Estud. fem. vol.4 no.se Florianópolis 2008

Governing women's bodies among garbage pickers: (re)thinking implications of Health Education

Fabiane Ferreira da Silva
Universidade Federal do Rio Grande

Paula Regina Costa Ribeiro
Universidade Federal do Rio Grande

ABSTRACT
In this present work, we aimed at analyzing the discourses on sexual and reproductive health of women who join the Solidary Movement Association Beehive, in order to understand to what extent these women have been focused by the discourses of education in health, more specifically, the policies and campaigns towards female bodies. To do so, we analyzed the women's narratives produced along the meetings of the course Women and Citizenship. In this study, we problematized how such discourses inscribe different signs in the bodies, teaching habits, values, beliefs, ways of perceiving, being and acting as women as well as thinking and acting towards their bodies. In this sense, we established connections with the cultural and gender studies in its post-structuralist verges, and with some propositions of Michel Foucault.
Key Words*: Women; Sexual and Reproductive Health; Biopolicies; Education in Health.*

Introduction

This article analyzes the network of discourses[1] about the sexual and reproductive health of women who participate in the Associação Movimento Solidário Colméia [The Beehive Solidarity Movement Association], in order to understand to what degree these women have been interpellated[2] by discourses related to Healthcare Education,[3] in particular, the policies and campaigns aimed at feminine bodies. To do so, we analyze the narratives that they produced during meetings of a Women and Citizenship course. In order to discuss and analyze how these discourses inscribe marks on bodies - and thus teach habits, values, behaviors and ways of being and acting as women and of thinking and acting in relation to their bodies - we establish some connections with Cultural[4] and Gender Studies,[5] in their post-structuralist lines[6], and with some propositions of Michel Foucault.

In this sense, we understand that the propositions and discourses that normatize Healthcare Education policies act as a regulatory strategy for sexual and reproductive health, which has a biopolitical matrix. This technology of power regulates the sexuality of the population through mechanisms for control and intervention based on biological phenomenon such as natality, AIDS, sexually transmittable diseases (STDs), etc. For Foucault, biopolitics is "the way which, since the 19th century, attempts were made to rationalize the problems presented to government practice by phenomenon unique to a set of living beings constituted in a population: health, hygiene, natalities, races [...]."[7] Discipline is another element that integrates this technology and is aimed at the individual body, and at the regulation of sexuality by controlling the body through gestures, attitudes, behaviors, habits and discourses.[8] This other technology of power "is centered on the body,

---

[1] For Foucault, discourses, more than groups of signs that refer to contents or representations, are "practices that systematically form the objects that speak" (Michel FOUCAULT, 1995a, p. 56).

[2] In the context of this study, interpellation is understood as the act of identification of an individual (already a subject) in the discourse of the "other," who when identified becomes a subject (Céli PINTO, 1989). There is a constant struggle of discourses that intend to interpellate the subjects, who, at the same time that they are interpellated by discourses, become transformed in accord with their life stories. This process involves an articulation of the positions of subject, others are rejected and assumed that provisionally confer a sense of belonging to a certain social group.

[3] In this context we use the concept of "Education in Health" to designate the educational practices realized in the realm of healthcare (Denise GASTALDO, 1997).

[4] Cultural Studies constitute a field of theory, research and intervention that studies the cultural aspects of society, and has its origin at the foundation of the Center for Contemporary Cultural Studies at the University of Birmingham, England, in 1964. About this issue see: Marisa COSTA, 2004; Tomaz SILVA, 2004; and Alfredo VEIGA-NETO, 2004.

[5] "Post-structuralist feminist approaches distance themselves from those that treat the body as a universal biological entity (presented as the origin of the differences between men and women, or as a surface upon which culture operates to produce inequalities) to conceptualize it as a socio-cultural and linguistic construction, which is the product and effect of power relations" (Dagmar MEYER, 2003, p. 16). For discussions about this issue see: Guacira LOURO, 2004; MEYER, 2003; and Joan SCOTT, 1995.

[6] For discussions of post-structuralism, see: Michael PETERS, 2000; SILVA, 2004, 2005; and VEIGA-NETO, 2004.

[7] FOUCAULT, 1997, p. 89.

[8] FOUCAULT, 2003, 2005, 2006b.

produces individualizing effects and manipulates the body as a focus of forces that must be made simultaneously useful and docile."[9]

Based on these understandings, we maintain that the educational practices undertaken to promote health and prevent disease, act as mechanisms that govern the population and discipline the bodies of individuals. It is an educational process which, by interfering in the personal choices of women and men about how they can or should act to live their lives in a healthy manner, agency behaviors to be followed by the population.

The article is organized in three parts. First we discuss some healthcare policies, articulating the concepts of biopower and disciplinary power. Second, we present the methodological strategies used in the production of the narrative data. Third, we present and analyze the narratives of the women of Colméia about the discourses about sexually transmittable diseases, HIV/AIDS, contraceptive methods, preventive exams and care for the body.

The power over life and healthcare policies

From a historic perspective, the trajectory of the social movement that legitimated, in the Brazilian public sphere, concepts of women's health, more specifically sexual and reproductive health, is very recent. Although it is only two decades old, this trajectory has had many social and political transformations, which to a certain degree have altered the national scenario concerning healthcare issues. Since the 1980s, the field of women's health or sexual and reproductive health began to receive great attention and investment from the feminist movement. In this context, the freedom of decision about issues of reproduction and sexuality function as leverages to pressure various changes, such as new legal codes, production of knowledge about the feminine body, and the installation of new healthcare services, based on parameters created by women themselves.

According to Ávila and Corrêa,[10] in the context of the reflections and demands concerning women's health, since the beginning, there has been interest and questioning of medical knowledge and power,[11] which was both a disciplinary knowledge as well as a knowledge that justified the hierarchy between the sexes. For these authors, all the concepts about women's health or healthcare which the feminists confronted were anchored in an understanding of women as fragile, uncontrolled beings who are destined, because of their biological conditions, to social reproduction, and caring for children, husband and domestic chores. In this perspective, the contemporary feminist movement established a premise of autonomy, or that is, that women could and should have a project that is based on the experience of women and their needs in the fields of sexuality and reproduction.[12]

In this sense, it is important to highlight the importance of the National Women's Health and Rights Conference,[13] held in October 1986 as a consequence of the 8th National Healthcare Conference, held in March of the same year with the support of the National

---

[9] FOUCAULT, 2005, p. 297.
[10] Maria ÁVILA and Sônia CORRÊA, 1999.
[11] The expression "knowledge/power" is used in the sense used by Foucault in which power and knowledge are directly entwined, or that is, "there is no power relation without a co-relation in a field of knowledge, nor knowledge that does not simultaneously suppose and constitute power relations" (FOUCAULT, 2006b, p. 27).
[12] ÁVILA & CORRÊA, 1999.
[13] BRASIL, 1987.

Council of Women's Rights (CNDM) of the Ministry of Health. The event deserves special mention because of its breadth, the intense participation of the feminist movement and consequently, its ramifications. Preparatory conferences were held in all Brazilian states, at which delegates were chosen and priorities defined. The women's movement had broad participation in this event, both in terms of political representation as well as in the conception and organization. Although supported by federal government ministries, the conference was converted into a forum for debates that raised profound and deeply rooted criticisms about the government's lack of action and commitment to the issue of health and, more particularly, women's health.[14]

In this new context, the creation of the CNDM and the formulation of the Integral Women's Healthcare Program (PAISM)[15] in the 1980s by the Ministry of Health constituted essential references, because they expressed the institutionalization of the feminist agenda by the State. The movement for the implantation of PAISM channeled an important portion of the action of autonomous groups that were involved with the issue, not only in terms of political mobilization, organization and representation, but also in terms of actions related to the production and promotion of information and knowledge. This process was significantly different for the middle class and poor women involved with the movement. According to Ávila and Corrêa,[16] for the middle class women, the movement and its results signified the construction of feminine citizenship based on conceptualizations, studies, experiences and reflections of the women themselves. Meanwhile, for women from the popular classes, the struggle for healthcare with room for the construction of citizenship had a more urgent meaning for the transformation of the quality of their lives, because, as users of the public healthcare system, they were the ones most harmed by its inefficiencies.

Concerning the global situation, the dimension of the International Population and Development Conference held in Cairo in 1994 should be emphasized. The Cairo Conference established as a central focus of the population issues the right of each individual to complete sexual and reproductive health, in all phases of life, and guaranteed access to the means to exercise this right.[17] According to Cavenaghi,[18] since the CIPD, the international community has recognized that universal access to sexual and reproductive healthcare constitutes a fundamental condition for gender equality and social development. In addition, the author argues that the evidence indicates that sexual and reproductive health are determinants for achieving the Millennium Development Goals, to the degree that four of the eight objectives are related to the issue: the promotion of gender equality and the autonomy of women, reduction of infant mortality, improvement in the health of mothers and the fight against HIV/AIDS.

In this perspective, a proliferation of healthcare policies aimed particularly at women is now found in Brazil. These policies are proposed and developed by the Ministry of Health through the Single Healthcare System (SUS), while women represent 50.77% of the Brazilian population and are the main clients and or users of SUS.[19] These policies

[14] Suzana CAVENAGHI, 2006.
[15] BRASIL, 1984.
[16] ÁVILA & CORRÊA, 1999.
[17] FUNDO DE POPULAÇÃO DAS NAÇÕES UNIDAS, 1995.
[18] CAVENAGHI, 2006.
[19] BRASIL, 2006a.

include the National Policy for Integral Women's Healthcare (2004–2007),[20] whose general objectives include: promoting the improvement of the living and health conditions of Brazilian women by guaranteeing legally constituted rights and expanded access to the means and services for healthcare promotion, prevention, assistance and recovery throughout Brazil; to contribute to the reduction of female morbidity in Brazil, particularly from avoidable causes, in all cycles of life and in various population groups, without discrimination of any kind; and to expand, qualify and humanize integral women's healthcare in the Single Healthcare System.

In addition, the federal government recognized 2004 as the Year of Women, which in Brazil was marked mainly by the realization of the 1st National Conference on Women's Policies, and by the preparation and release of the National Women's Policies Plan (PNPM).[21] According to the Implementation Report for the PNPM, these policies include a series of objectives, goals, priorities and actions aimed at:

> The improvement of healthcare, a guarantee of rights and expansion of access to services; sexual and reproductive rights; reduction of morbidity and mortality; expansion, qualification and humanization of integral attention to women's health; guaranteed access to contraception and exams; regional expansion of existing programs; prevention and control of HIV/AIDS and other sexually transmitted diseases; obstetric care; and finally, the criminal punitive legislation concerning voluntary interruption of pregnancy.[22]

With this focus, policies and programs have been produced in the realm of sexual and reproductive health aimed especially at the female population and that assume distinct configurations according to specific historic and cultural contexts and economic and political interests. In this sense, it is important to analyze issues related to healthcare, in this case, women's health, to the degree to which we understand that the subjects are subjectivated and objectivated through various sociocultural discourses and practices that are part of daily life, which teach certain modes of perceiving the body and exercising sexuality.

Foucault, upon analyzing the history of sexuality,[23] not in "terms of repression or of law, but in terms of power,"[24] presents the mechanisms of power created in modernity and speaks intensely of sexuality and through it disciplining, managing and normalizing the bodies of individuals. In this sense, a contribution from Foucault that deserves highlighting concerns the understanding of power to the degree in which it problematizes the traditional notion of power.

> When I speak of power, I do not mean to signify "power", as a set of institutions and apparatuses that guarantee the subjection of citizens to a certain State. I also do not understand power as a mode of subjection that,

[20] BRASIL, 2004.
[21] BRASIL, 2006b.
[22] BRASIL, 2006b, p. 56.
[23] According to Foucault, sexuality is a historic device in the form of a network "in which the stimulation of bodies, the intensification of pleasures, the incitation to discourse, the formation of knowledge, the reinforcement of control and resistance, unleash each other, according to strategies of knowledge and power" (2003, p. 100).
[24] FOUCAULT, 2003, p. 88.

> in opposition to violence, takes the form of a rule. That is, I do not understand it as a general system of domination exercised by an element or group over another and whose effects, by successive derivations, run through the entire social body.[25]

For Foucault, power does not emanate from a center – the State – but acts as a network "based on numerous points and amid unequal and mobile relations."[26] In this network, individuals not only circulate but are in position to exercise power and suffer its action.[27] Upon considering power to be a relation of actions upon actions – something that is exercised, which takes effect and functions in a network – Foucault calls attention to the role that some exercise over others and to the multiplicity of mechanisms of power and resistance that function in the social body. He also understands power not as coercive, repressive and negative, but as productive: "it invents strategies that give it potential; it engenders knowledge that justify and shield it; free us from the use of violence and thus, economizes the costs of domination."[28]

Foucault was concerned with understanding how the procedures of power produce docile, disciplined and governable subjects. For Foucault, two technologies of power appeared in modern times that center their actions on the life of individuals: disciplinary power, which acts on the bodies of individuals, and biopower, which acts on the population.[29] Although disciplinary power has been functioning since the 17th century, Foucault indicates that in the 18th and early 19th century, another technology, biopower, began to work together with it, although "they are not antithetical and constitute, to the contrary, two poles of development interlinked by an intermediary range of relations."[30]

Disciplinary power, as a set of miniscule inventions and techniques aimed at bodies, allows the increased usefulness of the multiplicities and control of individuals.[31] According to Foucault,[32] the individual is a fabrication of this technology that calls itself discipline.

Biopower, for Foucault, refers to mechanisms employed to control the phenomena of the population as a species. In Foucault's perspective, biological life becomes a political event concerned with the collective phenomena of the population (the proportion of births and deaths, the reproduction of the population, longevity, the occurrence of disease etc.), essential to the economic and political problems of government. Thus, biopolitics concerns a new body, a multiple body, "concerns the population, and the population as a political problem, as a problem that is simultaneously scientific and political, as a biological problem and problem of power.[33] The mechanisms implanted by biopolitics have as their objective the regulation of the population, seeking to control through forecasts, statistical estimates and global measurements the series of fortuitous events that can occur in a population and perhaps modify the probability of these phenomena.[34]

---

[25] FOUCAULT, 2003, p. 88.
[26] FOUCAULT, 2003, p. 90.
[27] FOUCAULT, 2006a.
[28] VEIGA-NETO, 2004, p. 63.
[29] FOUCAULT, 2003, 2005.
[30] FOUCAULT, 2003, p. 131.
[31] FOUCAULT, 2005, 2006b.
[32] FOUCAULT, 2006b.
[33] FOUCAULT, 2005, p. 292-293.
[34] FOUCAULT, 2005, p. 292-293.

According to Foucault,[35] sexuality is found at the articulation between these two technologies – disciplinary power and biopower – to the degree to which it is directed at subjects as a series of procedures, such as discipline, constant control, spatial dispositions, medical or psychological exams, that is, a series of micropowers over the body, as well as measures aimed at the masses, the statistical estimates, interventions and campaigns aimed at the entire social body. Therefore, sexuality is access both to the life of the body as well as life of the species.

Foucault[36] maintains that since the 19th century, sexuality has acquired extreme medical valorization. An understanding emerged according to which sexuality, when it is not disciplined and regulated, has effects on the body "on the undisciplined body which is immediately punished by all the individual diseases that the sexual libertine attracts to itself"[37] and on the population, "given that it is supposed that that which was sexually depraved has a hereditary nature, a descendence that, will also be disturbed, and for generations and generations."[38]

Since then, medicine is configured as a political strategy for intervention, whose actions are aimed at public healthcare problems, such as, for example, control over reproduction, of sexually transmitted diseases, of HIV/AIDS, and others. As Foucault argues, "medicine is a knowledge-power that incides simultaneously on the body and on the population, on the organism and on biological processes, and which therefore, has disciplinary and regulatory effects."[39]

In this sense, we perceive the functioning of technologies aimed at controlling the population's sexuality through mechanisms of knowledge-power such as policies, campaigns and television programs aimed at prevention of diseases and the promotion of health. These mechanisms, legitimated by scientific knowledge-power, present as their objective the promotion of the population's health as well as a disciplined society.

In this way, we can consider healthcare policies aimed at feminine bodies as strategies that have been operating to have women become responsible for their own lives, and for the lives of their children and partner, making use of available medical knowledge, managing their bodies through the realization of preventive exams for STDs and HIV/AIDS and uterine and breast cancer, using condoms and contraceptive methods in sexual relations etc.

Based on these understandings, diseases or unhealthy attitudes come to be related to the lifestyle that each person maintains and to the "risk behavior"[40] maintained by the subject, and are often understood as a result of resistance to and or negligence of prevention and care for the body, and to a lack of knowledge and information. This understanding is justified by the fact that they have available to them various prescriptions supported by medical knowledge, indicating attitudes, habits, rules and norms and lifestyles that determine how the individual, in this case the woman, should proceed to live in an increasingly healthy manner and to protect her body from disease.

---

[35] FOUCAULT, 2003.
[36] FOUCAULT, 2005.
[37] FOUCAULT, 2005, p. 301.
[38] FOUCAULT, 2005, p. 301.
[39] FOUCAULT, 2005, p. 302.
[40] We use the concept of "risk behavior" associated to conduct adopted by individuals such as practicing sex with various partners, anal sex, drug use, etc. (Paula RIBEIRO and Mirian DAZZI, 2000).

Considering the proposals presented until now about the body and the population, we will attempt to analyze and understand how and what discourses about STDs and HIV/AIDS and practices of prevention and care for the body are signified and shared by the women of Colméia.

Methodological Routes: the narrative investigation and the focus group

Narrative, according to Connelly and Clandinin,[41] is situated in a qualitative research approach, "because it is based on experience and on the qualities of life and education." For these authors, the use of narrative as a research method is justified in the understanding that we are story-telling beings, we are beings that, both individually and socially, live narrated lives.

In this sense, we understand narrative as a social practice that constitutes subjects, or that is, it is in the process of narrating and hearing stories that individuals build both their senses of themselves and their experiences, as well as of others and of the context in which they are inserted.

For Larrosa,[42] narrative is a discursive modality in which the stories that we tell and the stories that we hear, which are produced and measured in the interior of certain social practices, come to construct our history, to give sense to who we are and who are others, thus constituting identities – of gender, sexuality, race, religion, profession and social class, of mother-father, son-daughter, husband-wife and others. In this way, we construct and express our subjectivity based on linguistic and discursive forms that we employ in our narratives.

Based on the supposition that narrative investigation allows the use of various tools for the production of narrative data, we elect as a methodology the focus group, which is characterized as a qualitative research technique often used when the objective is to understand the "representations, perceptions, beliefs, habits, values, restrictions, prejudices, languages and symbologies prevalent in considering a given question by people that share some common traits."[43]

To use the focus group as a research methodology, a group of people was brought together to discuss and comment on a specific issue that is the object of the study. In this sense, the composition of the focus group should obey some characteristics common to the participants according to the research proposal, such as, for example, those related to gender, age, socio-economic conditions, type of work, marital status, education and place of residence.

In this study, the focus group was organized from an extension course in Women and Citizenship offered to women who are members of the Associação Movimento Solidário Colméia to establish a space for discussion and reflection about issues related to the body, gender and sexuality.

Colméia is a private not for profit organization that has as its principal goal the creation of opportunities to strengthen citizenship and improve the quality of life of the participating families. It is currently composed of 36 families, totaling 160 people, living in a situation of extreme poverty, in the neighborhood of Castelo Branco and its surroundings,

[41] Michael CONNELLY & Jean CLANDININ, 1995, p. 16.
[42] Jorge LARROSA, 1996.
[43] Bernardete GATTI, 2005, p. 11.

in the municipality of Rio Grande, in Rio Grande do Sul State. The community at which Colméia's actions are aimed is composed of women, men and children who survive by picking through a garbage dump, from which they extract clothes, furniture and household appliances. The needs of these people required actions that conditioned the profile of the Associação Movimento Solidário Colméia. The requirement for the families' participation in projects is that their school age children are properly registered in and attending school. Another important objective of Colméia is to provide situations that support the self-sufficiency of these families. To achieve these objectives, various projects are undertaken with women, youth and children and courses, workshops and encounters are organized. In conjunction with the Fundação Universidade Federal do Rio Grande, through the Department of Education and Behavioral Sciences, an extension course in Women and Citizenship was established, organized by the research group in Sexuality and School, and organized in eight two-hour meetings in 2004-2005.

Twenty women from 18-60 years of age who are attending school in the Youth and Adult Education program participated and had professional training in courses and workshops to establish their self-sufficiency. The women who participated in the meetings are housewives and mothers with an average of five children, most of them have husbands or partners. Only one had a paying job. The women had extreme socio-economic needs, are unaware of their social rights, have suffered or had been victims of sexual abuse, violence and bad treatment from husbands or boyfriends, and in most of their families, there was an incidence of alcoholism and cigarette smoking, among other issues that are part of the current socio-environmental crisis.

The course functioned as a space in which women could tell and hear stories about their lives, what they thought about their bodies and sexuality, their social relations, identities, beliefs, myths, values, attitudes and feelings, or that is "the place in which is built or transformed the experience of oneself."[44] This strategy also had the goal of analyzing, de-stabilizing and denaturalizing the stories narrated by these women and perhaps to modify the meanings they attribute to the body, gender and sexuality.

The discussions in the focus groups began with a specific issue or focus that was previously determined by the researchers according to the research objectives and were designed to encourage interaction among all of the participants of the group. Therefore, the researchers played an important role in the group, because they acted as mediators, coordinating the discussions and activities referring to the proposal to produce the information. The idea of the focus group was not to establish consensus, but to create conditions for the participants to express their points of view and interact with each other.

In this sense, the meetings of the Women and Citizenship Course were previously planned and organized by the Sexuality and School research group (the coordinator of the course, a master's student, a recipient of a scientific initiation grant from FAPERGS and other participants), which prepared flexible questions and activities in order to stimulate the group discussions, as a function of the guiding focuses of the group – body, gender and sexuality. All of the meetings were conducted at the João de Oliveira Martins municipal elementary school, located in the Castelo Branco neighborhood, because this school, in addition to having the physical space to realize Colméia's activities, was also the place where the children of the women in the association study. This facilitated their participation

[44] LARROSA, 2002, p. 57.

in the course, because when they took their children to school, they remained there to participate in the course activities.

The audio and video recording of the group interactions allowed a more detailed analysis of the data produced. Some of the meetings of the Women and Citizenship course were filmed and other moments, such as discussions in small groups, were recorded on audio cassettes to register the declarations, which would be difficult if they were just filmed. Other strategies were used to complement the production of the narrative data, such as the realization of semi-structured individual interviews and the response to a questionnaire, in order to understand a bit more about the course participants through information such as education level, age, number of children, types of childbirth, disease history, marital status, socio-economic conditions, profession, housing conditions and others.

Concerning ethical issues, when the narrative data were presented, we requested that each one of the participants in the course choose a code name to protect her privacy. We also prepared a Free and Informed Consent Form that indicated to the participants the objectives and procedures adopted during the meetings and clarified the commitments to be assumed by both parties.

When opting for this type of research methodology, it is important that the researchers understand that the participants in the focal group "are expressing themselves in a specific context, in interactions that are particular to that group of participants and, for this reason, the perspectives of each one of them cannot be taken as definitive positions."[45] In this sense, the narratives produced take shape as contingent, provisory and limited to the context in which they occur.

The strategy of analysis consists in "seeing" the narratives of these women – declarations, posters, designs, actions, expressions – what they say about their lives, about their bodies, about their reproductive and sexual health, in order to understand and analyze the discourses and the social practices that were and are involved in the production by these women.

Analyzing the narratives of the women of Colméia

In this article, we seek to investigate and understand the network of discourse about women's and reproductive health of the women who are members of Colméia in order to understand the degree to which they are interpellated by the discourses refering to Healthcare Education, in particular to the policies and campaigns aimed at the feminine body. To do so, we (re)visit the encounters of the Women and Citizenship course to focus on the moments in which we analyze the policies and actions related to gender equality, access to education, and to public healthcare policies, principally those aimed at "reproductive and sexual rights,"[46] pre-natal assistance, the use of voluntary, safe and legal

[45] GATTI, 2005, p. 68.

[46] Reproductive rights refer to the right of people to decide, freely and responsibly, if they want to have children or not, how many children they want and at what time in their lives; the right to information, means, methods and techniques to have children or not; the right to exercise sexuality and reproduction free of discrimination, imposition and violence. Sexual rights correspond to the right to live and freely express sexuality without violence, discrimination and imposition and with complete respect for the body of the partner; choice of sexual partners; living sexuality completely and without fear, shame, guilt and false beliefs; to live sexuality regardless of marital status, age or physical condition; to choose if they want or not to have

contraceptives, access to sexual information and to prevention of STDs/AIDs and preventive exams. The narratives analyzed below present factors referring to sexual and reproductive health, to practices of prevention and care for the body and to the way that they are signified and shared by these women.

Concerning these women's reproductive health, we noted that most of them use the oral pill or underwent feminine sterilization, which we can verify in the following narratives:

> *I take the pill, I don't forget to take the pill.*[47]
>
> *The first was normal, and for the second and third I had to have a cesarean, because I would have my tubes tied, so I had to do a cesarean.*[48]
>
> *I took it once [the pill], but I menstruated three or four times a month. The doctor told me to stop and said to me: the only method for you to avoid a family is to use a condom and then as years go by if you want, to have a tubal ligation, and even so use a condom because of disease, because its not just about children today.*[49]

According to Arilha,[50] the use of contraceptive methods has reached high levels in Brazil, comparative with those in developed countries. As occurs in other Latin American countries, economic development and various State "interventions" affect reproductive patterns in Brazil, especially considering changes in women's occupational standards. In addition to these factors, there is an active network of non-profit groups dedicated to family planning, the development of healtchare programs by the Ministry of Health and television programs promoting the use of contraceptives. According to the author cited, the reduction of fecundity caused the rates to change from an average of 4.5 children per mother in the 1980's to an average of 2.5 in the 1990s. Nevertheless, the author warned that this reduction was obtained by the high use of feminine sterilization and the pill in Brazil, for 44% and 41% of the women from 15-54 respectively. In relation to tubal ligation, it should be emphasized that voluntary sterilization is only permitted for informed and competent men and women older than 25 years of age or who have at least two living children (article 10, I of Law n. 9.263/1996), with surgical sterilization principally prohibited for women in conjunction with a birth or abortion, except in case of risk of life to the woman, according to article 10, § 2º of Law n. 9263/1996 and Decree SAS/MS n. 048, of February 11, 1999, which regulates sterilization in public health services.

In this sense, upon analyzing the participant's narratives, we perceive that there are some problems associated to feminine sterilization, mainly the violation of medical ethics and of reproductive rights, such as the right to be informed and understand the irreversibility of the procedure, the right to have the decision-making process supported and

---

sexual relations; to freely express their sexual orientation: heterosexuality, homosexuality, bisexuality, among other issues; to have sexual relations independent of reproduction; to safe sex for prevention of unwanted pregnancy and of STD/HIV/AIDS; to healthcare services that guarantee privacy, secrecy and quality care without discrimination; to information and sexual and reproductive education (BRASIL, 2006c).

[47] Maria. Interview conducted at the Women and Citizenship course.

[48] Júlia. Interview conducted at the Women and Citizenship course.

[49] Laura. Interview conducted at the Women and Citizenship course.

[50] Margareth ARILHA, 2006.

guided psychologically, the right to have information about the cesarean and to have a sterilization not associated to childbirth.

The woman's body is riddled by a network of strategies to govern her body and her sexuality; procedures are organized that are aimed at phenomena of life such as sterilization or contraception campaigns. According to Foucault,[51] various strategies are diffused in the social fabric that attempt to discipline the bodies of individuals and regulate the life of the population. In addition to the strategies mentioned above, we perceive the functioning of medical discourse, which by investing in the woman's body, manages, for example, the number of children that a mother can or should have. In this perspective, we understand that biopolitics has been acting on the control of natality, which through various actions – such as incentives to use contraceptive methods, mainly the pill and condoms, or to adhere to irreversible methods such as feminine sterilization – tries to control and govern feminine bodies.

It is also important to consider that, based on the theoretical perspective that we adopt in this study, statistical data, such as those cited above, do not directly reflect reality, but are involved with its production, given that it is through this data that some strategies and control mechanisms are developed.[52] Among them we highlight family planning, implemented by the Integral Women's Healthcare Program, which encouraged the use and promoted the supply of contraceptives linked to medical care to guarantee the program's effectiveness.

In regard to the family planning program, according to data published by the Ministry of Health,[53] since August 2005, new strategies have been adopted to improve the program's effectiveness, which in sum involve: the purchase of 100% of the contraceptive methods for users of SUS and the provision of contraceptives to be effectively provided at basic healthcare units and by workers in the Family Healthcare Program; and also the expansion of access to tubal ligations and vasectomies at SUS. According to data published by the Ministry of Health,[54] from July to December 2005, 12 million combined pill packets, 787 thousand mini-pill packets (which can be used by women while nursing) and 311 thousand viles for monthly injections of contraceptives were distributed; and 16,482 tubal ligations and 6,298 vasectomies were performed at the approximately 570 health care institutions approved to conduct these surgeries by SUS, under the family planning law.

Another mechanism of this technology of power that is currently intensely present in the media are government campaigns for control of HIV/AIDS and other sexually transmitted diseases, which emphasize the use of condoms, usually for men, in all sexual relations.

In relation to the male condom in sexual practices with their partners, some women express that they do not use them. The lack of use seems to be explained, either by the dissatisfaction of the partner in using it, or because they believe it is not necessary in stable sexual practices. The declarations of the women suggest that they are found in submissive conditions in relation to their partners and that they are not able to impose their will in their emotional and sexual relations, and the partner determines whether a condom will be used

[51] FOUCAULT, 2003, 2005.
[52] FOUCAULT, 2005.
[53] BRASIL, 2006a.
[54] BRASIL, 2006a.

or not. This can be seen in the following statements, in which the women highlight the arguments of the men, which are associated to bodily pleasure:

> *Except sometimes, not always, he doesn't like it. He says it's no good, that he feels no pleasure, so I let him, ok.*[55]

> *I'm not even going to use it, just if it's a feminine [condom] because he won't use it under any condition. He says that he hates it. He says he isn't going to go locked up in that thing (laughs).*[56]

> *I never used it, he says that he doesn't like it, that he feels like he's suffocating. He says it playing, you understand? So, if I don't go with anyone? "It's just us" [husband speaking]. But I try to explain to him lots of times [...].*[57]

In this sense, an essential factor to be considered in the analysis of the narratives of these women are the unequal gender relations, that is, the power relations existing between men and women. Consequently, this differentiated power between women and men also expands the vulnerability of women, because it relegates feminine sexuality to silence, above all, in terms of care for the body and for sexual health or even because of physical and sexual violence against women. In our society, the exercise of masculinity associated to the understanding that men should initiate their sexual life as early as possible, have many sexual partners and that sexual practices without a condom are more pleasurable, is involved in the vulnerability of women concerning prevention of HIV/AIDS infection and other STDs.[58]

Nevertheless, we are not emphasizing the concept that men are dominant over dominated women, as if women are victims or responsible for their hierarchically subordinated social condition. The theoretical presumption in which we anchor our research sees these understandings relatively, considering that gender relations are engendered by power relations and that these relations of forces, struggles and conflict produce resistance.[59] According to Foucault,[60] we cannot consider power as a solid and homogenous phenomenon of domination of one individual over others; in this case, of man over woman. Thus, it is important to think of the exercise of power, given that men do not detain power over women, but both exercise and suffer the effects of their actions. Therefore, the subjects are not inert targets of power, they can resist, contest, transgress or negotiate their social relationships. Nevertheless, it is important to highlight that, for Foucault, the exercise of power always takes place between free individuals, because only a free individual has the opportunity to resist; if not, what is found, he maintains, is not a power relation, but a

[55] Fernanda. Interview conducted at the Women and Citizenship course.
[56] Claudia. Interview conducted at the Women and Citizenship course.
[57] Paula. Interview conducted at the Women and Citizenship course.
[58] BRASIL, 2007.
[59] For Foucault, "there is no power relationship without resistance, without subterfuge or escape, without eventual inversion; all power relationships thus imply, at least virtually, a strategy of struggle […]" (1995b, p. 248).
[60] FOUCAULT, 2006a.

relationship of violence. Thus, gender relations and power relations between genders interfere in the safest sexual practices.

In the following narrative, the woman takes the initiation of proposing to her partner the introduction of condoms in the relationship, she affirmed: *he said: I don't like that thing. So I said to him it has to be like that, and he used it*;[61] or, also, asked, that, at least in the street, with other women, he use it to not bring any disease home, as another said: *I use it with my partner because I am afraid that he gets around, although I know that he says that he is careful, that he carries a condom, so I order him to take it and use it[...]*.[62] In this sense, we realize that these women have been interpellated by the discourses of "safe sex" and of "negotiation of safe sex," which have been frequently emphasized in the campaigns for prevention of HIV/AIDS and STDs.[63] These campaigns address discourses to the subjects, especially women, with a strong appeal for the use of the male condom in sexual relations, showing the woman as a conductor of the negotiation process in an attempt to encourage women to become disciplined and autonomous subjects. Thus, we believe that the participants in Colméia are being convoked by the discourses for prevention of STDs and HIV/AIDS in the sense that they are responsible for their own protection and for the protection of the partner, and by the notion that men "by nature" cheat.

In the daily life of these women, the understanding that a man, by nature, has a sexual impulse that he cannot control, appears to function as a mechanism that explains male infidelity.[64] The narratives presented below illustrate these understandings:

> *I am only careful because men are men, right. Because we don't know if a man goes with other women, he goes to work and we don't know what happens in the street, we stay at home taking care of the children right, so I use a condom.*.[65]

> *I am careful because of syphilis, of all the other things, he travels, he goes out. Do I know if he goes out with someone? Do I know if he will bring me something?*[66]

According to Oliveira et al.,[67] with the feminization of AIDS, sexual negotiations came to be more important in the protection of women against the HIV/AIDS infection as a strategy to decrease heterosexual transmission. According to the authors, "analyses of the causes of the advance of the epidemic among women increasingly emphasize that this advance is related to the inequality of power that traditionally organizes relations between men and women in all social dimensions."[68]

In this context, one of the issues that takes on new importance based on the perception that women are vulnerable to the virus, is the difficulty that they have in negotiating with their partners the adoption of preventive measures, because the male

---

[61] Júlia. Interview conducted at the Women and Citizenship course.
[62] Gabriela. Interview conducted at the Women and Citizenship course
[63] Dora OLIVEIRA et al., 2004.
[64] MEYER et al., 2004.
[65] Letícia. Interview conducted at the Women and Citizenship course.
[66] Gabriela. Interview conducted at the Women and Citizenship course.
[67] Oliveira et al., 2004.
[68] Oliveira et al., 2004, p. 3.

condom is a method controlled by men. This factor led to the repositioning of women in the context of HIV/AIDS prevention in the sense that it is necessary to promote the training of women to negotiate safe sex, training that frequently has been sought through government campaigns aimed at women's sexual and reproductive health, presented through various channels, including television.

In this sense, Santos,[69] by analyzing a group of television ads from official HIV/AIDS prevention campaigns presented by the Ministry of Health from 1986-2000, found that between the years of 1994 and 2000, the "discovery" of women as one of the segments in which HIV infection was growing the most had as a consequence a larger number of prevention ads aimed at women, emphasizing feminine self-esteem and empowerment. These prevention campaigns operate with "representations that position and define health promotion and disease prevention actions as feminine attributes, which are produced or assumed and reinforced by the very knowledge and policies that guide and legitimate these actions."[70] In the educational context of these campaigns, the strengthening of a woman's self-esteem and her capacity to negotiate the use of condoms in all sexual relations, generally the male condom, are important strategies to guarantee the effectiveness of these campaigns.

In this perspective, the feminization of AIDS earns special attention in the Integrated Plan for Confronting the Feminization of the AIDS epidemic and other STDs,[71] presented by the Special Secretariat for Women's Policy and the Ministry of Health, together with the National STD and AIDS program of the Technical Area of Women's Health. The goal of the plan is to confront the feminization of the HIV/AIDS epidemic and of other STDs by reducing the vulnerabilities of women, establishing policies for prevention, promotion and integral care.

Concerning the prevention of STDs and HIV/AIDS through the use of condoms, we highlight, as an illustration, the analysis of a dialog that emerged in the group in relation to the use of the feminine condom, in which women argue that the feminine condom "hurts" a woman's body or that they do not feel pleasure when they use it.

> Joana: *The women's condom is very different to use [...]*
> Researcher: *Do you use it?*
> Joana: *I do.*
> Researcher: *Do you like it?*
> Joana: *Sincerely not.*
> Researcher: *Why not?*
> Joana: *Ah, because[...] I don't feel desire for anything[...]*
> Researcher: *It doesn't give you pleasure?*
> Joana: *that's right.*
> Researcher: *Is there anyone here who also used it and also thinks that?*
> Paula: *I gave it to my sister to use and she didn't like it, she said it hurt.*
> Researcher: *And you never tried to use the feminine condom??*
> Maria: *No because everyone says it hurts, right [...]*

[69] Luís Henrique SANTOS, 2002.
[70] MEYER et al., 2004, p. 57.
[71] BRASIL, 2007.

> Researcher: *And the feminine condom, have you tried to use it?*
> Letícia: *Ah, I used it, but I didn't like it. I like these better […]*
> Researcher: *Why didn't you like it?*
> Letícia: *Ah because it hurts. But this here [referring to a feminine condom] I didn't like, it hurts, and he didn't like it either.*

These narratives lead us to think that, in our culture, from an early age, individuals learn shame, guilt, what is allowed or prohibited, who can do what, what can be shown or hidden; they experiment with censorship, control and discipline. They learn that issues of sexuality are private and that knowing one's body is not allowed, factors that are important for a woman to be able to introduce the feminine condom in a sexual relation.

Another important issue that was approached with women concerns the realization of the exam to prevent uterine cancer. Of the twenty women who participated in the course, only four of them said they had conducted at least one exam. When we mentioned in the group the preventive exams and the feelings associated to them and their bodies, the following narratives emerged:

> *No. I have to do it, I set a date. I am scared to do it because they say it's horrible. Others say it's not, I don't know.*[72]

> *Not me, I'm scared.*[73]

> *Ah, I did it and I didn't like it, I was saying to her that I have to do it again, but I was thinking. It hurts a lot!*[74]

> *I never had any exam. I had to do the uterine test, I didn't, I didn't do any of them.*[75]

> *I was ashamed, most people here are ashamed. I don't know how to explain it, it was really embarrassing. They can say: ah, with so many children she has and her age, how can she be ashamed. But even with the doctor, when I was pregnant with my two sons and I had to do the touch test, I was also ashamed (laughs), right, we aren't used to that*
> *[...].*[76]

The Pap test is one of the most important exams for the prevention of diseases related to the feminine reproductive system. It is also important to highlight that, in addition to being a simple exam, it is provided free of charge by SUS and the Feminine League for Fighting Cancer in the municipality of Rio Grande. Nevertheless, these narratives demonstrate that many women still resist this exam because of fear, shame, lack

[72] Claudia. Interview conducted at the Women and Citizenship Course.
[73] Helena. Interview conducted at the Women and Citizenship Course.
[74] Maria. Interview conducted at the Women and Citizenship Course.
[75] Fernanda. Interview conducted at the Women and Citizenship Course.
[76] Paula. Interview conducted at the Women and Citizenship Course.

of knowledge of their own body, lack of information, and other reasons that leave them vulnerable and susceptible not only to uterine cancer but also to STDs and HIV/AIDS.

From this perspective, we understand that the pap-test is a political health control strategy, whose action based on scientific knowledge-power is designed to prevent and control possible diseases among women seen as universal. The strategies launched by the public policies in health are planned to have the individual become responsible for their own health, taking the initiative of conducting preventive exams, thus managing their own life. Nevertheless, a lack of consideration for the feelings and particular reasons of individuals, leaves a significant number of women at the "margin" in this case.

Additional considerations

By reviewing some encounters of the Women and Citizenship Course, we were (re)constructing and (re)signifying the narratives produced by the women of Colméia. In this article we discussed and analyzed some discourses and social practices that are involved in the production of certain types of subjects (con)forming and governing the bodies and lives of people, according to socially and culturally established codes, rules and conventions.

In this sense, we understand that the women in this study are inscribed by meanings that circulate in the recurring policies and campaigns aimed at prevention of disease and promotion of sexual and reproductive health. These policies and campaigns, through biological and medical discourses aimed at the body – the anatomical physiological knowledge, the mechanisms of disease and the forms of prevention and control – intend to assure protection against STDs and HIV/AIDS, improve the choice of contraceptive methods, decrease the birth rate, discipline individuals, etc, regulating people's lives and thus regulating the social body. These instances, as pedagogical strategies, present behaviors that should be adopted by the population and that interfere in personal choices, establishing how women and men can or should be to live their lives in a more healthy manner. Therefore, these instances exercise a pedagogy, which in addition to teaching women how to prevent STDs and HIV/AIDS, breast cancer and HPV, also act in the production of bodies and gender and sexual identities. We also see in the narratives of these women that, if on one hand they are interpellated by strategies, such as those for the use of condoms and the pill, to conduct breast exams or tubal ligation, on the other, they resist conducting preventive exams for uterine cancer and using male or female condoms.

In this perspective, health education appears to operate with the presumption that all women are equal, which means the existence of a "universal" woman, who must accept the initiative and responsibility to negotiate the use of condoms, as well as responsibility for protecting the health of her partner, children and herself, representations that the discourses about health - and others - produce, reinforce and circulate. In the context of this discussion, we understand that to be a woman is defined not only in the form of relationship with a man, in a given historic, cultural and social context, but also in relation to different possibilities of establishing and living the body and sexuality in the same contexts.[77]

Therefore, we need to destabilize and deconstruct the existence of a "nature" or "essence" that leads to certain types of behaviors or preferences by these women and their partners. It is important to emphasize how much our society invests so that these behaviors

[77] MEYER, 2003.

are undertaken as a common and acceptable practice. Thus, we consider that it is in this multiplicity of behaviors, desires, feelings and preferences that the campaigns and programs in Healthcare Education must be considered.

To conclude, we believe that discussing and analyzing some of these discourses and social practices can contribute to other forms of understanding women and men, understanding that there are different ways to live femininity and masculinity, and to care for and perceive the body and exercise sexuality, which can collaborate to the construction of a more fair and egalitarian society concerning gender in all its relations.

Bibliographic references

ARILHA, Margareth. "Contracepção, empowerment e entitlement: um cruzamento necessário na vida das mulheres". In: BERQUÓ, Elza. *Reflexões sobre gênero e fecundidade no Brasil.* Disponível em: <http://www.fhi.org/en/rh/pubs/wsp/brazilabsport.htm>. Acesso em: 5 jul. 2006.

ÁVILA, Maria Bethania de Melo; CORRÊA, Sônia. "O movimento de saúde e direitos reprodutivos no Brasil: revisitando percursos". In: GALVÃO, Loren; DIAZ, Juan. *Saúde sexual e reprodutiva no Brasil: dilemas e desafios.* São Paulo: Hucitec, 1999. p. 70-103.

BRASIL. Ministério da Saúde. *Assistência integral à saúde da mulher: bases de ação programática.* Centro de documentação do Ministério da Saúde. Brasília, 1984. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/assistencia_integral_saude_mulher.pdf>. Acesso em: 30 set. 2005.

_____. Ministério da Saúde. *Relatório final da Conferência Nacional de Saúde e Direitos da Mulher.* Centro de documentação do Ministério da Saúde. Brasília, 1987. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/CNSD_mulher_parte_I.pdf>. Acesso em: 4 jun. 2007.

_____. Ministério da Saúde. *Política Nacional de Atenção Integral à Saúde da Mulher*. Plano de Ação 2004–2007. Brasília, 2004.

_____. Ministério da Saúde. *Portal da Saúde.* Disponível em: <http://portal.saude.gov.br/saude/>. Acesso em: 10 ago. 2006a.

_____. Presidência da República. Secretaria Especial de Políticas para as Mulheres. *Plano Nacional de Políticas para as Mulheres – Relatório de Implementação – 2005, 2006.* Brasília, 2006b.

_____. Ministério da Saúde. *Cartilha dos direitos sexuais e direitos reprodutivos.* Brasília, 2006c. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/cartilha_direitos_sexuais_2006.pdf>. Acesso em: 5 ago. 2007.

_____. Ministério da Saúde. *Plano Integrado de Enfrentamento da Feminização da Epidemia de Aids e outras DST.* Brasília, 2007.

CAVENAGHI, Suzana (Org.). *Indicadores municipais de saúde sexual e reprodutiva.* Rio de Janeiro: ABEP; Brasília: UNFPA, 2006.

CONNELLY, Michael; CLANDININ, Jean. "Relatos de experiencia e investigación narrativa". In: LARROSA, Jorge e al. *Déjame que te cuente: ensayos sobre narrativa y educación.* Barcelona: Laertes, 1995. p. 11-59.

COSTA, Marisa Vorraber. "Estudos Culturais – para além das fronteiras disciplinares". In: _____ (Org.). *Estudos Culturais em educação: mídia, arquitetura, brinquedo, biologia, literatura, cinema...* Porto Alegre: Ed. UFRGS, 2004. p. 13-36.

FOUCAULT, Michel. *A arqueologia do saber.* Rio de Janeiro: Forense-Universitária, 1995a.

_____. "O sujeito e o poder". In: DREYFUS, Hubert L.; RABINOW, Paul. *Michel Foucault − uma trajetória filosófica: para além do estruturalismo e da hermenêutica.* Rio de Janeiro: Forense Universitária, 1995b. p. 231-249.

_____. *Resumo dos cursos do Collège de France (1970−1982).* Rio de Janeiro: Jorge Zahar, 1997.

_____. *História da sexualidade I: a vontade de saber.* Rio de Janeiro: Graal, 2003.

_____. *Em defesa da sociedade: curso no Collège de France (1975−1976).* São Paulo: Martins Fontes, 2005.

_____. *Microfísica do poder.* Rio de Janeiro: Graal, 2006a.

_____. *Vigiar e punir*. Petrópolis: Vozes, 2006b.

FUNDO DE POPULAÇÃO DAS NAÇÕES UNIDAS. Resumo do Programa de Ação da Conferência Internacional sobre População e Desenvolvimento. In: CONFERÊNCIA INTERNACIONAL SOBRE POPULAÇÃO E DESENVOLVIMENTO – CIPD'94, 1995, Nova Iorque.

GASTALDO, Denise. "É a educação em saúde saudável? Repensando a educação em saúde através do conceito de biopoder". *Revista Educação & Realidade*, v. 22, n. 1, p. 147-168, 1997.

GATTI, Bernardete Angelina. *Grupo focal na pesquisa em Ciências Sociais e Humanas.* Brasília: Líber Livro, 2005.

LARROSA, Jorge. "Narrativa, identidad y desidentificación". In: _____. *La experiencia de la lectura.* Barcelona: Laertes, 1996. p. 461-484.

_____. “Tecnologias do Eu e educação”. In: SILVA, Tomaz Tadeu da (Org.). *O sujeito da educação: estudos foucaultianos*. Petrópolis: Vozes, 2002. p. 35-86.

LOURO, Guacira Lopes. *Gênero, sexualidade e educação: uma perspectiva pós-estruturalista.* Petrópolis: Vozes, 2004.

MEYER, Dagmar Estermann. “Gênero e educação: teoria e política”. In: LOURO, Guacira Lopes; NECKEL, Jane Felipe; GOELLNER, Silvana Vilodre (Orgs.). *Corpo, gênero e sexualidade: um debate contemporâneo na educação.* Rio de Janeiro: Vozes, 2003. p. 9-27.

MEYER, Dagmar Estermann et al. “‘Mulher sem-vergonha’ e ‘traidor responsável’: problematizando representações de gênero em anúncios televisivos oficiais de prevenção ao HIV/AIDS”. *Revista Estudos Feministas,* v. 12, n. 2, p. 51-76, 2004.

OLIVEIRA, Dora Lúcia Leidens Correa de et al. “A negociação do sexo seguro na TV: discursos de gênero nas falas de agentes comunitárias de saúde do Programa Saúde da Família de Porto Alegre, Rio Grande do Sul, Brasil”. *Cadernos de Saúde Pública*, v. 20, n. 5, set./oct. 2004. Disponível em: <http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0102-311X2004000500025&lng=pt>. Acesso em: 4 jun. 2007.

PETERS, Michael. *Pós-estruturalismo e filosofia da diferença: uma introdução*. Belo Horizonte: Autêntica, 2000.

PINTO, Céli R. Jardim. *Com a palavra o Senhor Presidente José Sarney. O discurso do Plano Cruzado.* São Paulo: Hucitec, 1989.

RIBEIRO, Paula Regina Costa; DAZZI, Mirian Baldo. “Representações associadas à AIDS nos livros didáticos de ciências”. *Estudos Leopoldenses*, v. 4, n. 6, p. 61-80, 2000. (Série Educação).

SANTOS, Luis Henrique Sacchi dos. *Biopolíticas de HIV/AIDS no Brasil: uma análise dos anúncios televisivos das campanhas oficiais de prevenção (1986−2000).* 2002. Tese (Doutorado em Educação) – Programa de Pós-Graduação em Educação, Universidade Federal do Rio Grande do Sul, Porto Alegre, 2002.

SCOTT, Joan. “Gênero: uma categoria útil de análise histórica”. *Educação & Realidade*, v. 20, n. 2, p. 71-99, 1995.

SILVA, Tomaz Tadeu da. *Documentos de identidade: uma introdução às teorias do currículo*. 2. ed. Belo Horizonte: Autêntica, 2004.

_____. “A produção social da identidade e da diferença”. In: _____ (Org.). *Identidade e diferença: a perspectiva dos Estudos Culturais*. Petrópolis: Vozes, 2005. p. 73-102.

VEIGA-NETO, Alfredo. “Michel Foucault e os Estudos Culturais”. In: COSTA, Marisa Vorraber (Org.). *Estudos Culturais em educação: mídia, arquitetura, brinquedo, biologia, literatura, cinema...* Porto Alegre: Ed. UFRGS, 2004. p. 37-69.

Received February 2007
In October 2007

Translated by Jeffrey Hoff.
Translation from **Revista Estudos Feministas**, Florianópolis, v.16, n.2, p. 557-580, May/Aug. 2008.