Sexuality Education, Contraceptive Use & Sexual Empowerment in Vila California, São Paulo, Brazil

by

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Introduction

Brazil is perceived as a sensuous country—their icon is a bikini-clad woman dancing the samba during Carnaval. Parker (1991) states that sexuality is the self-interpretation of Brazilian society. Scheper-Hughes (1992) writes, “sexual vitality is...a variant of the ‘autoethnography’ of Nordestinos¹, who do project themselves to each other and to outsiders as an erotic and intensely sensual, as well as sexual, people” (Parker 1991: 164). Quintas (1986) found that malnourished women in a shantytown of Recife expressed their vivacity through sex. Brazil’s sexually explicit telenovelas are watched all over the world, which continue to feed the perception of Brazilian sensuality.

Brazil underwent a dramatic fertility decline beginning in the 1940s. This fertility decline had reached all classes of society by the 1960s made possible by high levels of abortion at the beginning of the fertility decline and further assisted by high levels of sterilization later (Martine 1996). This fertility decline was prompted by the modernization of the health care sector, the nascent social security system, improved credit policies, the spread of mass media, and extremely high levels of urbanization (Faria 1989, Martine 1996). Demographers began to take note of this decline during the late 1970s when the TFR had falled from 6.0 children in the early 1960s to 2.5 by the mid-1990s.

Yet in spite of the low levels of fertility throughout Brazil, what does the reproductive health profile of women look like at a qualitative level? The framework which I embrace evaluates reproductive health not on acceptability and continuation rates of contraception alone, but in addition, women’s level of empowerment around their sexual and reproductive health. Sexuality is the field in which contraceptive use occurs. “Appraised as belonging to the social domain, sexuality comes to be understood not as a property of isolated individuals, but of social

¹ This research was made possible by a grant from the Ford Foundation and the Fundação Getulio Vargas.
subjects located in networks of meanings and values that shape behavior, desires and fantasies which can be redefined and resignified” (Barbosa 2001: 171).

The most significant advances observed in the area of women’s reproductive health in Brazil have occurred between 1997 and 1998. The union of the federal programs Programa de Assistência Integral à Saúde da Mulher (PAISM) and the Coordenação de Doenças Sexualmente Transmissíveis-AIDS focused greater attention on women’s reproductive health in the era of HIV/AIDS (CNPQ 1999). Passed in August 1998, Law 9.800 standardized and normalized the provision of contraception by Sistema Único de Saúde (SUS), the public health care system which covers all indigent patients. The purchase of contraceptives available to SUS clients was transferred to the municipal level which increased the responsiveness of the organization. Secondly, the ministry of health invested heavily in making sure that the women that most needed reversible methods of contraception obtained them (CNPQ 1999).

In interviews that Barbosa carried out in 1995 in Rio de Janeiro and Recife (Barbosa 1997), she found that sexual pleasure and personal fulfillment are regarded as a right and legitimate aspiration by increasingly broad segments of the female population. Women’s increasingly egalitarian role is equated with a more egalitarian and pleasurable exercise of sexuality. This change in power dynamics was brought about by women’s paid employment. Yet these changes do not call into question their fundamental premise. The normative reference for female sexuality was and remains that it is practised as a conjugal duty, and that pleasure is a man’s right. For the women in her study, sex is tied to affection—including a sexual relationship grounded in commitment which feeds the romantic narrative of sexuality (Giddens 1993, Bozon 1995). Monogamy stands as the idea. On the other hand, however, it is also true that women continue to perceive sex as a channel of communication and a medium of exchange so that it can be practiced without pleasure being the sole or main motivation.

1 Brazilians from the Northeast region of Brazil.
While my study focuses exclusively on women, recent research presented by Oliveira et al. (2001) on middle-class men’s contraceptive attitudes and use in Brazil shows that men consider pregnancy the women’s responsibility and as such, women remain the gatekeepers of contraceptive use. Men are willing to use condoms at the beginning of a relationship but much prefer their partner to be on the pill. This attitude from the males may help explain some of the actions taken by females. Yet it is important to keep in mind that Oliveira et al.’s (2001) research was conducted with middle-class men while my study looked at the situation of lower-class women.

This is an effort to qualify the TFR in Brazil and qualify Martine’s summary of what the statistics can tell us about the fertility transition in this country, lest we think that high levels of modern contraceptive use is all there is to reproductive health and a completed fertility transition. Therefore, to gain a greater understanding of the reality of reproductive health in Brazil, I carried out 28 interviews at a low-income health center in São Paulo, Brazil during 1999. Twenty-two interviews were carried out with health center patients and six were carried out with health center staff members. The topics of the interviews covered sexuality education, contraceptive use, and sexual empowerment—all three of which reside at the crux of fertility decisions and ultimately population growth. My guiding question is, “What is it about these experiences that can inform the social structure regarding sexuality?”

**Description of Health Center**

The health center, *Posto de Saúde Vila California*, is supported with funding from SUS and therefore all the services it provides to its clients are free of charge, as is the medicine it dispenses out of its pharmacy. But of course the accompanying problems are that the supply of doctors does not meet the demand for health care and the pharmacy is frequently out of medicine. The contraceptives distributed by the pharmacy are condoms, birth control pills (Neovilar and Nordete), diaphragms, and IUDs. Anyone who wanted to obtain birth control pills must have an
exam by the gynecologist first. The pharmacy distributes much fewer diaphragms that it does
condoms, pills and IUDs.\(^2\)

The gynecologist is one of the most frequently sought after services at the clinic which
also offers general medicine, dentistry, and pediatrics. Prior to the arrival of the gynecologist,
Dra. Nilma, who joined them in April of 1999, they were without a gynecologist for three years.
She was the only gynecologist on staff.\(^3\) Women traveled long distances to see her. Patients had
to wait approximately two weeks to get in to see the gynecologist once they made an
appointment. Women had to arrive when Dra. Nilma arrived, and then they had to wait their turn.
They were not given a specific appointment within the time the doctor was at the clinic, only an
appointment for a specific day.

Having one gynecologist on staff for four hours a day five days a week is the state
minimum but Dra. Nilma was only at the clinic for 4 days a week. Therefore, this clinic did not
even the state minimum of service at the time I was carrying out my interviews. According to the
Brazilian constitution, women have a right to receive care within the public sector, but in a
national survey carried out, the availability of physicians, especially of gynecologists, was found
to be extremely limited (Formiga et al. 1994). Availability of services was further curtailed
because physicians working for the municipality are paid extremely low salaries, which is an
incentive for them to keep their public sector hours to a minimum. Formiga et al. (1994) found
that instead of attending to 16 patients during a 4 hour clinic session, doctors often saw fewer
than 16 patients, and completed their daily consultations in two hours or less. This hold true for
the clinic I was in. While 16 women were scheduled daily to visit the gynecologist, frequently
not all women would show up. In addition, Dra. Nilma spent on average less than 15 minutes
with a patient, always leaving before the 4 hours of her service were complete. Nevertheless, Dra.

\(^2\) As of 1999, the governmentally approved contraceptive methods were the pill, IUD, barrier methods,
lactational amenhorrea, and periodic abstinence.

\(^3\) At the time that I was ending my interviews at the clinic, in late August, 1999, the health clinic was about
to receive 2 more gynecologists who were both going to be working there full time.
Nilma was perceived to be a progressive doctor. She spent longer with each patient than most public-sector doctors do, she spent more time educating women than most public-sector doctors do, and as a woman, the patients felt more comfortable with her as their gynecologist.

According to the receptionists for the gynecologist, the women who are coming to the gynecologist are coming for the most part because they are pregnant. The second most common reason they come to the clinic is because they are experiencing pain. The other most common reasons for seeking out the gynecologist were pap smears, reproductive organ cancer suspicions, and reproductive organ tumors (which may or may not be cancerous).

HIV is a concern of individuals coming to the clinic. This health center had the ability to run the test for HIV they had to send the result to another lab to have them diagnosed. This health center did not have the resources to treat people with HIV so they would redirect those patients to another public clinic that did have the resources, such as Hospital das Clinicas.

The health center offered one class on family planning which was held once a week. Some of the subjects covered in the family planning class were puberty, gender roles, and how to put on a condom. There was low attendance at the family planning classes. One of the ways that the gynecologist tried to encourage greater attendance was to require that individuals who wanted to receive condoms from the health center pharmacy needed to have attended the family planning workshop. The classes were run by a social worker and the gynecologist would join the class at the end to describe each contraceptive method. The class obtained brochures to distribute to the attendees. These materials were sent to them by the police, but they originated from the government.

The clients who were serviced by this health care center were in the middle to low-income socio-economic bracket.

Methods
I recruited interviewees from the gynecologist’s waiting room. My interviewees range in age from 18 to 49. I selected each health center employee who was able to take the time to talk to me. They ranged in age from 25 years old (the gynecologist) to 60 years of age.

The interview method used in this research was semi-structured interviewing. The questions are challenging. I encourage you to think about how you would answer these questions while you read to the respondents’ answers. Each name of a patient has been replaced by a pseudonym (see Appendix A). Each interview lasted approximately 30 minutes. The interviews were tape recorded and transcribed afterwards by a native Portuguese speaker. All of the translations are my own.

**Results and Discussion**

The three sections of the interview which were done with the patients at the health clinic covered sexuality education, contraceptive use, and sexual empowerment. Numerous prominent themes emerged during the interviews with the patients.

**Sexuality Education**

A study conducted by the *Folha de São Paulo* in ten state capitals in Brazil in 1993 demonstrated that 86% of the 5,076 people interviewed favored the inclusion of sexuality education in the school curriculum. Marta Suplicy writes in an article she wrote in the SIECUS Reporter, “Despite this overwhelming support, or perhaps because of it, only 32% of parents reported that they discuss sexuality with their children. An alarming 50% had never broached the subject of sex with their children” (Suplicy 1994).

I shall address:

1. How did you learn about sexuality?
2. When was the last time you learned something new about sexuality?
3. Where should sexuality education be taught?
4. What do you know now about sexuality that would have been important to know when you were younger?
5. Is virginity important to preserve until marriage?

6. When in a woman’s menstrual cycle is she most likely to become pregnant?

Turning to the first question of, “How did you learn about sexuality?” the most common answer was that the respondent never learned anything. The lack of adequate educational sources available to the interviewees came up again and again in the interviews. What passed for sexuality education was a class at Johnson and Johnson about menstruation; hushed words exchanged with friends who maybe had a little bit more experience; and only among two cases did women learn the most from their parents. No woman stated she learned anything about sex in school.

Almost all women reported growing up in homes where their mothers did not communicate with them about sex. Most women stated that they learned everything they know about sex from their husband. Iliana says, “I learned alone because I was 9 years old when my mom left….Once in a while I asked others, you know? And when it [sex] happened the first time, it happened normally.” Daniela also lost her mother. She says, “No one talked with me about it. My mom died when I was 7 years, you understand?” Mothers are seen as the ones who are expected to teach their daughters, and if mothers are not around, no one else steps in to teach the girls.

One-third of the respondents learned about sexuality by having sex. When I asked Priscila who taught her about sexuality, she says, “No one taught me. I did it [sexual intercourse] to do it, you understand? I didn’t know. I learned doing it.” Elza says, “My mom never said anything.” Marta explains, “When I got married, I had never seen a man naked…so when I got married and I saw it for the first time, for me it was an animal, a monster, something from another world, I was scared by it. I was married for 3 months without wanting to be close to my husband. I talked with an older woman who explained, ‘Child, it’s like this and like this and like this,’ and that’s how I accepted it. This quote illustrates the fear that accompanied many of these women into their sexual discovery because they had inadequate information. It also illustrates the
importance of information; once Marta had the male sexual being explained to her, she was able to accept her husband.

On the question of, ‘When was the last time you learned something new about sex?’ seven of the respondents said they never learned anything new about sex, implicit in this was that they never learned much about sex to begin with. Three respondents said they learned new things periodically from their husbands. Ana states,

Something new? Look…I never talk with anyone, I work in a hotel, ne. I started learning more watching the tapes of the hotel. I didn’t ask anyone questions and no one told me anything, I stay inside the hotel, ne….Only I don’t practice at home [what I learn on the tapes] because my husband could think that I was doing that outside [the house]….Watching the tapes at the hotel is a little rambling, they talk about this thing and that thing, and with that, sex is open.

Since Ana watches the pornographic tapes at the hotel, she has more sexuality information than she is able to let on at home.

Beata and Carla are acknowledging the difference between what learning about sexuality was like in the past—speaking about sexuality was not done—to what learning about sexuality is like today—it is possible to talk to others about it so as to no longer feel isolated. Beata states, “I think that people always have to keep on reading, renovating, ne? Do activities like read, watch TV, get a tape, you know? Attend [events where one learns more about sexuality], talk also, in today’s society, ne? In the past, I was very alone, but today I talk enough, ne? I think it’s important.” Carla states, “In theory, for everyone it’s easy, but in practice, it becomes much more difficult….It’s also the shame, ne? There are lots of women that have shame in asking, in opening up and for this [reason], many of them suffer.” Daniela says, “Há! I don’t remember [the last time I learned something new about sex]. In reality, I need to be learning. I need to be having conversations. I learned just the minimum.”

The respondents were divided about where sexuality education should be taught. Roughly half thought that sexuality education should be taught at home by the mother (and more infrequently by the parents) while the other half believed that sexuality education was more
appropriate to teach sexuality education in school. Ana believes that it is the parent’s responsibility to teach their children about sexuality and she has already taught everything that she deems needs to be taught to her 11 year old daughter. Representing the other viewpoint on this question, Carla says, “I think everyone in the world has the obligation to have a sexuality class. Just as in school, it should be obligated to have material that’s just on sexuality education. Not with biology because then it winds up being very little, ne?’” Gisa, a 43 year old mother of 2 grown children, states, “For someone who is becoming a girl today, she should be educated in the belly of her mother.” She goes on to describe that with 10 years of age, the girl can already “have a head like an adult” so she believes sexuality education should begin with 5 or 6 years of age.

The above examples illustrate a theme spoken of by many women which is the liberalism of sexual values today compared with their childhood.

Generally, the respondents were attempting to raise their children in a more sexually liberal environment than they were raised in themselves—although it can be a struggle. Iliana says, “I think mothers should teach their daughters everything because when girls leave to go into the work, they shouldn’t leave the way I left, without knowing anything.” Katerina says, “My mom never said anything to me. It’s good to start early in the house.” Beata goes on to say,

My eight year old daughter picked [my sexuality book] up and asked, ‘Mom, what’s this?’ Oh my god, look where she’s messing around, because she’s eight years old and she is ready, already, ne? And I said, ‘Look, I don’t believe you grabbed this book.’ I had to explain what it was, I was filled with shame, but I had to explain. I didn’t want to do what my mother did. I wanted to do it differently, ne? Because I think that she, she’s already a girl, she has eight years, and so here in a little bit, if she’s like me, she’ll start menstruating at age 11. Therefore, she has to understand some things. Some, not all, because she’s really young, ne? But I think it’s important.

This shows Beata’s commitment to breaking the silence that surrounded her in the past regarding sexuality. Although it makes her uncomfortable to discuss sexual issues with her daughter, she does it anyway because she is aware of the unhealthiness of denying her daughter than information.
Another theme that steps from inadequate sexuality education is regret at not having learned important information earlier. Interestingly, some of the interviewees lament their earlier chastity. When asked the question, “What do you know now about sexuality that would have been important to know when you were younger?” Carla states, “One thing I did not know in the past was how to have pleasure.” Later in the interview, when asked if she has different views about sex now than she did when she was younger, she answered, “Yes…When I was 15-20, I thought you should not have sexual relations. I thought the affections should stop after kissing…If it was now, in this day and age, I would have gotten to know others. Definitely, because a woman, she needs to learn. That’s not to say I didn’t learn, I’ve learned a lot with [my husband], up until today. But I think it would have been better [if I had gotten to know others].”

Marta also reiterates that she would have wanted to learn, “The pleasure of another person, without it being my husband.” These responses are informative on a number of different levels. Firstly, while both women claim to have positive sexual relations with their partners, they experience regret at only knowing their partners. It reflects a social belief sexual experimentation with more than one partner is valuable. Secondly, it also demonstrates the changing of social values taking place between when these women were single to when they married since while they were single it seems that it was not socially acceptable for these women to sexually experiment, yet now, the social climate has shifted so that both of these women wish they could have experimented more.

Other concerns brought up that would have been helpful to know about before were how to avoid AIDS and how to avoid pregnancy. Gisa says, “In my group, I had relations with persons that were drug users and I did not know that there were classifications of drugs that were injected that were more dangerous…I didn’t know this.” Iliana states, “The first time I had sex was a deception for me because I did not like it. But it was what I wanted…but nothing like it was supposed to be. So therefore I think […] I would have learned to [avoid] that.”
Yet not all women were in favor of pre-marital sexual experimentation. When Ana was asked about if she believes that a woman should wait till marriage to have sex, she states that she had sexual relations before marriage but she wants her daughter to wait until marriage. So she has already premeditated that when her daughter asks her if she had sexual relations before marriage, she is going to say, “No, I got married first,” which she acknowledges is a lie. This is her attempt at encouraging her daughter to wait until marriage to have sex. Yet the majority of women concurred that having sex before marriage was acceptable now and they saw no reason to wait until marriage.

Women across the board were confident that the sexuality education they had received from home or from school was correct, yet when probed regarding their sexuality education, there was doubt and confusion on the part of the women. When asked in what part of the menstrual cycle the woman has the greatest chance of getting pregnant, Carla responded, “Well, in this subject, I’ve always had doubt. I should have marked it but I was always wrong. Every time it was one thing, it wasn’t. It was another. So, I just got used to always using a condom, which is more practical, to avoid disease. And because I was never certain which day it was, I avoided it completely.” Therefore, the behavior of using a condom every time she has sex is a positive end result of not knowing when her ovulation occurs. As the most basic unit of reproductive understanding, she does not have any confidence that she knows the answer, although after further probing, she does come up with the right answer. Fatima answers, “More or less, I learned this in school. Its…my god…the fertile period of the woman is after…the menstruation. No, the menstruation is some ten days, I think the fertile period is around there, I don’t remember.”

A similar situation arose when probing for knowledge about sexually transmitted infections (STIs). When asked which STIs she learned about, Carla said, “Ha! Various names that I didn’t record. But what’s more important is to learn how not to catch them. The one I think I remember is this: you have AIDS, but in that era, in that epoc [when I was learning about
STIs] there were strong infections...that sickness with sores in the vagina. Therefore, there are those sicknesses. I don’t know the scientific names, but I was taught them all clearly.” When asked, “How does a person get infected?” She responded, “With the act of sex, logically.” But when probed about the risks of one act versus another, she said she did not know the difference between risks. Not a single respondent was able to discuss the comparative risk of STI transmission from different sexual acts.

**Contraceptive use**

Contraceptive choice is a central element of quality of care in the provision of family planning services, and it is a fundamental aspect of women's reproductive rights. A nationwide assessment within Brazil showed that public-sector availability and access to contraceptive services were highly constrained (Formiga et al. 1994), although they were specified as a component of Brazil’s Program for Integrated Assistance to Women’s Health (PAISM). Yet as Díaz et al. (1999) point out, when access is problematic, quality of care becomes less of an issue.

In Brazil, the word contraception is synonymous with the birth control pill. While tubal ligation is the most commonly used contraceptive method in Brazil, the vast majority of women did not name it as a contraceptive method until prompted. The pill is the second most commonly used contraceptive method in Brazil.

The questions I shall be discussing in this section are:

1. When did you learn about contraception for the first time?
2. Do you plan on getting a tubal ligation in the future?

Contraceptive use began primarily after marriage. The number of contraceptives women could name on their own without any prompting was extremely limited, although they seemed to know about a greater variety of methods when prompted. Five of the women reported learning about contraception for the first time after they had their first child. Two reported learning after they got married. And only two were taught about contraception by a doctor. Iliana states, “When did I learn? When I had my first child and the doctor passed [the birth control pills] to me
and I started taking them.” Many of the women who have taken the pill report how it left them ill and so they discontinued. It is also uncommon for these women to get oral contraceptives from a doctor because in Brazil it is possible to obtain oral contraceptives without a prescription. When Beata was asked how she learned about contraceptives for the first time, she related telling a friend she had had sex for the first time and the friend oriented her to oral contraceptives. She never went to the doctor before she began using oral contraceptives. “To go to the doctor and stay in that position, goodness! Die of shame!”

Brazil’s high sterilization rate gives feminists pause since many people not familiar with the contraceptive situation in Brazil assume that a sterilization rate that high must be from forced sterilizations. Yet my interviews demonstrate yet again that the high female sterilization rate is not product of coercion, but simply of preference. Five of the respondents had had tubal ligations, and two of their partners had had vasectomies which was unusual to find because in 1986, only 0.8% of the male population of Brazil was sterilized. Ophelia has a particularly interesting story to tell about this because both she and her husband were sterilized. Her husband had a vasectomy after the birth of their fourth child, but Ophelia didn’t have confidence that the vasectomy would prevent her from getting pregnant, and so she spoke to a doctor who was willing to sterilize her as well. She says, “I wasn’t tranquil after the vasectomy. Now I am. God liberated me.” This demonstrates that the lack of common social experience with the vasectomy left Ophelia feeling mistrustful that a vasectomy would actually prevent a pregnancy. The doctor who gave Ophelia a tubal ligation apparently did not educate her about vasectomies and instead just gave her a tubal ligation to make her feel tranquil about not getting pregnant again.

All of them spoke about the attractiveness of obtaining a tubal ligation in the Northeast of Brazil at some point in the future. Each woman who had connections to family living in the Northeast reported that if she were to get sterilized, she would return to the Northeast where a sterilization is free and easy to come by. The impression among the interviewees was that
sterilizations were expensive and that they could never afford the cost of them if they were to try to have them done in São Paulo.

Iliana: “If I could have it done now, I’d have it done. But they won’t operate.”

Interviewer: “Who says they won’t operate?”

Iliana: “There are people that say that they won’t operate because I am very young, because I only have two kids, but in my opinion, I’d operate.”

Katerina at age 24 is already considering it for her future. “Hum! It’s a case to think about. I think I would. It could be….” Helenita, 27 years old with one child, plans to have a sterilization after one more child.

Ann: “Do you plan on having a sterilization in the future?”

Helenita: “Ah ...I intend to. After I have one more....”

I asked Veronica, “Have you talked to your family about having a tubal ligation?

Veronica: “Yes, of course.”

Ann: “Why?”

Veronica: “Of course, because in the time that we are in, a woman should have one, two children, because it is a very difficult situation today in which to raise children…”

This demonstrates the economic and social constraints felt by women to only have a few children due to modernizing and urban influences.

Sexual Empowerment

This section attempted to engage the interviewees about more abstract conceptions of sexuality, such as attitudes towards different sexual behaviors as well as ideas about what it means to be a sexually healthy woman. I wanted to hear women’s voices as to whether they felt sexually empowered—whatever that meant to them. I was not trying to impose a U.S. version of that concept—most simply, it means non-coercive and voluntary sexual experiences. It was very difficult to engage the interviewees on this more abstract level—many of them did not understand what was being asked and when they did, stated repeatedly that they had no idea how to voice
their feelings on the subject matter. It is not surprising that the sexual empowerment discourse\(^4\) was foreign to the lower classes—is it occurring under a different name or no name at all or does it not exist? Their inarticulateness about sexual health may not mean that they do not know how they feel about the subject, it may simply be a reflection of the lack of dialogue around sexual health which makes finding the right words difficult.

The work that has been done on sexual empowerment is mainly qualitative. A low-income community outside of Belo Horizonte studied by Kaufmann (1991) shows not all first sex was wanted. Rape was not uncommon—especially among lower-income and younger girls (Kaufmann 1991). Parents were aware that adolescents are growing up in a time when traditional sexual norms are being challenged. One informant blamed *telenovelas* for destroying families by encouraging kids to have sex and women to desire independence (La Pastina 1999: 143). Muraro (1996), Faria and Potter (1999), and Miranda-Ribeiro (1997) all document the role television has played in the diffusion of more liberal sexual ideas.

The questions I shall be focusing on in this section are:

1. How did you discover your sexuality?
2. How do you describe a sexually healthy woman?

When asked, “How did you discover your sexuality?” Most women interpreted that as the first time they had sex. I was expecting more varied experiences among the informants about other types of sexual discovery, but I did not encounter that. Iliana states, “I felt a lot of shame, fear of being with a [boy]. The first one [I had sex with] just tried me and dropped me. That’s why I say that for me it wasn’t very good, né.” When Fatima was asked, “Do you have the self-control to be able to say, ‘I don’t want to do this, I won’t do it?’” She responded, “To say what I want and what I don’t? (laughs) No, because I’m like this...I have hours where I am insecure, I

\(^4\) I held a conversation with Brazilian feminist demographer Jaqueline Pitangy (1999) regarding my exploration of the concept of sexual empowerment and she recommended I use the words “empoderamento sexual” to get at this concept with my interviewees.
am really and truly insecure with myself. There are times when I’ll do whatever things to keep people happy which starts to break me up.” Marta responded,

How was it? It wasn’t a good experience because you are learning, you are learning with other persons improper methods, né? That’s why it wasn’t good for me, but I learned. It served me like lots of things serve, né? It wasn’t the best, but it also wasn’t the worst but I think it could have been better, you know?

When asked, “Do you think you had enough autonomy to decide about sex?” Marta responded, “No, no.”

Daniela states that her first experience was forced. “My first time was like this, it was forced, I didn’t want it. I don’t know what to do with this now.”

When asked, “How do you describe a sexually healthy woman?” two of the respondents described how they had been raped and how they were not able to relate healthfully to sexuality. Numerous other respondents described what a healthy sex life would be in juxtaposition to their own sex lives. Iliana says,

I think it’s great, …with a husband! In spite of the fact that I said mine isn’t good. Mine for myself is not good because I don’t have any desire, he has, but I don’t have, I don’t have any desire…I have the desire to cry. But I think it’s great if a person has a sexual relation with their husband or with their boyfriend and you feel the pleasure to do it. You have desire to make it happen. But not me, I’m different, I cry.

Most of the definitions of what is sexually healthy remained simplistic—on the level of—“She has relations with someone she loves” (Katerina). “Happy. I think it’s the best thing for a woman, if she’s good in this part, I think that she’ll be good in all parts, almost all parts” (Elza).

The sexuality education they received was experiential or primarily from peers. The majority of respondents were not seeking answers to biological questions about sex—the questions dealt more with pleasure and sexual desire. Yet only one respondent knew with confidence when the fertile period is in the woman’s cycle. Although these women are sexually inquisitive, they are still lacking fundamental biological information about their sexuality. The women were all well aware of the need for better sexuality education and the interviewees were for the most part trying to better by their own children than had been done by them.
Contraception was learned primarily after childbearing had begun and again through informal networks of communication. One woman learned about it in school and another learned about it in an Evangelical church. Almost all women intended to get sterilized in the future.

The sexual empowerment section of the interview was the most challenging for the respondents. There was general difficulty in answering abstract questions on sexual discovery and sexual health. Sexual discovery was interpreted as sexual debut and sexual health was understood as non-coercive, regular sexual intercourse with a steady partner. Therefore, while these women are part of the globalizing economy, contraceptive users and media consumers, sexual health in the emotional and biological sense remains elusive. Several respondents told painful stories of sex being forced upon them. This of course impacted their view on what a sexually healthy woman is like: while it was mostly answered in vague language, some women answered it in the first person to juxtapose their sex lives with how they imagine healthy sexuality to be expressed.

So how do these personal experiences inform the social structure surrounding sexuality? Most women expressed a desire to be more sexually liberal than their upbringing had permitted them to be. This was demonstrated by women stating that they wished they had sexually experimented before marriage and that they were attempting to raise their children differently than they had been raised. While each woman knew about more than one contraceptive method, none of them could confidently and accurately identify the most fertile time in a woman’s menstrual cycle, demonstrating a dearth of adequate sexuality information. Lastly, women did see sexual pleasure as part of a healthy sex life yet they varied greatly on what they thought constituted sexually healthy behavior. That variation did not seem to be correlated with age or educational attainment.

**Conclusion**

Aspects of Brazilian sexual culture rival that of a sexually liberal country. In the early 1990s, Marta Suplicy had a television program that discussed issues of sexuality, health and
gender relations in an incredibly open and progressive manner and it was widely followed. This national figure went on to win the position of the major of São Paulo in 2000 demonstrating how widely respected she is. Therefore, in spite of extremely progressive aspects of Brazilian sexuality, man low-income women disenfranchised from aspects of their sexuality.

There is not one sexual health portrait portrayed by the women at the Posto de Saúde Vila California. Each woman represented another version of reality in this low-income community. During the interview process, I was struck by the respondents’ candidacy, their humor and their honesty. They were able to reflect upon past experiences and interpret those experiences subjectively. The patients interviewed were engaged, reflective and interested in their reproductive health but were lacking the most rudimentary form of knowledge about their own bodies as none of them knew with certainty when a woman ovulates during her menstrual cycle. These realities also demonstrate the shift which is occurring among transmission of knowledge and sexual expectations.

The women reflect a lot of sadness and deception about their sex lives. I believe that if appropriate educational resources were made available to these women, they would take advantage of them to learn more about their bodies and this would help them become more sexually empowered and in addition, more effective contraceptors. During my interview time at the clinic, I witnessed numerous women finding out that they were pregnant with an unwanted pregnancy. In a country where abortion is illegal, that type of tragedy could be avoided with better knowledge on the part of the patients on how to avoid pregnancy.

I still have a lot more work to do with these interviews but the data demonstrates already that the values of the ICPD are distant from the sexual experiences of these respondents. My end-goal is to bring the ideology and the reality closer together. My desire is to have sexually healthy women everywhere—so I wanted to assess where I was I was starting from. I am going to go back to the adolescents for my next field work experience to try to address the issue from the earliest appropriate age possible.
The needs of the community are overwhelming—a shortage of medicine, trained staff members and doctors all compromise the health care that patients are able to receive in this low-income community. My recommendation are to institute comprehensive sexuality education nationally, to expand contraceptive choice in public health clinics in Brazil, and to encourage a greater national dialogue about sexual rights which of course encompasses reproductive rights. As Rodger Ingham, from the Center of Sexual Health at The University of Southampon says, we want to move away from reproductive health and towards sexual health.
## Appendix A

### List of Interviewees with Basic Demographic Identifiers

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Parity</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ana</td>
<td>36</td>
<td>4</td>
<td>Cleaning woman</td>
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<tr>
<td>Beata</td>
<td>31</td>
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<td>Seller</td>
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<tr>
<td>Carla</td>
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<td>0</td>
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<td>Nurse’s Assistant</td>
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<tr>
<td>Elza</td>
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<td>Fatima</td>
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<td>2</td>
<td>Pamphlet distributor</td>
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<td>Gisa</td>
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<td>2</td>
<td>Waitress</td>
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<td>Helenita</td>
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<td>1</td>
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<tr>
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<td>Factory worker</td>
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<tr>
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<td>Baker</td>
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<td>Ophelia</td>
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<td>Roberta</td>
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### List of Health Clinic Workers with Basic Demographic Identifiers

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<td>Andrea</td>
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<td>Beatriz</td>
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<td>Elisia</td>
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<td>Administrative Supervisor</td>
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</table>
Bibliography


La Pastina, Antonio. 1999. “A Telenovela Way of Knowledge: An ethnographic reception study among rural viewers in Brazil.” Dissertation. The University of Texas at Austin, Austin, TX.

Leal, Ondina Fachell. “Blood, fertility.....


