounts of daily activities there is no evidence that (1) they used to go out for long periods of time with the baby in a situation that they would need to breast feed in public, and (2) that they ever went out and left the baby with someone else for long periods of time.

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[56] The fact that in Brazil it is common to see women breast feeding children in public does not indicate that the rates of breast feeding in Brazil are very high. However, the reasons for not breast feeding are not related to public exposure of the breasts but to a concern with the nutritional quality of breast milk. According to native classification systems breast milk can be "weak" or "strong" which takes into consideration mainly qualitative aspects such as colour and density but rarely quantity. One indication that a woman's milk is "weak" is the baby's crying pattern. For more about breast feeding in Brazil and the weak milk belief see Behage (1992).

The middle class informants, especially those who had a home birth, and were influenced by ideas of recovering the lost "natural" (in the sense of belonging to the natural realm) reproductive functions of the body, were much more keen on breast feeding. They managed to organise their routine in such a way that they could go out with the baby without having to breast feed in public because they also felt very embarrassed about the fact that people could stare at them. These women were also much more confident in relation to the amount of milk taken by the baby, they did not feel that they had to see how many millimetres of the milk the baby had taken to believe that they had been properly fed. Participant observation of SELMGP post natal groups meetings revealed that breast feeding during the meetings was a well accepted and praised act. In fact one of the main functions of the post natal groups was to boost the new-mothers' confidence on their ability to nurture their babies.

As mentioned earlier, the informants who did not breast feed usually gave many reasons for not doing it, such as: *"I couldn't cope with it." "He was still hungry." " He was not getting enough." " I couldn't leave him."*

One of my informants who gave up breast feeding her child three weeks after birth reported that she stopped because she realised that the baby was using the breast *"for comfort not for feeding",* implying that there could be a clear difference between these two functions for a new-born baby.

One informant's (male) partner who was present in one of the interviews suggested that men feel embarrassed with the sight of a breast-feeding woman because they are afraid of sexual arousal. He also suggested that it was necessary to separate the breast as a sexual organ from its feeding function. The points he raised helped me to understand the issue in terms of the bodily boundaries experienced within a culture.

In situations where strict body boundaries are the rule, ideas of invasion and privacy are quite relevant. People "staring" for instance is perceived as an invasion of the body's boundaries.

In the case of a breast feeding woman, the ambiguous condition of the breast as a sexual organ and as a feeding organ brings about embarrassment. In that sense, the distinction between comfort and feeding must be clearly defined and the issue of how much the "baby is getting" becomes crucial. If the baby is put on the breast exclusively to be fed, the amount of milk needs to be measured. Together with that there is the problem of physical contact between the baby's mouth and the mother's breast that can also be felt as an invasion to the individual body. Considering that my informants' husbands did not really "help" to feed the baby, I suggest the husband's role - the husband's help - is to make sure that his wife's individual bodily boundaries are safeguarded.

Finally what I am suggesting is that the notion of an individual body with clear and strict boundaries, coincident with the boundaries of the physical body (identified with the biomedical body) are likely to be related to feelings of invasion in different degrees. This is certainly the case of the interpretation of an unwilling sexual intercourse as in the case of rape because there is a violation of what the victims consider their "private" body. It may as well account for difficulties in breast feeding, where there is also a type of invasion of the boundaries - caused by the physical contact between the baby's mouth and the mother's breast and/or by people staring - which women find very difficult to cope with.

As for the women who were involved with the SELMGP I understand that one of the challenges of the home birth experience is to bring about a more relaxed experience of body boundaries, even if temporary. This is not to say that home births are less structured events where anything could happen. On the contrary, they are highly structured events but the type of structure they impose is based on specific cultural ideas of a "natural" body and the way it functions. It is thus easier for the middle class educated group who

have been exposed to those ideas to take the task of breast feeding as part of the natural body functions.[57]

Graphic images of the reproductive system

Following the same kind of research procedure I did in Brazil I asked my British informants to make a drawing of the reproductive system in an empty silhouette. It seemed non-problematic for my informants to repeat the biomedical model of the body and general information about the reproductive system they said they had learned at home, in school, with friends or through the media. There were very small differences between the working class and middle class groups' drawings. The main difference being that middle class educated women tended to make the drawings slightly more detailed, especially in the men's silhouettes.

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[57] It seems relevant to highlight that the middle class educated group who took on ideas of a more natural body did not change the way they perceive their bodies. However, the model of the natural body presented by the home birth ideology actually gives the sense of a more relaxed experience. Women report they have enjoyed being allowed to have a bath during a long labour, or to a drink, eat, or even make sounds and body movements they would otherwise avoid in hospital. Women experience home birth as a more flexible event because their point of reference is a hospital birth seen by them as a very restricting experience.

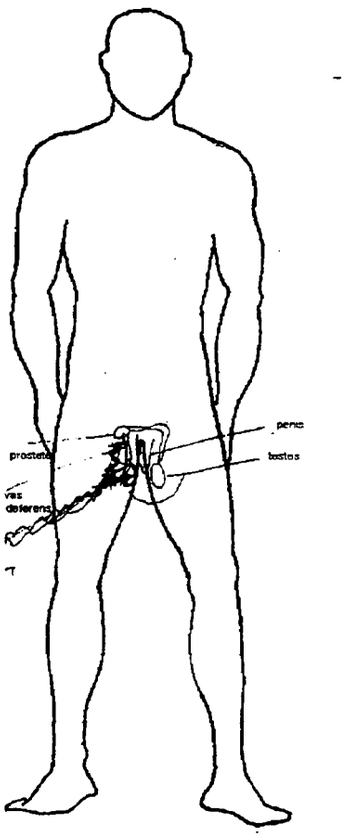

Figure 38: British informant's drawing - detailed male reproductive organs

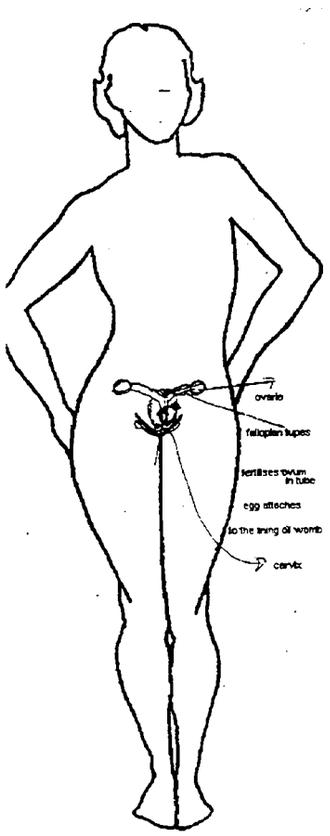

Figure 39: British informant's drawing - detailed female reproductive organs

The above figures are drawings of male and female reproductive systems made by two different middle class educated informants. In the figures where the informants' handwriting came out too faded in the scanned pictures, I have typed them over. Nevertheless the words correspond exactly to what the informants have written in the original drawing.

Drawing of the male organs included prostate, vas deferens, in a scale and location fairly consistent with the biomedical model.

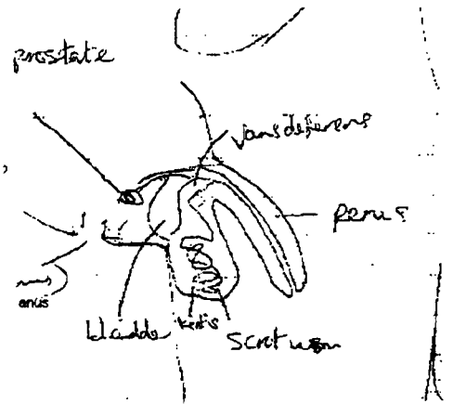

Figure 40: British informant's drawing - separate picture showing details of male reproductive organs by middle-class educated informant

Comparatively the drawings of the working class women were more schematic, showing basically the ovaries, the Fallopian tubes, the uterus and the vagina.

In general the explanations given by all informants about the functioning of the reproductive system used simple biological terms: semen meets the egg in the Fallopian tubes; egg if fertilised attaches to the lining of the womb developing into an embryo.

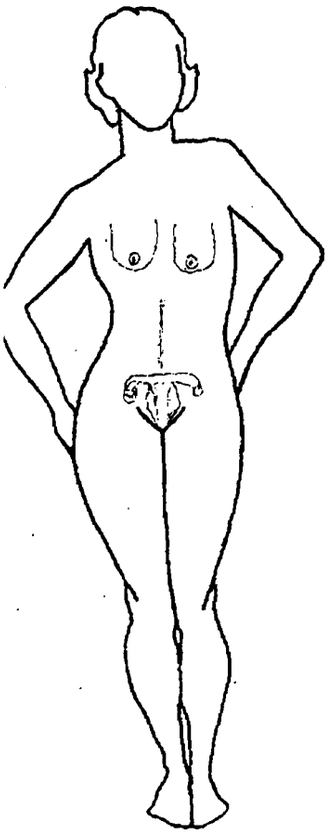

Figure 41: British informant's drawing - basic picture made by working class informant (A)

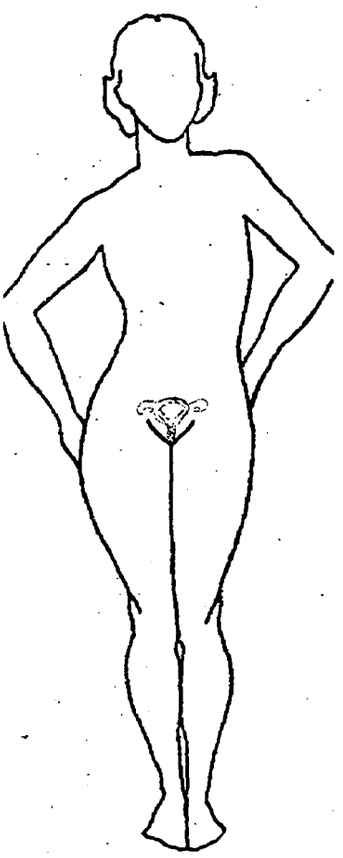

Figure 42: British informant's drawing: basic model made by working class informant (B)

Figures 41 and 42 are drawings of the reproductive system made by working class women consistent with the biomedical image.

Another aspect related to the drawings of the female reproductive system in general - middle class and working class women - is the marked presence of the vagina. Next figure is an example of that.

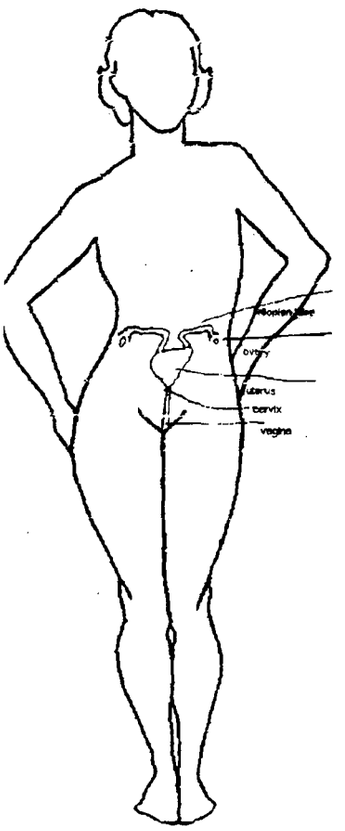

Figure 43: British informant's drawing - large size vagina

McCormack and Draper (1987) whose research has been described in chapter 1, have also observed the marked distinction between graphic images of the reproductive system in drawings made by Jamaican women and British and American university students. Their data showed that the latter "drew vaginas of large size, often in considerable detail, but had rather rudimentary representations of the uterus and the rest of the reproductive system", while in the Jamaican women's drawings the vagina was represented as a small rudimentary line. (McCormack and Dapper 1987: 146-7)

Ardener (1987), working specifically on iconography of the vagina refers to two systems one in relation to a symbolic sexual body, the other to a western, medical body. According to her,

" (...) the classification of these two systems is, of course, not identical. The boundaries of "the vagina" in the symbolic body seem to extend further than in the medical body to include, for instance, the vulva. Indeed this seems to be the primary reference in many cases. The vagina in the medical body seems only to be the hidden recesses of the wider category label "vagina" in the sexual body, and it is interesting that it is this hidden recess that seems the most potent symbol. The womb incidentally, is distinguished in the sexual body, and its symbolic force seems to be quite different." (Ardener 1987:123)

What McCormack and Draper, and Ardener are saying is that, to a certain extent what women represent in their drawings of the vagina is related to their phenomenological experience, which does not seem relevant to the medical system. But when it comes to comparative studies about sexuality the problem becomes a bit more complex. To say that Jamaicans for example, do not make clear representations of the vagina may imply that the organ is not phenomenologically relevant for them. In that same line the next step would be to assume that, "western" women are sexual beings while "non-westerns" are reproductive beings, which in my understanding is a very simplistic view of models of the body.

I agree with Ardener on the assumption that the symbolic sexual body is different from the western medical body. However I must add that the symbolic sexual body is not an independent model based on sensorial experience. Graphic images of the reproductive system are, to a large extent, learned in contact with biomedicine, even though they keep the phenomenological-cultural experience as a background reference.

"I knew the basics": Information about reproduction and menstruation

I asked my British informants how they had been informed about menstruation and the reproductive system. In general there were not many differences in their answers. They all mentioned sex education or science classes at school and some explanation given at home by their mothers or older sisters. Most of them commented about the detached way they were informed, through books, films or diagrams. In fact some informants comment they had very little explanation when they got their first menstrual period, as seen in the following report by one informant in the working class group living in council estates:

"It was Christmas I was putting some decoration up the Christmas tree. I felt blood running down my leg. I went to the toilet and called my mum. I told her my bum was bleeding. She didn't explain anything . She gave me a towel and said: 'all girls get it. This is a plaster, put it on'." (I., 30 years old)

It is not my intention to discuss the way parents educate their daughters in relation to the functioning of their bodies, just to point out that most of my informants objected to the way they were informed in the sense that the explanations were exclusively biological. However, later in the interviews when I asked the same informants how they would explain the reproductive process to a child or teenager, most of them replied they would show them books and diagrams, basically reproducing the way they had been taught. Only two informants said they would also speak about partnership, caring and love, putting reproduction in the context of a relationship.

In relation to the brief and detached information some of the women received when they were young girls, it is not surprising that some of them describe the experience of their first menstrual period as a shock, surrounded

by remarkable embarrassment. This data is consistent with cross cultural studies about the menarche. (Martin 1987; Delaney, Luthon and Toth 1976) Among my informants there were some cases when the embarrassment was such that the informants did not tell their mothers they had the menarche, as seen in the following reports:

"I was shocked. I thought I had wet my knickers. I was scared thinking it was not normal. I thought maybe if I kept cleaning, like a cut in the skin, the bleeding would stop (...) I didn't tell anybody until my second period." (S., 28 years old, had the menarche at 13)

"I didn't tell my mum. I told my sister who explained me the biological facts". (K., 32 years old, had the menarche at 13)

Other informants, especially those who had been exposed to some information about menstruation before they had their first period, said they *"knew the basics"*, or that they *"knew what to expect"*.

Some of the points raised here, especially about menstruation have been discussed in much more detail in chapter 4 in relation to the Brazilian shantytown groups. I do not want to repeat the arguments presented there, just to point out the similarity of the phenomenological experience of the menarche where ideas of shock, fear, and embarrassment are evident. This first experience is later reinterpreted in the light of new information received by women, possibly through women. (McCormack 1987, Victora 1991) I suggest that is a crucial time in the female life cycle for the embodiment of an specific model of the body and the reproductive system. Needless to say that such "embodiment" is not static, it is an on-going process, that changes over time and experiences, but always within certain acceptable cultural models.

The idea that they *"knew the basics"*, means that they understood the biological process of menstruation and even used the biological terms to express it, identified with the "failed reproduction" view (Martin1987) -

discussed in chapter 4. But it was also clear that *"the basics"* meant a biomedical reference to the experience, like a background, not the experience itself.

For instance, the notion that menstruation is the result of failed reproduction can be responsible for ideas of "waste" associated with menstrual blood although this kind of verbal statement was not recurrent. The pollution represented by menstrual blood was mostly presented in their accounts of avoidance of physical contact either with sexual partners or with themselves. Most of my informants highlighted that during menstruation (1) their partners went completely off them,[58] or (2) they did not feel like having sexual contact with anybody. In the words of one of my informants:

"My husband goes completely off me when I get my period." (D., 30 years old)

"My husband has a terrible attitude towards menstruation" (K., 32 years old)

They did not literally express any repugnance towards menstrual blood as the Brazilian shantytown informants did, but most of them spontaneously recalled the time when they started to use tampons instead of sanitary towels. The use of tampons allows less contact with menstrual blood because it is remains inside the body. In that case the menstrual only becomes "visible" when the individual spontaneously decides. For this reason it gives the woman a feeling of "liberation" as on informant put it:

"If you use lillets, then: liberation!" (S., 28 years old)

Perhaps when the informants stress that there was a significant change when they started to use tampons they mean that through that experience they have reinterpreted the meanings of menstruation. Even

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[58] For a detailed account of men's views about menstruation in Britain see Laws (1990).

those who had been "shocked" when they had the menarche, comment on the changed perception when they stopped using sanitary towels, described as "huge", uncomfortable and potentially "visible" through their clothes. Besides, the avoidance of physical contact with menstrual blood allows a more positive view of the whole process. In this case, where the phenomenological experiences of sight, touch and smell of menstrual blood are blurred by the use of tampons that are kept mostly hidden inside the body, the "basics" of the process remain an important source of reference.

The only reported limitations brought about by the menstrual period are sexual intercourse and swimming. A symbolic analysis of these limitations must address the fact that in both situations women are exposing their bodies more openly and there is an increased risk of exposing menstrual blood to people other them themselves. There is also the issue of contact with other fluids - semen and water - even though in the case of the swimming pool water, contact with the internal body is only symbolically possible.

Within the *"basics",* consisting mainly of the combination of the four elements: (1) sexual intercourse; (2) ovulation; (3) menstruation; (4) conception where the likely possibilities are that:

a. (1)+ (2) = (4) or

b. (1) - (2) = (3)

"Hormones" remain an important element not as drive for the whole process - as seen in a more detailed biomedical discourse - but as a causality factor for behaviour associated with the reproductive process. This in particular is the case of mood swings and more aggressive behaviour during Pre Menstrual Tension - PMT - and pregnancy sickness.

Pregnancy sickness - presence or absence - has also been associated with a female family trait expressed in terms of "it runs in the family" with examples of mothers and older sisters who have also suffered from the problem. In any case, hormones and hereditary traits are both "invisible" elements that are taken by the informants as part of the biomedical rationale.

Mothers and older sisters are extremely important references in female issues. It struck me that only one informant in the whole British study made a drawing that did not present any the basic trio - ovaries, womb, Fallopian tubes - but included just face, breasts and pubic hair. She was also different from the others because she said she did not know how to explain the functioning of the body and if she ever was in a situation she had to explain, she would ask her husband to do it. Looking at her life story I realised that she was brought up exclusively by her father since her mother walked out on them when she was 3 years old. Perhaps the reason for that relies on the fact that most of the information about the female reproductive function is passed on by women, usually mothers, unless there is a particular interest in studying the female bodily processes, which did not seem the case with that informant.

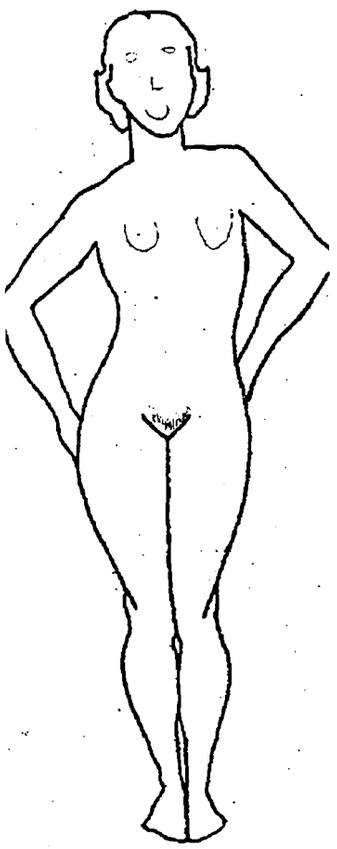

Figure 44: British informant's drawing - unusual model among British women

The biomedical model that in general lines makes up what my informants understand as the "basics" are a very important reference in their

own models of the reproductive system. But they are not important as a reference because they are the biomedical model, but because that is what their mothers, older sisters and teachers tell them since early age. That is not to say that they do not re-interpret the meanings of certain biological notions according to experience. It means that the bodily experience exists within a cultural frame, that in this case makes reference to the principles of reproduction as stated by biomedicine.

Criticism and images of the body

Perhaps the most recurrent complaint, observed in all interviews in all groups, was against the NHS and the way medical consultations were carried out by most GPs In part the criticism came up during the interviews because the women were well informed of the fact that I was doing a research about different views of the body in relation to the biomedical view. They had previously received an information sheet (and a written consent form from Hillingdon Hospital patients) where there was a brief explanation of my aims, and could have been induced to speak about that by knowing of my interest about the differences. It was possible to distinguish different types of criticism, some directed specifically against the doctors and others against a more general level of "the system". At first sight it seemed to me that the criticism against biomedical practice necessarily reflects disagreement with biomedical principles, but this is not always the case. Criticism refers to the possibility to question established power relations. For example, among the impoverished informants in the Brazilian shantytowns, where the images of the body are clearly different from the biomedical model, there was less criticism of biomedical practice than among the British informants.

The main criticism here referred to the quality and length of consultations, and misdiagnostics. As seen in the reports below (followed by my comment on them):

- *"I can't really understand the doctor"* . The women stressed they could not understand what the doctors were saying because (1) their language is too medicalized; (2) they are from a different ethnic origin (especially Indian).

- *"I go in and out in a minute".* The women complained that the consultations were too quick.

- *"I feel I am bothering him".* They think doctors are not interested in their patients.

- *"I feel I am wasting my time".* GPs do not listen to what they are saying nor do they believe they know what their problem is.

In general what the informants wanted was a more sympathetic, caring approach. Someone who listens and understands them, someone who has more time to spend with them. (Frankenberg 1992; Pritchard 1992) This is quite evident in the home birth experiences, where the figure of the midwife is crucial for the success story. The fact that the birth happens at home not in a hospital ends up being much less important than the fact they had their own midwife. All of my informants who enrolled with the SELMGP stressed the fact that having their own midwife made all the difference. The way they refer to their "personal" midwife is very distinct from the way they refer to other health professionals. They often refer to them as:

"Someone I can call in the middle of the night."

" Someone who was there for me when I needed."

" Someone who came to see me twice a day for 10 days after delivery."

" Someone who helped me to start breast-feeding."

Some informants proudly mentioned that while they went to have a bath after a home birth, their midwives cleared up the room where they had delivered the baby, others cooked a meal, or made sandwiches for them to eat, behaving in such a distinct way from other health professionals. At the

same time the ones who had to go into hospital because of possible complications praised the midwife's ability to diagnose a possible problem and act appropriately at the right moment - which in this case means take them to hospital - stressing their biomedical competence.

This adds to the point that even if the informants criticise biomedicine and welcome a friendlier health professional, their notion of the body is fundamentally based on biomedical principles. I go further to suggest that even those informants who are highly critical of the way their are treated by their GPs do not object to all kinds of typically "objective" medical approach, as seen in the following report by an informant in the "home-birth group" who had some blood loss during the pregnancy and went to hospital for a scan with a woman doctor:

" The woman was great, very professional. It was very impersonal, and at that moment that was just what I wanted. She heard the baby's heart beat and I started crying. She said: 'Don't move your stomach'. And that was just what it was, a stomach. "

Along the development of the research I often wondered how the informants class experience - middle class, educated, working class who owned their houses and working class living in council flats - influenced their views of the body. Based on my previous research experience in Brazil, where the further down in the socio-economic spectrum people are, the less biomedical their views of the body and the reproductive system tend to be. I looked for these differences here as well. I took the two informants whose life history seems to be further down is the working class spectrum and compared their views of the body and the reproductive system with other informants from the other two groups. I will first summarise their life story and then comment on their and the others views.

The story of I.

I. is 30 years old and lives in a two bedroom flat in a large council estate in south east London, with her husband and three children, G. (9 years old), B. (3 years old) and R. (1 year old).

She is the oldest daughter of a family of 2 older brothers and 2 younger sisters. She recalls a not very happy childhood due to a series of difficulties she had with her mother whom she blames for many of her problems, including a depressive episode and an attempted suicide. In her words: "Since 1980 I've been in that. Me and my mum don't get along. My mother used to beat me. I was raped by an uncle and even after I told her she didn't believe me and continued to let him come in the house. Everything built up until 1991 when I took an overdose after being very depressed. I just wanted to finish with everything. "

According to I., her mother was very cruel. She could not say anything but she got beaten. Once her mother made her sit on the bedroom's floor naked in the winter with all the windows opened. She also told me she could not read very well when she was a child so, when her father was out, her mother used to wake her up at 2 A.M. to make her read. Although they had electricity, she used to light a candle and if she did not read properly her mother would burn her with candle wax. She recalls going to school by bus, and while waiting for the bus in the cold weather, placing two coins on a cold place, and when they were very cold, put them on her eyes to lower the swelling caused by crying at night.

As soon as possible she applied for income support, and lived restricted to her bedroom upstairs at her mother's house. Every time she went downstairs her mother would not move, or talk to her. If she opened the cupboard to get something to eat, her mother would give her funny looks.

At 20 she fell pregnant the first time while still living with her parents. After the baby was born she moved in with G.'s father. He beat her and abused her, she said. Behind his back she had applied for a council flat. She compares her situation with the character in a television soap opera - Brookside - who stabbed her partner to death because he abused and beat her. She said she could understand why she did it.

After she moved away he kept threatening her until he was given an injunction not to come near her house. Even though he has moved near her house and sends his friends around. Because of that she has recently put her name down to move to another place. Her husband also wants to move.

It was after she moved to the council flat that she attempted suicide. She was found by her boyfriend - now her husband - who took her to hospital. After that he moved in with her and many things in her life changed. She says her husband is different , a good man, a good father to all her children.

I. and her boyfriend got married after she had her second child (his first). There are pictures of the wedding on the living room wall.

During one of the interviews we had, I. received the visit of a social worker who came to check on the progress of B., and give her instructions on how to deal with him when he is hyperactive. Several times in our interviews I. mentioned B.'s behaviour and speech difficulties, stressing the ways she had to go about to get him into counselling and into speech therapy.

The story of H.

H. is 26 and grew up in the west part of London. Her mother put her into care, when she was 8. She does not know who her father was. She went to a regular school for some time and later to an special centre because she refused to go to school. She describes it as being like a hotel with other kids.

She tells me her mother lives on her own. She slept with H.'s first husband, but she adds: "I respect her because she gave me birth". She complains that her mother refuses to tell her who her father is. She really wants to know it. All she knows is that he was married and that her mother got pregnant to try to trap him. H. recalled she would be locked in her room while her mother slept with men. She could have 5 men in one day. H said her mother did not have anymore children, and she regrets having had her, so she used to tell H..

She got married at 17 but divorced soon after. The man she married was a minicab driver. He had a new born baby (3 1/2 weeks) that he moved

in with them for her to look after. But she says this man was not willing to support her and kept having other women. One day she found him in bed with one of them with the baby lying at the end of the same bed. She lost her temper, beat them, threw one of them out of the window, and as a result of that she now has a police record. She packed and left to stay with her grandparents. Not long after that her ex-husband got drunk, beat the baby and killed him. She says she never completely got over that. She said he used to be nice, but he changed after marriage.

H. got married again at 19. But her second husband, J. abused her for 4 years. She said she had "Four years of domestic violence". In the interviews she recalled a number of violent episodes she went through, so much that she ended up going to a refuge for battered women.

The refuge team managed to place her in the council flat she presently lives in with her new partner A. whom she "met first for a friend" but who presently represents, together with the place she lives in, security for her.

H. has been undergoing infertility treatment for some time. The pregnancies she had ended up in miscarriages. She interrupted a previous treatment when she divorced her second husband and went back again now that she has a new partner. Unfortunately her new partner also has difficulties in the reproductive area.

It clear in the stories of I. and H. that they rely heavily on specific support agencies such as social work, counselling, besides benefits. Their stories are permeated by psychological arguments that explain their unfortunate fate such as the relationship with their mothers, ideas of "depression", "domestic violence", etc. Apart from that they are quite instructed in the biomedical functioning of their bodies.

H. for example mentions that one of the reasons she wants to know her father is to ask him about hereditary health conditions she has that must have come from his side. She described conditions such as talipes, eczema, kidney problems and asthma which she was sure were not found in her mother's family. Besides, her and her husband's infertility problems have also

been described to me in medical and psychological terms, indicating major exposition and reliance in biomedicine.

To say that they agree with the biomedical explanation - biomedical principles - in relation to their conditions is not the same as to say that they agree with the biomedical practice. They are very critical of certain biomedical procedures and will not expose themselves to practices they do not agree. In the medical jargon this type of behaviour has been called patient's "non-compliance", a term that I would rather avoid at the moment because of its physician oriented characteristics, not very appropriate for a research that deals mainly with lay perspectives.[59]

One example of that is a situation lived by I.. She told me that because her sister had had a Down's Syndrome child, they wanted her to have an amniocentesis test. She refused to have it because it could increase the risk of miscarriage. She suffered pressure, according to her. She had a scan, and they found that the baby had a mark on her head, and used this as an argument to force her to agree to have an amniocentesis. She didn't agree, and was very upset because she suspects they were actually doing a research and she was being used as guinea pig.

In another occasion , she accused the GP of forcing her to accept contraception. In her words: *"When you go back to the GP after delivering a baby, they try to pressure you to get some contraception. It is not just informing you, it is pressure."*

When I point out that they believe in biomedicine but they protest against certain practices, I am not saying that there is ambiguity in their procedure. What I see is that there is an attempt to "negotiate" the practice, once the diagnostic has been agreed.

I., for example showed me a written "birth plan" for one of her children's birth, stressing the things she wanted and the ones she did not - such as anaesthetics - from hospital staff. She carefully kept the birth plan in

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[59] Frankenberg (1995) suggests the term "non-compliance" used by practitioners of biomedicine is almost abusive because it implies patients' ignorance, irresponsibility, irrationality and moral blameworthiness. For a distinct aproach to non-compliaance see Hunt, Jordan, Irwin and Browner (1989). For the discussion about non-compliance, doctor-patient communicaction in relation to lay and biomedical explanatory models, see Kleiman 1978b, Helman 1990.

a plastic bag, together with the photographs of the child, as an important component of her "negotiation" with the hospital. In my view, the birth plan is a proof that she refused to hand in the control of her body in labour to the hospital staff. In this case everything went accordingly to her terms of the negotiation.

In the story of H. the negotiation of medical practice is also evident in different ways. In her latest appointment at the hospital she was told that she needed an operation to increase her chances of conceiving, but they could not operate on her because she was overweight. She was obviously upset because she claims that her overweight was partly due to medications she had been prescribed previously either to increase ovulation (Clomid) and for asthma (steroids). Nevertheless she agreed to lose weight and told me she would try to get other medication that could help her to slim, this time with her GP.

Discussion

In chapter 3 I have presented some of the similarities I found within the British groups studied, pointing out that in their recollection of their life histories my informants make reference to three life phases, which I have classified as: (1) a stable period living with their parents while still going to school; (2) an unstable period which may include leaving home, travelling abroad or starting to work; and (3) another stable period after marriage. In the present chapter I focused on the diversities observed within those background similarities showing that another level of diversity within homogeneity may still be identified regarding individual *habituses* and class *habituses*. I took my informants' experiences of education, work, relationship with family, marriages and pregnancies pointing out how they differ in the discrete groups.

The movement from what is common to all groups to what is specific of each group or individual, and vice-versa was exactly what has permitted me to see how their specific class experiences are based on an overall experience of time and space as described earlier.

In my view, the overwhelming presence of the biomedical model based on universal regularities in my informants' accounts fit in that twofold movement. Even though my informants have different bodily experiences which are more immediately related to their individual and class *habtuses* their experience of quite rigid body boundaries reflect a more rigid embodied notion of time and space.

Chapter Seven : Conclusion

"The Balinese have their fantasies of bodily disintegration, but as one watches an adult Balinese, one is impressed with a sense of the whole body, with the way in which the tip of the finger is an integrated part of the whole. Watching a member of our own culture, one receives quite a different impression; the body appears as a trunk and the arms and legs as appendages which are never quite in unison with it, Peoples differ strikingly in the emphases implicit in their handling of the boy; some think of the human body as a trunk, with orifices at both ends, while others think of the trunk merely a central element in a unified body. But the human infant at birth brings to his cultural experience an almost uncoordinated body and a series of orifices by which he initially meets and interprets the world. What his primary interpretation will be and whether this interpretation will persist, must depend largely upon the way in which those about him handle him." Margaret Mead - The Balinese Character

Bodies and culture

In the last part of this thesis my purpose is to bring together some of the findings of the research and suggest ways of thinking about them. Still it is clear to me that this "conclusion" does not represent that this is a finished work or that I have conclusively addressed all the possible alternatives within the present debate.

The guiding line of the thesis has been the argument that the categories we use to "know" our bodies are the same categories embodied through our experiences of space, time and domestic organisation within a specific habitus. This argument originated from the two case studies carried out in Britain and in Brazil where I observed a remarkable distinction

between the way my informants experience time, space and domestic organisation in each case. I have also pointed out in chapters 4, 5 and 6 several differences in the way they experience their bodies, their reproductive systems and their body boundaries which do not necessarily coincide with what I defined as the biomedical body in the beginning of this book.

As the ground of culture, bodies do not have objective boundaries since culture does not. It is not possible to define where a culture starts and where it ends for the simple fact that it is not an object, but an experience, a process of experiencing.

One of the positive aspects of conceiving bodies and cultures as experiences is that it allows me to get out of the idea that the "cultures" I studied are homogeneous entities, strait jackets where people either fit or do not fit. This was very clear in both studies where I observed many inter-cultural differences - mainly described in chapters 4 and 5, and 6 - indicating that cultures are rather processes in a range of possibilities than static realities. Such a view also makes it possible to understand that there is no contradiction for instance in the same person perceiving the same thing (such as their reproductive systems) in different ways. Even in the same context it is possible to experience the same event differently depending on the circumstances. Perhaps the most accurate way to define my approach to culture in the present research is as *embodied experiences within a range of possibilities*. The possibilities are not infinite in my view, rather they belong in a certain repertoire.

Within such conceptualisation of culture, the challenge has been to produce ethnographic descriptions clear and coherent enough to present the reader the facts that guided my interpretations without sounding normative as if the situations described were the only immutable truth. Perhaps the most difficult task has been to take the issue of body boundaries in a comparative way, focusing on intra-cultural similarities but not ignoring inter-cultural variations.

Embodiment of cultural experiences and knowledge about the reproductive system

To complete the present exposition I wish to recall some aspects of the embodied cultural experiences of my informants in both case studies and propose interpretations of how they come up in the way people experience their reproductive system.

I have argued in chapter 5 (The Brazilian study: the male world) that risk is not an odd event, a fear that something may not go as expected. Rather risk is an ordinary part of the lived reality. Violence in the shantytowns and threats to personal and family safety reinforce the implicit risk involved in the simple fact of being alive. I realised that one way my informants dealt with it was to experience violence as a multifaceted event, therefore negotiable according to the circumstances. In the Brazilian case study, the practical aspects of living in a shantytown where the struggle for money to supply basic needs is a problem literally dealt with on a daily basis strengthen ideas of risk and the sense that "anything can happen."

At the level of the reproductive body, risk is also an embodied category. Risk of pregnancy, for example, is an intrinsic part of being an adult female. It is always there, no matter what contraceptive practices are adopted. This seems to be associated with an understanding of the functioning of the body also as a place where "anything can happen". As with any other risk, pregnancy is also socially negotiable. It is the result of this negotiation that determines whether the outcome of a pregnancy is a child or a termination.

Still regarding the shantytown context and the idea that "anything can happen" I wish to take people's difficulties in making long term plans to illustrate the relationship between the embodiment of spatio/temporal experiences and knowledge about the reproductive system. I do not mean that people are unable to make plans at all, or that they do not have dreams they wish to fulfil, only that it is very difficult to make long term plans in a context where everything changes very quickly. As described in chapter 3, in

the dynamics of the shantytowns even short term plans are likely to be changed. For an outsider it may seem that people's positions are very variable. This is easily translated and qualified in terms such as "shantytown people are unpredictable, they do not know what they want".

I recall my first contact with one of the community health centres. The health professionals reported that they could not understand why some women patients who had come in for contraceptive advice saying they were absolutely sure they did not want to have anymore children came back pregnant again just a couple months after having being prescribed contraceptives. I observed that the pregnancies that follow such events are often qualified as "unwanted" by professionals who claim to have the right to intervene (medical staff, social workers, politicians, demographers, journalists) and the children born in those circumstances are therefore also classified as "unwanted" children. These professionals obviously fail to understand the difference between events that are "unwanted" and those that are "unplanned", especially in a context where planning is hardly possible. My point is that the fluidity observed in the shantytowns is an integral part of people's lives, so much that they do not perceive the changes in their environment as quick, because the fluidity of space and the flexibility of time are integral parts of their living experiences. In fact I believe that this is what makes life in the shantytowns possible, reasonable, absolutely "normal".

I have argued in the beginning of this thesis that one of these different ways of knowing our bodies is through our bodily experiences. In many reports the Brazilian shantytown informants reported their bodily experiences as the main source of knowledge, for example, the "emic" organ the Body's Mother (Mae do Corpo) which is experienced primarily through the body. This is not to say that it is not a cultural experience as well, since its meanings are given within a cultural repertoire. In that sense the idea that women have an organ that changes place - the Body's Mother is described as an organ that moves from side to side in the woman's body - can only be conceived within an embodied notion of fluid space.

The Body's Mother, according to the informants is "something" that "looks after the baby before it is born", and "it looks for the baby after delivery" which reflects cultural notions of space occupation and correlated ideas about how people should dwell. As I have observed in a previous chapter people in the shantytowns do not think one should be alone, those who live on their own are pitied. This is even more clear in the case of babies who are seen as tiny and defenceless creatures. The Body's Mother is there to keep the baby company. The Body's Mother as a phenomenological experience is a bodily produced knowledge based on embodied (cultural) notions since it is the body that enables the perceptual experience. It was difficult for the informants to place an organ with such characteristics in the silhouette because it is a moving organ and the drawing represents an static body. Besides, the silhouette represented a biomedical knowledge not a bodily knowledge.

The arguments that we know our bodies in different ways and that one of the dimensions of knowledge production takes the body as its principal source of information is also valid for all the groups studied. The difference between the groups is not on the means of experiencing but in what kind of embodied experiences they have.

In the British case study I have observed that in comparison with the Brazilian shantytowns the informants' experiences of space and time are much more regular and stable, where making long term plans is a common and valuable practice. Through the study of the similarities within the diversity observed in the different British groups studied, it was clear that my informants had a relatively linear sequence of life events lived in a quite fixed household composition based exclusively on the nuclear family. These characteristics are consistent with a more rigid space organisation both in the household and in the individual body and with ideas of privacy.

Through the British informants' recall of rape experiences and breast-feeding practices, I suggested that their experience of a private body attend to clear and strict boundaries and therefore are more likely to be related to feelings of invasion. In such perception of body boundaries there is an

association between the person's body, understood as private, with the actual physical body, in the sense that whatever touches/invades the physical body also touches/invades the entire person. Because of their structural similarities, the physical body and the biomedical body are taken as the same experience. This suggests that where the notion of private body is prevalent, biomedical ideas about the body are more consistent.

But, as I observed earlier, this is not to say that body boundaries are immutable shields that protect from the outside world or act as containers for the self. The interviews and observations among women who attended the SELMGP, and who had been exposed to ideas about the functions of the "natural body" suggest that through the home-birth and breast-feeding experiences they were able to experience - at least temporarily - more relaxed body boundaries. The analysis of my informants' reports about home birth experience indicate that the "natural body" is the biomedical body with slightly more relaxed boundaries.

What seems relevant for the purposes of this final presentation is that the British informants embodied cultural experiences of a more rigid space organisation are absolutely consistent with their perceptions of the private body. My point is that the private body through its boundaries is associated with the physical body which in its turn is equated with the biomedical body. This could be the reason why the British informants seemed more "knowledgeable" about the biomedical model of the reproductive system than the Brazilian informants. It is not because the British informants are more able to learn the biomedical model, it is because the biomedical model makes more sense in their range of life experiences. Bodily experiences exists within a cultural frame, that in this case makes reference to the principles of reproduction as stated by biomedicine.

It is not surprising that the British informants' reports about the functioning of the reproductive system are very much the transcript of what the biomedical manuals contain. That is what they called "the basics" which consist of an important reference to their bodily experiences. There were obviously relevant peculiarities based on my informants' experiences since

they also take their bodies as a source of knowledge production (see chapter 6). But in spite of that even those informants who were very critical about biomedical practice still held very biomedical views of the functioning of the body. Their criticism did not speak of a different model just at a more humanised practice.

This takes us back to beginning of this last part where I pointed out that the difference between the Brazilian and British groups lie on the type of embodied experiences they have.

May I return to the beginning...

I have suggested in the beginning of this thesis that there are different ways of knowing the body, which I have classified for analytic purposes, in three dimensions of knowledge production.

To recapitulate, the first one consists of a graphic dimension. Working with body image I have observed that part of what people do, when requested to make a drawing of their bodies and/or internal organs, is to represent the biological view of the body, as shown in books, magazines and television. Most of the female Brazilian informants and British informants have pictured the female internal organs quite like the biomedical model. The Brazilian male informants who have been much less exposed to the biomedical model, mostly refused to make a drawing indicating that as a research technique the drawing in a ready made silhouette elicits primarily the biomedical model. The men who agreed to make a drawing produced a picture of the external sexual organs pointing out the relevance of embodied gender experiences in the recognition of bodily processes.

The second dimension of knowledge production refers to an experiential knowledge, a sort of learning accomplished by the body and through the body. This was clear through my Brazilian informants' explanations about the reproductive system which most of the time were only loosely related to the biomedical model. Many informants mentioned that each body functions

differently, because "it" feels differently and because, in the life course of a person, "it" has lived different experiences. The meanings conveyed to the functioning of organs were sometimes based on the physical perception of these organs (i.e. the Body's Mother exists not because women think of it but because women can feel it). At the fundamental level it also refers to the primacy of the sensorial experience in a concept of culture as embodied experiences within a range of cultural alternatives. The embodiment of specific notions of space and time are related to different experiences of the body.

Following that same line I suggest that the reason why the British informants account for their bodily experiences in a similar way to the biomedical model is because they actually experience a more rigid space organisation and a much stable cycle of life events (especially if compared with the Brazilian shantytown life). There is a correspondence between those experiences and their experiences of more rigid body boundaries, in a model that resembles the biomedical body.

The third dimension I suggested is a social dimension, through which people make sense of their bodily phenomena. It is in contact with other people who share the same cultural references that we "learn" to decipher the signs of our bodily experiences. The social dimension accounts for the legitimisation of body sensations within a cultural repertoire as well as for the negotiation of meanings, of attitudes, etc., between people involved in the same event. In the case of the British study the negotiated relevance of the distinction between the breast as a sexual organ and its feeding function is a good example of social meanings associated with a bodily organ. These meanings incorporated by women made the experience of breast-feeding "difficult to cope with" and therefore legitimately abandoned.

In the case of the Brazilian study I recall the negotiation of pregnancy as one relevant example of the social dimension of knowledge production. The physical condition of menstrual cessation is only recognised as pregnancy if there is someone to take responsibility for the (pregnant) woman and the child she bears.

This initial and final point about knowledge production projects this issue into the political domain rather than the academic one. In fact I believe this is what motivated this project in the first place. Shantytowns have often been described as surrealistic, crowded, promiscuous places, adjectives that reflect not just differences in conceiving spatio-temporal experiences but also profound ethnocentrism since mere differences take on negative values. Shantytown people's re-evaluations of bodily meanings against new experiences promoted by the dynamics of their lives are also target of criticism by conservative doctors, politicians, social workers involved in family planning strategies among the urban poor. This is because these re-evaluations are seen as structural incoherence, rather than conjectural changes resulting from an experience of fluidity giving way to another set of qualifications such as "shantytown people are unintelligent, they do not have proper knowledge about their bodies."

Failure to recognise that there are different ways of knowing our bodies limits the whole process of reproduction to the common sense notion that knowledge about the body is a commodity which people acquire in contact with educational agents (school, biomedicine). As a result of this supposed lack of knowledge they claim that poor people have "unwanted" children. I believe that it is these views that lie behind crimes such as killing of street children and mass sterilisation in Brazil.

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