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Naturalization and medicalization of the female body: social control through reproduction*

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ABSTRACT

This study discusses, through bibliographic research, the recurrence of naturalization as basis for the medicalization of the female body, as a means of social control through biological reproduction, whereby behavioral standards, social class, ethnic and race differences are rearranged/redefined. Through this process, male patriarchal and class predominance is maintained and the rift of social and gender inequalities grow wider. It is important to identify the role of technological developments and their complexities - which do not allow lower-income classes to take decisions in regard to their own bodies and reproductive health - and schooling, specially through science and physical education classes whereby upper-class predominance is sustained.

Key words: human reproduction. medicalization. naturalization, social control.

INTRODUCTION

The *medicalization of the female body* (Vieira, 2003) reports the case of a patient who, asked about how many times he should seek the doctor, replied: Every day! (P.11). The exaltation and hegemony of the medical professional as responsible for ordering and standardizing issues concerning the female body is not new. It has been built step by step and is deeply involved with the construction of medicine as an area of scientific knowledge.

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* This study is part of a literature review for the development of the doctoral thesis about infertility.

However, it is important to clarify the historical process referred in our study. The XIII century brings the emergence of Medicine as an area of technical and scientific knowledge of male domain that since then, it is increasingly involved in the interests of population control, disciplinarization of the workforce and hygienization of space and social relations.

But these concerns vary according to contexts and times. Thus, among the XIX and XX centuries, the existence of an overpopulated European continent should be considered in opposition to Americas, by demanding settlement, absorbed immigrants, and also, discussions and ideas from Europe. The Eugenic ideals, for example, characterize the colonial phase of European imperialism, ongoing since the end of the XIX century, are visible in Brazil only in the second decade of the XX century.

However, discursively linked to the improvement of race and population development, the eugenics took so aggressive and destructive under the Nazi-fascism in Europe in the decades of 30-40 of the XX century, forms that covered the need for control of the industry workforce and the struggles of social classes for distribution of wealth and socialist ideals.

In the global scenario of the XXI century, the spread of the reproduction issues in newspapers of great range, with headlines that highlighted the increased fertility in the slum, and the higher birth rate among adolescents in low-income classes, and illustrates the importance of this subject today and more: the perpetuation of a hierarchy of genders and maintenance of the biopolitic strategy mentioned by Foucault (1989), in which

[...] The current forms of medicine organization and the complexity of the technology associated with them ... in many cases withdraw or increase the withdrawal of the participation of common people from decision-making regarding their own body, for their well-being and in the limit, the fate of their lives. (Corrêa, 2001, p.25).

This study is part of a literature review for the development of the doctoral thesis of the Post-Graduate Program in Bioscience and Health Education - Oswaldo Cruz Institute (IOC) / Oswaldo Cruz Foundation (Fiocruz) on the recurrence of naturalization as a basis of the female body medicalization process. The article presents the consensus view of literature (Alves - Mazzotti & Gewandsznajder, 2004) in relation to two thematic blocks, so organized: Part 1 discusses the historical recurrence of the naturalization process as background for the medicalization of the female body, establishing a form of social control based on reproduction. Part 2 presents a discussion on the medicalization of the female body at the present time.

It deals about an initial exploratory research held in the Virtual Library of Health that found 78 references under the heading medicalization (67 in the Lilacs base- Latin American and Caribbean literature on Public Health; eight in BDEnf - Database of nursing; two in Medline and two in Adolec-health in adolescence). At the Hisa base (history of public health in Latin America and the Caribbean / *Casa de Oswaldo Cruz* / Fiocruz), 19 references were found; which, among those compatible with this study (seven), the majority were theses. Under the title medicalization of the body, only three references were found (Lilacs). Under the title medicalization and female body, three references were found (Lilacs), and under the title naturalization and female body, only one (Lilacs). For the title history of gynecology, 473 references were found, many of which dealt with periods previous to those mentioned above.

Among the items found, the historic vision of the medicalization process of hospitals, parturition, society, the fight between health professionals and midwives, the relationship between medicalization and social exclusion, the emergence of gynecology, the social image of the gynecologist, the medicalization of the female body, feminist struggles were emphasized.

More general references discussed social medicalization as biopolitic device, the medicalization of the gestation and female body, naturalization *versus* reproductive rights.

Statistic data from national researches that have made reference on the female reproductive health have not been included yet. The use of technology has been stressed to describe, through numerical data collected from literature, how the medicalization process that deepens inequalities of gender / race / class is arranged at the same time as it maintains and perpetuates the bourgeois hegemony. As for naturalization, data that enabled the discussion of motherhood as conditioning of the female identity were also considered.

Part 1: About the recurrence of the medicalization process

Social medicalização and medicalization of the female body

The emergence of the modern medicine, consolidated as scientific knowledge, can be located at the end of the XIII century, and has progressively been consolidated as experimental science, based on rationality and neutrality, excluding any judgment of value or subjectivity and on neutral observation, the development of universal laws (Vieira, 2003). It thus promotes a change on the relationship between visible and invisible (Foucault, 1980).

The ancient medicine is characterized by a limited diagnostic and therapeutic instrumental and a narrow technical intervention. The great change on the role of medicine has been through social normalization via development of moral rules related to work and daily habits and hygiene principles. This social normalization, in addition to the expansion of acts, products, and even of medical consumption, comprises the social medicalization.

The discursive medical normalization now re-describes events considered as natural and physiological and deviating social behaviors, and addresses to the intervention of specialized practices. Therefore, any aspect of social or individual life can be re-described in medical terms (Ilich, 1975) [2]. According to Corrêa (2001, p.25), medicalization comprises:

On the one hand, expansion of acts, products and medical consumption; on the other, the interference of medicine in the daily life of people by means of rules of conduct and standards that reaches an important spectrum of individual behavior.

The emergence of the modern medicine is given by the gradual recovery of the medical knowledge, including the biopolical strategy (Foucault, 1989), ie, medicine as scientific knowledge in the heart of the capitalist society emergence invested in the somatic, biological, and body. It is a "*social control that begins in the body, with the body*. [...] *The body is a biopolitic reality. Medicine is a biopolitic strategy*" (Foucault, 1989, p. 47). However, the author points out that "*it is not the consensus that brings forth the social body, but the materiality of power acting on the body of individuals*" (Foucault, 1989, p.82).

Capitalism sees the body as a force for production and medicine gained a new rule (Foucault, 1980), which allows the emergence of the medical profession and the myth of the eradication of diseases (Herzog, 1991), which proliferate and back feed medicalization that expands as a continuous process. The most important difference from the modern medicine, if compared to models previous to the XIII century goes from the association between the healing function of the doctor and his own figure, to the political function of creation and transmission of standards (Martins, 2005; Corrêa, 2001).

The social medicalization process transforms not only the social role of the doctor and medicine, but also the construction of diseases (nosology) and the medical corps, which will be professionally organized. The consolidation of the university education ensures the competence and regulates the technical activity through the installation of a moral code. Thus, impostors and people who make use of empirical practices are put away (midwives are a good example).

The social role of the physician is expanded, incorporating functions of educator and guardian of morals and customs. The definition of a new object of medicine, which shifts the focus from disease to health, starts controlling the virtualities, risks and also prevention (Vieira, 2003). The medical-hygienic speech considers the disease as a deviation, which causes are disorganization and poor social functioning, on which the medicine should act targeting "*neutralizing any possible danger*" (Costa, 1987, p.10).

This role derives from the hygienization project that took place in public space of cities, which reaches homes and the private life of families. By means of the regulation of individuals in the attempt of adapting them to a new order, the production of body, sentimental and social characteristics are observed. The modern government, moved by industrial interests, needs to maintain the demographic and political control of the population, which is suitable for this purpose. To do so, the organizational structure of the population should be attacked, in other words, the family (Costa, 1983). The objective was to discipline the conception and physical care of children, and for low-income families, to prevent the dangerous "political consequences of poverty and pauperism" (Costa, 1979, p.51).

Positivism - relating biological and social determinations - in force in the XIX century, elevates biology to the status of the bearer of laws (universal) that should govern societies. Supported on the very biological evolution of the individual and in conditions alleged "excellent" for this evolution, a change on the family organization, culminating with what Costa (1979) named *medical creatures*. This medicalization of privacy reached, primarily, women and children. The characteristics of women are redefined and their cultural role is enhanced, assuming the condition of the main domestic richness generator: the population. Mother and son are in harmony as "a devoted mother and beloved child will be the adult and adolescent's seed (Costa, 1979, p. 73).

In 1859, Charles Darwin presented the theory of evolution in the book *On the origin of species through natural selection or the preservation of favored races in the struggle for life*. This and the inheritance theories, which began to be developed at the same time, provide the emergence of a thought current characterized by the genetic fatalism that would culminate in eugenics [3]. The evolutionist theory was not limited to biology, and impregnated other disciplines.

The human diversity was determined by nature. The human hierarchy justified divisions and distinctions - of class, status and work - which should be valued, since they would ensure the progress of society. "*Liberty, equality and fraternity* were transformed into *discredited metaphysical fictions*, *inherited from the XIII century still not scientific*" (Rohden, 2001, p.26). For the scientists of the XIX century, nature was highly hierarchical and hence non-democratic and, therefore, inequality would have been decreed (Moscucci, 1996; Peter, 1980).

The European white civilized man would represent the evolutionary maturity in contrast to the black and primitive woman, in other words, the non-European. The very nature already defined the scales and values. Scientists have only served as interpreters for their determinations. The combination of such theoretical perspective with the vision of the world of educated men in an environment of privilege of the male authority and strong distinction between the public and private spheres and between the social functions of men and women would be at the core of the knowledge production on women and sexual difference in the XIX century. (Rohden, 2001, p.27)

The woman, on which the Hygienic precepts had directed the focus (besides the child), had, since then, threatened the patriarch, scientist, intellectual and working hegemony of the bourgeoisie man. Rago (2000) underscores the struggle of the first medical Brazilian women, in the second half of the XIX century, to join the traditionally male world of medicine.

The threat of bourgeois domain reflected in the manner in which women who claimed rights were identified in medicine: "*non-sexed, men-women, degenerated, vampire, murderer hybrid species*" unable to achieve or get married or maintain family (Gay 1984 apud Rohden, 2001, p.27). At the end of the XIX century, a "getting ill" process in relation to the transgression of the female standards could be observed. Nymphomania and hysteria hid the fear of the order disturbance (bourgeois) as a result of the female emancipation.

The irrational nature of women, in contrast to the male rationality, was already present in the Illuminist discourse. The demand for formulation of general classifications and universal laws (scientific method) produced, through the discourse of science, two separate groups, with well-defined and internal homogeneity: men and women, whose natures - male and female - were also different.

Since the end of the XIII century, the female nature was gradually linked to reproductive organs. This association referenced the speech of doctors and authorities about the limitations of the roles of women (social and economic). The sexual division of labor, reinforced through the urban industrial capitalism, restricted the female activities to the domestic space.

The medical descriptions about men and women bodies, in which the difference was highlighted, were combined to evidence that the female sexuality was also associated to the functions of mother and wife, and that the sexual desire of women was, by nature, less than that of men. Based on the different roles in reproduction, different social roles for men and women are prescribed: to the former, activities of the public world, labor, politics and trade, and activities in the private sphere of the family, performing functions of mothers and wives are prescribed and to the latter (Martins, 2005).

However, changes in the female nature involved disease, whose origins reside in the reproductive organs and could be cured by gynecological surgery, the most guaranteed means of treatment. Thus, the professional status of a new medical specialty was consolidated: the gynecology (Rohden, 2001), responsible for normalizing standards of sexual behavior. These standards, however, applied in a way more effective for women, since men were not defined by genitalia, and, although they had more sexual desire, they could manage it, and its excess would not necessarily be associated with disease.

Otherwise, the female normality is, by nature, potentially pathological (Moscucci, 1996). Women, because they are less likely to control themselves, more easily cede to sex, which characterized not only disease but danger to the family, to civilization and to the moral order, as these abnormal behavior could be hereditary and incurable. This threat gained importance as women demanded opportunities to sexual experience and autonomy.

The life conditions of women changed from the second half of the XIX century, what would contradict the prescription of the unique roles of mother and wife. Unlike the presumed passivity, modesty and domesticity, women started to demand access to education, to engage in public debates on prostitution and rights, to join the workforce, to marry later and to reduce the number of children. While doctors hoped to define femininity as fixed and static, it was rather unstable and fluid. (Rohden, 2001, p.28).

The need to control the population, allied to the fact that the reproduction is focused on the woman, transformed the demographic issue in a problem of gynecological and obstetrical

nature, and allowed the possession of the female body as object of knowledge, namely, the medicalization of the body female. The way to medicalize was reproduction. The reproduction management is crucial, expressed in a greater interest in pregnancy, childbirth, lactation, in childcare and even marriage "(Rohden, 2001, p.23-4).

The surgical and technological knowledge approaches medicine to childbirth (Vieira, 2003), enabling the creation of obstetrics (XIII century) as a field of medical knowledge and break the hegemony of Midwives (women). The configuration of gynecology and the installation of maternity facilities (spaces specific and appropriate for births), in the XIX century (Rohden, 2001), promoted the exaltation of motherhood as something inherent to the "feminine nature."

According to Vieira (2003, p.69-70), the production of ideas on a "feminine nature" in the context of the larger hygienization project of the capitalist society in the XIX century ...[allows] its medicalization. The author warns on the existence of multiple female types: one under the condition of sex and other according to the social condition.

Therefore, the naturalization is the basis of the medicalization of the female body.

... Through the legitimization of the medical knowledge, normality parameters restricted to the formation of the female identity were constructed, limiting women to be a good reproducer and educator of her offspring... The female gender is then constructed and sanctioned as true by the incontestability of the inexorably natural science, in the narrow space of a reproductive normality. (Vieira, 2003, p.71).

Birth control, eugenics and maternity-patriotism: reproduction control until the first decades of the XX century

Since the second half of the XIX century, there were questions and propositions on reproduction, in which fertilization and fertility were emphasized, especially by doctors. Rohden (2003) reviewed studies of that time, some of which are shown below.

The issue reproduction was first raised by Guimarães, in a thesis of the Medical School of Rio de Janeiro (1872). In 1908, Crescencio Antunes da Silveira considered immoral processes which *performances* were in detriment of the conception, offensive to marriage and crime against society (Brazilian). Settlement was the central concern.

The decrease on the birth rate on a voluntary basis is defined as anti-natural behavior, with serious consequences for social order and for the nation. "*While there are women who refuse the duty of motherhood, others are living in the most ardent wish of a ray of light in the darkness of their dreams, in the infinite anguish of being mother*" (Carvalho apud Rohden, 2003, p.28).

This condition was not unique to Brazil. The birthrate and the hygiene of race perpetuated by eugenic ideals characterized the relationship between medicine and public authorities in various contexts (Rohden, 2001, 2003). Although, in the period which was later called demographic transition (from 1870 to 1920), the reduction on the number of children was considered complex phenomenon and the result of various changes, an attempt to control the birth rate by individuals and an increase on the use of contraceptives and abortion were observed, which, in practice, would allow the fusion of these two strategies (Rohden, 2003).

Especially for worker women, restricting the number of pregnancies and children, in other words, the reproduction control, would be key to the control of their lives. Particularly in urban areas, the use of contraceptive methods and abortion involved a lucrative market and broad dimensions. Brodie (1994 2003) emphasized the role of gynecologists in campaigns against abortion and contraception, which evident background was to stop female sexual liberty,

bringing prestige to the new medical specialty, which defined the health of women as medical problem (medicalization of the female body). At the same time, they promoted the growth of nations within the already mentioned eugenic standards.

The intricate relationship between motherhood, contraception and eugenics results the recurrent statement that the doctor (allied to legislators) must be ahead of studies and control of issues concerning reproduction and, in particular, the control of the birth rate. For healthy couples, the rule is to procreate and to disapprove forms of birth control. The family life and motherhood are valued as result of the eugenic project.

There was a great interest in the scientific study about humanity, including its divisions into classes, races, nations. Differentiation and hierarchy were stressed in the reflections of scientists from that time (Wells et al., 1950). Eugenic programs encouraged the reproduction of individuals considered talented and well equipped and discouraged the reproduction of undesirable ones.

The formation of a healthy population, which is the guarantee of the future of nations, advocated in the actions of doctors (most visible part of the state intervention), comprised the fight against the progressive and hereditary degradation allied to the incentive and control of the birth of healthy citizen. Indeed, the breed improvement was conditioned to the increasing birth among higher classes, since the poor were responsible for the reproduction of the degenerated.

Interestingly, the doctors themselves admit that there is some social pressure - and some say it is stronger among women - for the spread of contraception. It is according to this pressure that doctors say are summoned to respond. Their answer comes in the form of a motherhood recovery project that includes advertisement on behalf of birth, especially facing women. Facing the panorama installed by eugenics and the nationalism, which means the number of citizens as a guarantee of sovereignty, it was necessary to convince healthy women of the importance of their role as mothers, [...] recover in their hearts, perhaps touched by the over civilization, education and work, the maternal instinct. And also [...] to improve the ability of being mother in accordance with the principles of eugenics, hygiene and childcare. (Rhoden, 2003, p.118-9)

Here, in addition to some difference between the concept of race and class, what is once again evident is the naturalization process of the female body as the basis of its medicalization, what allowed the seizure of this body by experts with the purpose of normalizing the sexual and reproductive behavior. The reproduction increasingly is no longer a matter of the private field and takes part of the public field, which must be controlled [4].

Birth control of and reduction of poverty: neoliberal discourse and eugenics

Unlike the period of *demographic transition*, which encouraged procreation and birth, since 1960, the international development plans promoted the population control as a means of reducing poverty, expressed in massive investment in the research of contraception methods. The "*contraception is a historic product of medical evolution and ideas that became popular and were disseminated after the first half of the XX century*" (Vieira, 2003, p.62). New technologies and changing values that permeated the birth control process (Back apud Vieira, 2003) are identified, for example, in the development of techniques for surgical sterilization - "*extreme of the contraception medicalization aspect*" (Vieira, 2003, p. 62). Thus, if then sterilization occurred with eugenic purposes, it is now a voluntary choice, solution for the fertility control, legitimized by the medicine and funded by the government (Vieira, 2003; Barroso, 1984).

In Brazil, the fertility rate has remained virtually constant from 1930 until 1965, when it began to decline. The total fertility rate (TFT) dropped from 5.8 children in 1970 (Ipea, 1996) to 2.3 in 2003 (National Survey through Home Sampling - PNAD, IBGE, 2003).

After 1970, an increase on the use of contraceptives, practice of abortion and sterilization was evidenced (Berquó, 1982; Barroso, 1984), with regional differences: sterilization was relatively more important in the Northeastern Brazil than in the state of Sao Paulo, with more expansion between women with lower education levels (Rodrigues et al., 1979, 1980; Nakamura & Fonseca, 1978).

Sterilization represented different realities for social groups and involved Fallopian Ligation (FL) rather than vasectomy (Barroso, 1982). According to the National Survey on Demography and Health (PNDS, Bemfam, 1997), 43% of Brazilian women were submitted to FL. In relation to the use of contraception, 77%, included limiting (63%) and spacing (14%) pregnancies, reflecting consistency with the high sterilization prevalence (Bemfam, 1997).

Analysis of the PNDS showed higher risk of sterilization in 44% for brown women, compared with white ones. For black women, the risk of sterilization was statistically significant and less than that of white, which indicates that "*this group of women finds obstacles and difficulties of access even for sterilization*" (Caetano, 2004, p.242).

White women have the highest percentage of use of contraceptives (pill or other more modern means, more likely). Conversely, black women present the lowest chance of use, that is, they have the highest chance for not using any kind of contraceptive procedure. Brown women present the highest proportion of sterilization. Similar data have been reported in literature (Carreno et al., 2006; Olinto & Olinto, 2000; Costa & Olinto, 1999). The difficulties of access and use of contraceptive methods are being met, especially in poorer areas, through sterilization.

The combination of an unfair social structure with a health system that has historically favored the hospital medicine, curative and intensive in technology is a determining factor in constructing this reality, which tends to affect disproportionately the black population. (Caetano, 2004, p.244-5)

The causes and mechanisms of the growing practice of sterilization, above all among low-income women, attracted the attention of activists and social researchers, especially from the end of 1980. The medicalization of the female body is among the causes found (Vieira, 2003; Corrêa & Loyola, 1999), in which doctors, decisive agents on the daily life, suggested this option to the low-income people, to whom only few contraceptive options were left. A significant concern, especially on the part of the Black Movement, was to report an alleged racist motivation and eugenics hidden by massive sterilization of poor women.

While in November 1997, the Ministry of Health has regulated the implementation of sterilization services in the Public Health System (SUS) - making it even paid by the government - and the Program of Full Attention to Women's Health (PAISM) is an example of national public policy profoundly influenced by the women's movement (Osis, 1998), the study of Caetano (2004) shows the emptying of the proposals of social movements and an appropriation that masks inequalities of class and gender.

On the other hand, the population control does not seem to be effective in reducing poverty. The results of the birth prevention in peripheral countries, in 1990, estimate that 412 million births have been avoided (Jejeebhoy, 1990), while poverty reduction is not made according to expectations, which shows that "*the network of programs, "development with population control" is an example of failure of international policies aimed at poverty reduction*" (Giffin, 2002, p.105).

Furthermore, the *transition of gender*, embodied in the provider women, even accumulating *natural* functions historically attributed to it - expressed in the figure of the independent woman - hides the "*deepening of the double journey, the exploitation and the way in which these strategies help in the reproduction of the inequality in the gender and social class level*" (Giffin, 2002, p.105). Thus, the old sexual division of labor is restructured and reinforces the feminization of poverty, as warned by Brito (2000): from the 1.3 billion people who live in conditions of poverty throughout the world, 70% of them are women.

The PNAD results (2003) reveal the presence of a percentage of 12.48% of domestic workers, in other words, composed of people who, at the time of the study, worked "*providing domestic service paid in cash or benefits in one or more household units* "(IBGE, 2003, p.25). This number (6.047,710 people) is higher than that found in the agricultural sector (4.426,871 workers) and concentrates significant percentage of women (5.618,902 or 92.91%).

The feminization of poverty, when analyzing the feminization of the workforce, updates and reformulates vulnerabilities of the genders added to the increasing number of excluded people, or "*more and more vulnerable men, women, children and elderly, who still survive interlaced in this social tissue under wear out process*"(Giffin, 2002, p.106), as result of the current macroeconomic model. In the field of reproductive health, gender should be focused as relational and *transversal* (Kergoat, 1996; Saffioti, 1992), namely: interactive of social class, race / ethnicity, differences of generation, cultural capital, etc. not as a condition that determines, in itself, vulnerability differentials [...] the vulnerabilities of gender cannot be abstracted from vulnerabilities as a result of poverty (Giffin, 2002, p.109).

The experience of issues relating to reproductive health and the type and quality of rights to such health suffers strong influence of race, social class and / or ethnic origin. "*Ethnicity, race, gender and sexuality are related" (Sansone, 2004, p.57),* and the*" race is an inexorable dimension of the reproductive trajectory of the Brazilian women* "(Bastos, 2004, p.255).

PART 2: About contemporary medicalization

Reproductive rights, contraception, maternity and naturalization: still medicalization of reproduction?

According to Giffin (2002), the process of controlling fertility in Brazil comprises a case of *perverse modernity*. Poverty and lack of citizenship determine the reproductive choices (perverse face) at the same time as the methods and rates of use are modern (modernity). The use of contraceptive methods reflects social and sexual inequalities between different social groups in the same society (Citeli et al., 1998).

Although the pill has been referred to as the most important contraceptive method and the first to be used (Citeli et al., 1998), the surgical sterilization is the procedure for fertility control most used in Brazil (Caetano, 2004; Giffin, 2002), supported by the high prevalence of surgical deliveries (36.4%), one of the highest in the world (Vieira, 2003; Giffin, 2002; & Loyolla Correa, 1999).

A discussion regarding FL relates to the formation of a culture in which this surgery will be seen as a trivial phenomenon of the reproductive life. Sterilization then comes definitively as a *natural* moment, arrival point for the female reproductive experience. The naturalization is evident in a new established cycle menarche-conception-pregnancy-birth-sterilization cycle instead of menarche-conception-pregnancy-birth-menopause (Citeli et al., 1998).

With respect to pregnancy and motherhood, the same naturalization process impregnates and crosses the history of societies, reaching the XXI century. Paim (1998) described the relationship of gender in urban working classes and emphasized the distinct tasks undertaken to maintain social reproduction. The domestic, internal, private and natural space as female domain; to man, the exteriority, the social and the public. Thus, on the one hand, the provider husband, and on the other, the task of caring (of the husband, children, home), the contraception, pregnancy and breastfeeding, as female liabilities.

Being women, in popular groups, includes maternity as inherent and necessary condition for her full accomplishment as subject. [..] Pregnancy and maternity are experienced not only as body process, but also as the assignment of a superior status to women in relation to those without children [...]. (Paim, 1998, p.35)

Data from the 2000 Census (IBGE, 2003) on the profile of Brazilian mothers corroborate the study of Paim. From 1991 to 2000, the growth on the number of young girls between 10 and 14 years as mother for the first time illustrates inequality as the Brazilian social brand that should be interpreted based on a number of factors such as low education level, low income and early awakening of sexuality. From mothers of this age group, more than 80% got pregnant still in elementary school (30.2% were between one to three years of study; 53.19 from four to seven years), 25.29% did not have any income and 52% lived in households with income of up to three minimum wages.

The lack of information about contraceptive methods not always configures the leading cause of pregnancy, but the search for self-esteem - being mother *is a way of finding its place in the world and have relative independence in relation to parents* (Escóssia & Lins, 2005) in an universe in which there is no perspective of professional or intellectual growth (school).

The importance of the first pregnancy and motherhood as rites of passage in popular groups have already been demonstrated (Paim, 1998). The status of adult, valued in the working classes, accepts the pregnancy of young girls after they menstruate for the first time (Duarte, 1986). Pregnancy and motherhood, then, are the constituent elements of the female identity (Leal, 1995; Leal & Lewgoy, 1995), the first one being perceived as a manifestation of health (Paim, 1998). "*So, in popular groups, the complete female identity is closely associated with playing the role of mother and wife*" (Paim, 1998, p.36).

Scholze (2002), examined representations on women in contemporary novels of writers, and stressed the recurrence of female images and historically built speeches: the private and domestic space of women, the exaltation to motherhood (versus the frustration of the *lifeless womb*), the exclusion of female sexuality through reservedness. In conclusion, the observation that "*even contrary to existing social rules, women self-punish*" (Scholze, 2002, p.27), [...] "an *infinite feeling of guilt, failure, guilt* ..." (Scholze, 2002, p.32).

One last question about the naturalization of the female condition should be added. It is the role of the church teaching, especially Catholic, about human procreation, of great importance in a predominantly Catholic country such as Brazil. Marriage is a divine institution, founded in the *natural law* and, accordingly, the union and procreative aspects of the conjugal act are inseparable.

In the encyclical Mulieris Dignitatem, the expectation of the mastership in relation to the role of the female gender in explicit in motherhood and in the consecrated virginity. In contrast, in the Education and in the Final Communication, the representation of the woman is focused on her role in pregnancy as a means (womb) for the development of another person. In that context, it seems that the obscuration of the gender dimension in texts is less related to the egalitarianism doctrine than to the incorporation of the biomedicine language that "consecrates the autonomy

of the body and the indifference of the subject that embodies it," representing the human person in terms of an "archipelago of isolated organs methodologically isolated from each other. (Le Breton, 1995, p.187)

However, it is not only in the world of Catholic schools that these processes occur. According to Louro (2003), the school forms subject in a dichotomized, rigid and binary way, assuming two opposite universes: male and female. The constitution of the subjects meets this dichotomy and is based on what is natural: heterosexual male and female subjects. Concurrently, analyses of didactic and paradidactic textbooks point to the conception of two different worlds: one public - male - and other, private - female.

Furthermore, the representation and indication of activities "characteristics" of men and women as well as professions or assignments also "characteristics" of white, black and Indians confirm and deepen, in most cases, the hegemony of the white man. Allied to these representations, the "*typical family composed of a father and a mother, and, usually, two children, a boy and a girl*" (Louro, 2003, p.70).

The power, entered in the curriculum establishes and reinforces inequalities (of gender, race, class). Thus, school collaborates for the maintenance of a divided society, manufacturing subject and producing, through the relationship between inequality, identities - of gender, class, race - according to the conceptions circulating in this society (Louro, 2003)

The school, if on the one hand presents and allows the discussion around new technologies, on the other, maintains and deepens the dichotomized, sexist and binary structure, in which the discussion on the body - of men and women - must manage themselves in predetermined biological standards and will be cared by the adequate professional: the doctor.

The IBGE study found; however, for women over forty years, mothers for the first time, financial stability and the high level of education, showing the deep inequality of the Brazilian reality with regard to the reproductive health. The emphasis on maternity, even in that group, highlights the demarcation of the role of motherhood in constructing the identity of females, "[...] *since their role is considered biologically defined and characterized by maternity [...], ie to be a complete woman, she should be mother* "(Borlot & Trinidad, 2004, p.64).

It is important to observe that the new reproductive technologies allow these women to have the right to determine when they want to be mothers, and the growing search for assisted reproduction services involves, once again, the medicalization process, since the absence of children configures pathology.

The biopolitic strategy of domination, maintained through medicalization, causing a level of ambiguity within the practices highlighted in the speeches of people, especially women. Just as the naturalization process "pushes" women for motherhood, as a condition and natural identity, the fragile structure of the current families and the model of capitalist economy make them ask themselves: "why to have children if I am not able to create them and provide them?" This same reasoning holds the biopolitic strategy because the way out is the performance of the surgical sterilization, usually during cesarean section, in other words associated to motherhood.

However, the regret of FL reported in literature (Osis et al., 1999; Osis, 1998; Ades, 1997; Cedenho et al., 1996; Barbosa et al. 1994, Prado & Venegas, 1993), expressed the power of the motherhood desire (particularly in the context of the constitution of a new family) and, once again, the medicalization (reversal surgery), on the one hand, extremely medicalized, on the other, with no effective universal access to medical care of concrete societies. This is the way the female body is presented, as a product of a medicalization that favors the reproduction or its denial. This is the basic prism through which the female body has been treated. (2003).

Final considerations

The reproduction control, which is base of the medicalization of the female body, crosses the centuries. It involves a form of social control, through which behavior standards and differences of social class, race / ethnicity are sorted / re-described, maintaining the hegemony and deepening inequalities of gender and class.

Over time, the maintenance and perpetuation of the representation of pregnancy and motherhood could be identified as something inherent to the nature of women, required to the formation of the female identity and its full accomplishment as subject. This naturalization perpetuates and deepens inequalities of gender and, above all, of class, since, especially among popular classes, the desire of being mothers is usually associated with a project of life, perceptible with the increase on the pregnancy rate among adolescents, while in social groups of higher levels, motherhood can be programmed and equipped with technological resources for this specific purpose.

In terms of reproductive health, the differences between classes, races / ethnicities clearly express the exclusion processes (and eugenics). Black women are the most affected, including by a process of surgical sterilization naturalized as the end of the reproductive life.

The problems emphasized also illustrate the difficulties of access to health services in the lives of women since early age (Carreno et al., 2006). To expand the access to the means for fertility regulation, and information on available methods (Law 9263/97 Family Planning) would be the way to ensure one of the key elements of the reproductive health concept: that people could, in fact, decide on when and how many children to have and to regulate their fertility through contraception methods instead of sterilization.

The *visualization* of the gender (Giffin, 2002) is an integral part of hegemonic and macroeconomic policies and masks the deepening of social inequalities and conflicts between women from different social classes. The neoliberal state, within its decline, suppresses the notion of justice and social welfare, and the notion of equity is restricted only to the neediest people.

Rifkin (2005) warned about the inadequacy, in the XXI century, of the old American dream of individual achievement in an environment that combines equal opportunities to maximum freedom and minimum government. Working towards social welfare, tolerance, cooperation and multiculturalism is perhaps one of the possible ways for the installation of a real reproductive right, in which the notion of equity would refer to the inclusion and to the crossed dimension of genders.

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