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Authors: Maureen O'Dougherty
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Maureen O'Dougherty
University of Minnesota
1334 Eckles Av. St Paul Minnesota 55108
modoughe@umn.edu

Plot and Irony in Childbirth Narratives of Middle-Class Brazilian Women

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Brazil's rate of cesarean deliveries is among the highest in the world and constitutes the majority of childbirths in private hospitals. This study examines ways middle-class Brazilian women are exercising agency in this context. It draws from sociolinguistics to examine narrative structure and dramatic properties of 120 childbirth narratives of 68 low- to high-income women. Surgical delivery constituted 62% of the total. I focus on 20 young middle-class women, of whom 17 had C-sections. Doctors determined mode of childbirth pre-emptively or appeared to accommodate women's wishes, while framing the scenario as necessitating surgical delivery. The women strove to imbue C-section deliveries with value and meaning through staging, filming, familial presence, attempting induced labor, or humanized childbirth. Their stories indicate that class privilege does not lead to choice over childbirth mode. The women nonetheless struggle over the significance of their agency in childbirth. [childbirth narratives, cesarean delivery, agency, middle-class Brazilian women]

Brazil's rate of cesarean deliveries—36% in public hospitals (World Health 2005) and 70% and higher in private ones (Belizan et al. 1999; Ministério da Saúde 2006)—places it among the nations with the highest rates in the world and far beyond the recognized need for C-section delivery in approximately 15% of childbirths, where vaginal delivery would pose a risk for the mother or baby (World Health 2005; Bailey and Paxton 2002). Public health research finds that the inflated recourse to surgical delivery in Brazil is not the result of choice (see e.g., Dias et al. 2008). Anthropological approaches question the framing of childbirth decisions in terms of "choice" through research placing the decisions in context (McCallum 2005; Hopkins 2000). The contribution I hope to make revolves around women's agency over childbirth. I take as a starting point a similar questioning of women's choice in childbirth in Brazil. My project aims to shift our attention to what women are doing, that is, in what ways they are exercising agency in this context where C-sections predominate. Questions driving the research are: How, in their narratives of childbirth, do Brazilian women represent their own agency and the agency of others? What do key structural features of the narrative and dramatic properties suggest of a woman's sense of agency and her perspective on the experience? What are women doing to create the conditions of their childbirths and the meaning childbirth holds for them? Studies of medicalized childbirth have underscored the need for attention to women's experiences (Brubaker and Dillaway 2009; Rúdólfsdóttir 2000; Akrich and Pasveer 2004; Namey and Lyerly 2010). My sense too is that beyond our own interpretations, we need to learn how women themselves represent agency in childbirth and in turn integrate this understanding into reconceptualizations of this contemporary trend and into efforts to improve childbirth.

I gathered childbirth narratives from 68 women in Rio de Janeiro between 2004 and 2009 to gain an "agent-centered" approach to these life events (Garro and Mattingly 2000:16).

Seventy-four of the 120 childbirths (62%) were by cesarean delivery. Among the 31 low-income women interviewed, 53% of childbirths (29 out of 55) were by C-section; among the 37 middle- and upper middle–class women, 69% of deliveries (45 of 65) were by C-section. Just 3 of the 20 younger middle-class women (born between 1973 and 1984) had vaginal childbirths, compared to 8 of the 17 older middle-class women (born between 1953 and 1968). One guaranteed plot for the younger middle-class women, with "complicating events," "evaluative statements," "resolutions" and "codas" (Labov 1997), was cesarean delivery. In what follows, I focus mainly on the young middle-class women among whom private sector surgical births predominate. The stories illustrate that these relatively privileged women, like other Brazilians, currently do not have a "choice" over form of childbirth. Nonetheless, they are caught up in the debate over "normal," "natural" versus surgical childbirth, and they are active in efforts to create conditions for meaningful childbirth. I start by situating this study in the context of research on cesarean deliveries in Brazil, and I describe my approach to agency in narrative. I then turn to seven women's stories to explore ways they responded in this context where C-sections have become the norm and vaginal deliveries the alternative.

Debates on Cesarean Delivery in Brazil

The high rate of cesarean deliveries in Brazil has prompted intense scrutiny. Studies with diverse methodologies have found that the majority of Brazilian women do not "choose" cesarean delivery. Bastos Dias et al. (2008) report from a survey with a sample of 437 low-income women that 70% favored vaginal childbirth, but few went into labor; they were instead persuaded in the health care setting that circumstances indicated C-section. A survey of 909 women found that 76% had not preferred C-sections because of the difficulty recuperating (Barbosa et al. 2003:113-114). Interestingly, 19% who had delivered vaginally had actually asked for a C-section, a finding revealing "the limited power of women in determining the type of delivery they have, be it vaginal or caesarean" (Barbosa et al. 2003:116).

An important part of the Brazilian debate revolves around the role of middle-class Brazilian women in setting the trend for increases in C-section delivery from 1980 forward. According to Mello e Souza (1994), who interviewed 20 women and 20 obstetricians in Rio de Janeiro, middle-class women contributed to the initial inflation of C-sections by wanting to avoid surgery on the perineum. She reports that doctors attributed the rise in C-sections to women's lack of preparation for labor pain and to a belief that their sexual attractiveness would be diminished by a "stretched vagina" following vaginal childbirth. Although Mello e Souza finds that the physicians were remiss in failing to present surgical risks, she argues that middle-class women *were* exercising agency for C-sections, together with doctors, who benefitted financially and in scheduling from planned surgical births. Because of their higher status, this middle-class practice would have become an ideal for poor women.

Several works attribute the high rates of C-section in Brazil in good part to institutional and professional practices. A prime suspect for the inflation of C-section delivery is financial. While as of 1980 the reimbursement at public hospitals for C-sections and vaginal deliveries were equalized, hospitals receive twice the revenue from C-sections because of the longer hospital stay. Moreover, time is saved through surgical deliveries, especially scheduled ones. While these factors are critical, Béhague (2002) criticizes the terms of the C-section debate in Brazil, finding it tends to quantify preferences and lay responsibility solely on financial questions. Doing so, she argues, may "divert attention away from investigation of how

definitions of and indications for the use of the c-section technology have themselves been medically and socially altered" through active negotiations on the part of the women, as well as providers (Béhague 2002:498). Also questioning the individualist assumptions underlying the debate, McCallum (2005) observes that we need to better situate providers and women within their wider context. McCallum maintains that Brazilian doctors are better trained for and thus more confident about performing surgery, that hospitals place time limits on the progress of labor, and that a potentially viable recourse to obstetric nurses to assist with labor has met with resistance by doctors and obstetric nurses.

Systemic factors appear to contribute importantly to the rise in C-sections. Case control studies (D'Orsi et al. 2006, 2000) and surveillance studies (e.g., Padua et al. 2010) have found cesarean deliveries associated with numerous nonmedical reasons. Researchers underscore the use of C-section precisely where least indicated—at first childbirth, with better-educated women—and they suggest that the register of breech presentation is inflated to justify surgery (Freitas et al. 2008). Commonly used but questionable justifications for a C-section include slow progress of labor and a wrapped umbilical cord (Dias et al. 2008; Béhague 2002).[1]

It is in relation to these many contextual factors that one-on-one interactions of women with doctors over mode of delivery need to be viewed. In fieldwork in public and private hospitals in Natal and Porto Alegre, Hopkins (2000) surveyed 321 women postpartum and made direct observations of 29 deliveries, including 15 C-sections. She found that doctors' decisions for cesarean deliveries were often "obscured, most typically by their own power to frame the hospital birthing situation in terms of a women's choice or in terms of medical need" (Hopkins 2000:727). Both Hopkins(2000) and McCallum (2005) report that Brazilian doctors present themselves as receptive to vaginal deliveries; they use the phrase "let's try" in regard to them, but later introduce decisive evaluations against them.

Regarding low-income women, Béhague suggests that obtaining a C-section may be "empowering" in a context lacking a supportive environment for vaginal delivery. In the South of Brazil, she found from interviews with 80 mainly low-income women that those who actively seek medicalized birth do so with the knowledge that this will enhance their chances at better quality of care during birth (Béhague 2002:494). McCallum and Reis (2005) offer a powerful illustration of the poor conditions in public hospitals of Northeast Brazil. They emphasize the lonely and fearful experience of vaginal childbirth in a public setting, where family is not allowed to be present and women are subjected to insulting evaluations by health care providers (see also Diniz and Chacham 2004). McCallum's statement that stark race and class inequalities "mark the symbolism of birthing arrangements, and they sustain the system as a whole" (2005:235) registers that race and class frame childbirths. Concerning the apparent lack of contestation among Brazilian women to surgical delivery, McCallum concludes that "what some read as women's 'cultural' inclination towards abdominal birth may simply be compliance, born in the absence of both a coherent, culturally appropriate critique of existing practices and knowledge about vaginal delivery" (2005:230).

The literature on cesarean delivery in Brazil has made progressive gains in interrogating the terms of the debate, shifting it from a narrow focus on individual "choice" to a deeper contextualization of decisions for surgical delivery. My own research findings of the decisions over mode of delivery offer a similar array of doctors' explanations leading to C-section delivery, as I discuss below. Before examining the narratives, I turn to two areas guiding this research: theories of agency and approaches to narrative analysis.

Medicalization and/or Agency, as Emerging in Narrative

Recent Brazilianist perspectives on medicalized childbirth have sought to situate doctor–patient interactions in context. Anthropologists conducting work elsewhere underscore complexity and diversity in women's responses to medicalization. Lock and Kaufert assert that "ambivalence coupled with pragmatism may be the dominant mode of response to medicalization by women" (1998:2). Similarly, Root and Browner find from pregnant women in the United States a "dialectic between partial resistance (the voicing of one's subjugated knowledge as possibly equal to and a part of an authoritative knowledge) and partial compliance (the desire for authoritative affirmation of this knowledge)" (2001:202). Davis-Floyd argues, in relation to U.S. women who chose technocratic childbirth and those who chose home births, that "all were active agents in their birthgiving, albeit in radically different ways" (1994:1136).

These formulations register the centrality of structure and agency to examinations of women and medicalization. I find Ahearn's (2001;112) concise definition of agency as "socioculturally mediated capacity to act" a useful starting point, and I draw on feminist and practice theories to consider how women act in ways that can produce effects. Coole reconceptualizes the dynamic, interactive quality of structure and agency, with attention to agent potentiality and limitations. She says: "agents do not act on a field as if from the outside, but rather "emerg[e] from within it . . . even resistant strategies are shaped by the logic of a field they may nonetheless transform" (Coole 2005:137; see also Lovell 2003). McNay emphasizes that agents in any social field can generate effects. McNay asserts that "in order to draw out a more active conception of agency, it is sufficient to make the weaker case that individuals have the potential to respond in a nondefensive and occasionally creative fashion to complexity and contradiction regardless of whether these differences are effectively reconciled or not" (2000:102). In her work on pregnancy experiences, Rúdólfsdóttir notes (recalling Butler) that "subjecthood . . . tends to exceed the power involved in our subjectification" (Rúdólfsdóttir 2000:338). I share with these approaches a concern to register the diverse actions of women in relation to agents of biomedicine, and to acknowledge potentialities and challenges to effect change.

Life stories offer a privileged means for understanding the storyteller's sense of her own and others' agency. I adopt aspects of sociolinguistic analysis in order to focus on the telling of the story rather than solely the content (Riessman 2000:129–130). For the analysis of the women's narratives, I draw first on sociolinguist William Labov's work (Labov 1997). Labov identified key structural features of oral, personal narrative: complicating events, evaluation, resolution, and coda. For these narratives, the complicating events concern how and possibly why each woman believed she came to have a C-section. Evaluations of events and one's own and other people's acts are integral to narrative structure. I was attentive to statements of what should or should not have occurred in the childbirth process. Narrative resolution places closure on the story, and coda brings the story back to the present. A resolution and coda signal a full narrative structure. I considered whether the happy ending (a healthy baby) made it all fine or whether there were unresolved aspects.

Another way I approached the examination of childbirth narratives concerns dramatic properties. Akrich and Pasveer (2004) consider how actions and agency are "distributed" within childbirth narratives. Similarly, by reflecting on where the woman, the main protagonist, is located in the dramatic stage vis-à-vis others, I found another means of ascertaining how she

understood her own agency. As Mattingly says, "If narrative offers an intimate relation to lived experience, the dominant formal feature that connects the two is not narrative coherence but narrative drama" (in Garro and Mattingly 2000:269). The childbirth stories I present here were especially compelling to me for their heightened dramaticality, some serious, others light to comedic. Still others appeared to be a mixed genre, seeming to incorporate irony in the relaying of events. By considering the dramatic genres through which that the story is conveyed, I found it led me closer to the possible underlying significance that surgical delivery had as their childbirth experience (in the version of it that I heard).

It is good to bear in mind that the narratives were produced in a context where the interactive process (Riessman 1993) involved the tellers (diverse Brazilian women living in Rio de Janeiro) and a U.S. anthropologist, who was unknown to them prior to the first interview. For my purposes, the advantage of retrospective, constructed memories is that the stories are produced with some time and distance and are told as the teller wished for the stories—and themselves as protagonists—to be understood. Most women I interviewed began cautiously but soon became absorbed in telling their stories and took charge of the conversational flow. One-third of the interviews with low-income women were conducted with employees of a Flamengo neighborhood beauty salon (with renewed contacts over the years). Another third took place in a shantytown above Santa Teresa, and the remaining third at a maternity clinic in Laranjeiras among women waiting for an ob-gyn checkup. I met the middle-class women through two sources: most through friends (several of whom I interviewed repeatedly) and some through announcements by a Flamengo fitness club instructor at her classes. These women resided in the Zona Sul, Zona Norte (Tijuca) and Niterói.

The New Normal? "Complicating Events" and the Decision for Cesarean Childbirth

Carla, born and raised in Botafogo (with a monthly household income equivalent of US$2,500), had three babies when she was between the ages of 21 and 26. At her second childbirth in 2000, she waited to go to the hospital until the contractions were 10 minutes apart.

> Still [the doctor] waited eight more hours—I could have waited longer—but he thought it was too much of a sacrifice for me. I don't know, but I think it's the policy here in Brazil, to do all cesarean, people choose it much more than normal delivery, but I thought natural childbirth was more natural [*sic*], and I wanted to try, and I said this to him, so much so that we tried until the end . . . I had all the contractions, it wasn't a scheduled cesarean nor planned . . . I felt all the pain, just didn't manage to become dilated, so he did a C-section.

The 120 childbirths described by the 68 women in this study occurred between 1975 and 2009; of these 74 were by cesarean delivery. The complete set of reasons they gave for the decision to have a surgical childbirth and frequency is as follows: slow progress of labor, described by women as contractions but little dilation (20, including 5 "no passage"); prior C-section (13); 39 weeks of pregnancy or more (11); umbilical cord (could be) wrapped around the neck (6); the woman's choice independently of physician (5); abnormal positioning of baby (5); high blood pressure (4); bag of waters burst but labor did not begin (3); and tubal ligation following surgical birth (Janowitz 1982) (3). Four explanations were prior femur injury;

exhaustion with labor after seven hours and epidural analgesia; advanced age of woman (39 years); group b beta streptococcus.

The women's descriptions of the complicating events leading to surgical delivery ranged from a brief mention, such as "there was no passage," to fuller narratives like Carla's entailing constructed dialogues with their physicians. From the women's accounts, which often included mention of the level of dilation, it seems likely that the decision for a C-section was made based on a prolonged latent or early phase of labor (with fewer than 4 centimeters of dilation and fewer than 24 hours in duration) rather than stalled active labor (Enkin et al. 2000:233).[2] Five mostly low-income women described the decision for C-section as owing to "no passage." Although one might imagine the phrase refers to feto-pelvic disproportion, a Brazilian doctor I consulted said it generally meant "lack of sufficient dilation in the expected or awaited time period." In the accounts I gathered, it was the doctors who made this the basis for a C-section; with one exception (see Cira, below), the woman herself did not give up.

The next most commonly presented reason for surgical delivery was a C-section following a C-section. Nearly as frequently, the doctor said that if labor had not begun by week X (week 39 on), it would have to be cesarean. (Post-term pregnancy with possible risks is understood to begin at 41+ weeks.) Just one woman insisted on a vaginal birth in this circumstance, and she was of the older generation. She objected to doctors applying strong pressure (*forçação de barra dos médicos*) for C-sections. The common event of the umbilical cord wrapped around the neck ("nuchal cord") is not usually considered an indication for C-section. From the women's stories, all these decisions were made unilaterally by the doctor.

Cesarean delivery appeared to be a kind of generalized solution to many factors possibly affecting the trial of labor. Many decisions appear to have been made pre-emptively, prior to labor, hence before circumstances indicated need or were presented by the doctor as if there were no alternatives. It would be remiss not to recall that although the actual risks of cesarean delivery are not great, they are still greater than those of vaginal birth.[3]

Returning to the excerpt above, we find Carla mainly uses the active voice, both in reference to herself and to the doctor. As she says, "I had all the contractions, it wasn't a scheduled cesarean nor planned . . . I felt all the pain, just didn't manage to become dilated." The doctor, however, decides *for her* that her suffering was "too much a sacrifice" even though she disagrees (silently). Carla also suggests that in the end it was her unresponsive body that led the doctor to perform a C-section. This account of the woman's agency vis-à-vis the doctor's leads us to consider that the language women use to formulate the lived experience of their bodies during childbirth may itself contribute to the retrospective justification of the surgical delivery, as well as may contribute to a retrospective critique, as the next two stories illustrate.

Serious Drama in Opposition to C-Section Delivery

An Anxious Labor and an Accusation of Medical Error, Resolved

A high-level legal professional, Regina, resident of Copacabana, took a decisive, argumentative approach to life, and this included her pregnancies. For example, she informed me that during her pregnancies she had one cigarette every day or every other day "because I started to get very nervous. And when my spirits (*animos*) get overexcited (*exaltados*), then a cigarette calmed me, so it was better." She switched doctors in the first trimester of her first pregnancy, annoyed at his recommendation against taking medication for an allergic reaction. During the 36th week of her

second pregnancy (at 29 years of age), her doctor told her to rest following the passing of the mucus plug (a sign that the cervix was dilating). She said she told him: "I'm not going to rest. It's *carnaval,* it's hot and sunny. It's time for the baby to be born. I'm very fat and I don't want to gain more weight. So get ready, as I could be calling you any time." Five days later, Regina arrived at the hospital having lots of contractions.

> The doctor . . . said: "Wait a little until there's space in the maternity ward." I said, "Doctor, you don't understand, I'm going to have the baby here in the reception, I can't wait." . . . So finally, they brought me to the delivery room, gave me anesthesia and started in on the C-section without even checking the dilation. [M: Really?] They thought the second baby would be like the first, without dilation, and as I was always very hysterical, they thought it was ridiculous on my part [to be saying her baby was nearly born], when nothing was going on. So when they opened me up, I heard them say, "We have to push it back." The baby was already coming down and they had to push it back. It shouldn't have been a C-section. It was a medical error. [M: Were you upset?] Today I think perhaps it was better. I always feared normal childbirth because I wanted the baby monitored. As it was, there wasn't monitoring. He could have come out with the cord around him, I didn't have heart-rate monitoring, nothing. Because here in Brazil, they don't have experience with normal childbirth, they are afraid of medical error in normal childbirth, so they immediately opt for cesarean, understand? So, since he didn't reassure me much, I wasn't very secure or sure of what I wanted . . . At the time I was annoyed; later I thought twice. So I didn't really know what I wanted. It wasn't to be, you see?

I present Regina's childbirth story above almost without ellipsis to show its compressed dramatic style, yet complete with clear illustrations of all components of narrative structure. The first complicating event was, of course, Regina's being ready to deliver, without having a delivery room available. The second was that the medical team did not check her state of labor and pushed the baby back in order to continue with the C-section. Just at this dramatic height of the story, where evaluative statements are usually made, Regina decisively pointed out what should not have occurred: "It shouldn't have been a C-section. It was a medical error." After this climax, Regina launched into a critical evaluation of current inadequacies of obstetricians in Brazil. Although recognizing that she was about to have a vaginal delivery, and while annoyed, Regina didn't dispute the C-section. She was unsure of what she wanted. As noted, Regina used authority clearly and consistently, defying doctors and relying on her own embodied knowledge (Browner and Press 1996). Her uncertainty over mode of childbirth stood out all the more.

Let us review agency in the account. Regina tries unsuccessfully to demand the doctor's immediate attention. In the delivery room, Regina appears only to listen to the medical staff's shocking revelation that the baby was already descending the birth canal. Regina herself quickly supplies a resolution to the complication and to the question of agency with a post hoc evaluation of her surgical delivery. She says she did not object in part because of the doctor's lack of reassurance—evidently, that she could give birth "normally." Regina also says she would not have wanted a vaginal delivery without fetal monitoring (see Lazarus 1994). In a sense Regina recuperates her own usual authoritative stance through this explanation. Through the coda, she resolves the conflict between what should have been (a vaginal childbirth) and what was (a surgical childbirth that in her mind constituted a medical error). By suggesting that neither she

nor the doctor determined the childbirth method, but rather, the hand of fate ("it wasn't to be"), Regina regains some authority and her place as main protagonist in the story.

An Anguished Childbirth with Unresolved Depression

I met Sandra in her tiny apartment in São Gonçalo, Niterói, along with the nanny that had raised her and her four-month-old baby. Her crises were multiple: first the unintended pregnancy itself to a young couple with low income and uncertain prospects. Her monthly household income was the second lowest in the middle- to upper middle-class sample (the equivalent of US$1000 compared to Regina's $8000). She was one of the youngest mothers of this subsample, giving birth at 23 years of age.

One complicating event prenatally concerned the obstetrician. Sandra switched doctors in the ninth month of pregnancy. She was dissatisfied with her first doctor as he "didn't give the attention that I needed, you see? I didn't have his cell, he wasn't attentive. I'd get panicky. . . . So, I went to my mother-in-law's doctor. I actually already knew him. I only had three consults with him, but he gave me confidence, he gave me his cell number, his secretary's number, his home phone." After this decisive act, Sandra's effectiveness diminished. Her new doctor told her during an office visit that she wouldn't be able to have a vaginal delivery. She recalled him saying, "'I'm going to be honest with you, the size of your baby [52 centimeters] and the size of the passage you have, there is no way the baby can pass through. It'll be a sacrifice for the baby.' The doctor said this and scheduled the cesarean," Sandra said.[4]

The doctor's denial of a "normal" childbirth provoked an internal crisis in Sandra. She felt a scheduled surgery was wrong, "as it didn't come from God. I put such ideas in my head, you see." The date came, and Sandra became anxious when the bag of waters did not burst, and she didn't feel anything. Very apprehensive on arrival at the hospital and during the delivery, she says she kept thinking

> No, no, it's not the right time. At the moment the baby was coming out, I felt a very big sadness. I cried a lot with my mom after. Days after, I said, "Good grief, they yanked (*arrancaram*) the baby out of me." Because I heard one doctor say, "He's really high up." I heard her say this. As if he was still really high up, you see. And she went up to push him down. That sensation at the beginning, when they pulled him from me, they yanked him from me, understand? It wasn't time. So this got into my head, it stayed there for a month.

Sandra's final point was self-critical, but her evaluative statements strikingly convey the experience of violation with the doctor forcibly pulling the baby out, thereby countering God's will. Later, in this first interview, Sandra mentioned having depression. When I asked how long the depression had lasted, she said simply that it was not over.

What I want to point out first is that the form of childbirth was not the choice of any Brazilian women I met *unless* their choice coincided with the physician's. The women could be openly or passively resistant, ambivalent or acquiescent, they could be wealthy or not, but most still had C-sections. Despite differences in relative wealth, Regina's and Sandra's relationships with their doctors were parallel. Both changed doctors during their first pregnancies, out of dissatisfaction. Note that this form of agency is not available to low-income women, who use the federally funded universal health care system. Both were critical of their childbirths and

bolstered their evaluations with reference to powerful authorities. Regina alludes to malpractice of the C-section performed too late; Sandra invokes God's will against the C-section performed too soon. Neither openly objected at the time of childbirth; instead they made retrospective evaluations. The negative evaluation of these experiences led them to make subsequent changes in provider, as did others. After an unsatisfactory childbirth, the women would invariably change doctors. Childbirths following a C-section delivery, however, are most often C-sections in Brazil (see e.g., Padua et al. 2010).

The parallels in the two stories extend to their starkly serious dramatic style. It seems to me that the differing dramatic properties themselves registered something about the meaning of the experience. In both stories, the protagonists remained central albeit ineffectual. The experiences produced negative internal emotions of anxiety and anguish. But when we consider the resolution and coda to the childbirth experience itself, Regina and Sandra responded very differently. Regina found an intellectual resolution. Sandra's story lacked a resolution or coda. She was trying to distance herself from her belief that God had not ordained a surgical birth, but at the same time she struggled with depression (which she later overcame with the help of her mother).

It is instructive to consider one of the three young middle-class women in my sample who did have a vaginal delivery: Laura's doctor had scheduled her to have a C-section because she had hyperthyroidism. When Laura went into labor earlier, instead of informing her doctor (about whose treatment she had disputed weeks earlier), she walked the three blocks from her home in Tijuca over to the Veterans Hospital with her husband, who was employed in the military, and had a vaginal childbirth in the care of the attending physician. While we may count this as a rare example of resistance to surgical childbirth, Laura emphasized that the attending physician made the decision, countering the orders that she presented from her own doctor. As there seemed to be very limited potential for the young women to determine childbirth method, the question became in what *other* ways were they exercising agency? Let us turn to narratives where the women shaped the conditions for their childbirths.

Ironic Drama: Efforts to Recuperate Agency in Childbirth vis-à-vis the Agency of Others

A Deluxe Filmed and Scheduled Cesarean, Where, Ironically, the Mother is Peripheral

Marcela, a resident of Leblon and liberal professional not working outside the home (with a household income the equivalent of US$4000), prefaced her account of childbirth at age 29 in week 40 of her pregnancy with these comments:

> I wanted a normal childbirth. But here in Brazil, I don't know how it happens, but I think that it's a question of convenience for the doctors; they like to set up cesareans. For them it's easy. They work all day and at night they go to the hospital. I had my C-section on a Friday, I chose the day . . . because then I could take advantage of the weekend at the hospital. [Laughs.] I didn't actually go into labor. I didn't even insist on a normal childbirth; I regret it.

Marcela frequently conveyed a duality of perspectives. She commented that her yoga instructor, who espoused natural childbirth—which Marcela herself did not—had made her "paranoid" that the baby shouldn't come out too soon, that this would constitute a "trauma." But

she contested this view: “After all, everyone goes through this [at birth], but at the time I thought, ‘I want the best’—at least I want induced labor. I said, ‘Try to induce.’ ‘We can induce,’ the doctor said—but I ended up not trying. When I got to the 40th week, I became very anxious about the birth, so when he said, ‘Let’s set it up,’ I said, ‘Let’s.’” As others have found, these reports illustrate how Brazilian doctors formulate the decision for a C-section as if in response to the woman. This doctor’s wording is one of joint decision-making coupled with a characterization of risk with late-term pregnancy.

Marcela continued jovially:

> That morning, I went to the beauty salon, got my hair done, a manicure, had a nice lunch, my husband came for me, and we went. [It was] really great (*super tranqüilo*) —there were 50,000 people at my [laughing]—because there, at the perinatal clinic, they have a baby arrival room, a restaurant. It’s a really great space. Everyone called me, and I told them, “It’s on Friday, stop by.” I think there were more than 30 people in the perinatal restaurant.

Marcela went on to explain that the father takes the baby down the elevator and holds the baby up to the big window for everyone in the arrival room to see, that the mother is shown on the TV, and fireworks go off. Marcela said, “He went down, and I didn’t even see.”

At this moment, she broke off her train of thought and good-humored tone and then turned to what I believe was the central dramatic moment of her story. Marcela was disappointed because she had heard that they would bring the baby to her directly on delivery. But instead they took the baby away for a long time and then gave the baby to her, as she recalled, “in a green blanket. I was sort of confused; I thought I was going to cry; I was sort of paralyzed; my daughter already [in a blanket] . . . I was confused.” While her husband had a fabulous time (*curtiu horrores*), assisting with the cutting of the umbilical cord, taking the newborn to the cheering crowd, Marcela was first confused by the medication they gave her after the birth, which made her silly and stupid (*bobalhona*), an effect she emphatically disliked, and then she fell asleep: “If it had been normal childbirth, I wouldn’t have slept,” Marcela concluded.

Although Marcela began her account with a critique of C-sections as existing for the convenience of doctors, she made herself out to be the responsible party for not pressing for a vaginal delivery or induced labor. She was among many who had wanted to induce labor. Why do so when a C-section will probably occur? A woman with a breech presentation (Kátia, below) said, “Even knowing I would end up having a cesarean, I wanted to experience the feeling of labor.” By inducing labor, the women were striving for active embodiment and possibly to thereby experience childbirth as an achievement (Rúdólfsdóttir 2000:346). Marcela indicated several efforts to create conditions surrounding her childbirth. She scheduled her C-section, which allowed social planning and, with the hospital accommodations, fostered a staging of festivities complete with film, soundtrack, and viewing room. This reproductive ritual in the making (Davis-Floyd 1992) as played out, however, left Marcela a spectator at her own childbirth and kept her peripheral to the central events, even “off scene.” Hers was a somewhat disembodied, even alienating experience. In Marcela’s story, the centrality of others ends up prevailing, leaving her a discursive agency of retrospective, ambivalent evaluation. Her story lacked a resolution and coda, yet notably, Marcela conveyed her story to me with wry, ironic humor.

An Alternative C-Section, Where the Mother Is Grateful

Cira, a resident of Botafogo and unemployed graduate student (with a household income equivalent of US$2,600), framed the account of her efforts to have a natural childbirth (at age 33) by a forceful assertion: "I think that one of the strongest experiences of my pregnancy was this course—my doctor and the course instructor—it's impossible to speak of my pregnancy without speaking of them." The course, the instructor, and her doctor, all proponents of humanized childbirth (see Diniz 2005), were "fundamental" to Cira's pregnancy and childbirth. The instructor, Cira said in a curious phrasing, "forms the opinions of the pregnant women."

Like Marcela, Cira was keen on being able to be with the baby right away. She did not have her baby put in an incubator for two hours, which she said was "standard with middle-class Brazilians" and added, "This was something that I was very concerned about, this thing of being the perfect mother. Now all babies are born and go to the incubator and continue being normal people; it doesn't really make such a difference. But with this thing of being the perfect mother, you want to do everything that's the best possible, and childbirth has to be a fairytale." The course instructor had told her "all these stories" (about breastfeeding, having the baby immediately at the breast, having the husband give the first bath, choosing the pediatrician and ob-gyn), and "I *bought* these stories that she told [emphasis added], and I managed to do things the way she was saying, and it was better, and I loved it, every time I went to the class."

Cira ended up having a C-section because, as she put it, "In fact, I was psychologically prepared for a natural childbirth, but I wasn't prepared for a *difficult* natural childbirth, so I opted for a cesarean." She provided a fuller context: She'd spent a long night with contractions, but little progress with dilation. Her doctor explained that it therefore was not possible yet to give her anesthesia, and that it would be a slow labor. Cira noted, "Here in Brazil, it's very easy to opt for cesarean; it is outside the mainstream standard to opt for natural childbirth. The standard is cesarean, as a matter of fact, the standard is a *scheduled* cesarean" (*cesareana marcada*). The doctor said: "I'm going to be frank with you. I always try to have it be natural childbirth; I always try to encourage it, but in your case, I think it'd be difficult, a difficult scenario. It could be that we'd try for four more hours and it'd be cesarean anyway." Cira said she didn't feel she had it in her to wait two more hours for anesthesia. Cira's wasn't a "natural" childbirth, but she presented the final decision as her own. Without questioning the sincerity of the doctor's preference for vaginal childbirth, one can nonetheless register her persuasive outlining of the scenario that would ensue were Cira not to opt for cesarean. Still, Cira felt affirmed by her experience of humanized childbirth.

Cira's complicating event had a resolution. I was perplexed, however, by her insistence on the centrality of others in her pregnancy and childbirth and her choice of words: "It's [the course instructor] who 'sells this idea.' I followed the whole primer of [the course instructor]," she said. Finally, I asked, "You're saying that you 'bought' and that she 'sold' this idea. You seem to have a somewhat ironic relation (to this childbirth model)." Cira cut me off: "No! Not at all, I did buy the idea; I loved having done it; I would do it all the same, another time." I remained puzzled that she was self-critical of her ideal of being a perfect mother, yet not critical of the "fairytale" of childbirth and motherhood she "bought." Her self-representation is one in which she is on the receiving end, fundamentally, through the teachings and expertise of the doctors she chose, to whom she felt greatly obliged. Cira's characterization of her own position raises the question of agency. Despite many differences between Marcela's and Cira's childbirth narratives, both women appeared peripheral to the events. Both also appeared to distance

themselves from the experience, the one with irony and a nearly literal sense of being marginal, the other by characterizing the experience as mediated by consumption and grateful dependence on the fundamental agency of others.

Let us reconsider irony in the stories. Muecke finds that in the "irony of events . . . the ironic incongruity is between the expectation and the event. We say it is ironic when, after we have more or less explicitly or confidently expressed reliance in the way things go, some subsequent unforeseen turn of events reverses and frustrates our expectations or designs" (1969:102). Muecke emphasizes that an unexpected event itself is not ironic. It depends on innocent or overly confident expectations thwarted. (We see from Cira's perspective versus mine that irony also depends on the eye of the beholder.) Marcela's representation of herself initially as happy-go-lucky but clueless provides the perfect protagonist for an ironic turn of events; the situation itself is an ideal set up precisely because it is so unanticipated that irony would be linked to a childbirth story.

Marcela's self-irony can be seen as a way to recapture power after it was diminished (Taylor 2001). Perhaps more usually, it is seen as self-protective. Muecke underscores the distancing effect: "The stronger his sense of irony the more he will be enabled to detach himself from his situation and become, by a kind of double-think, the ironical observer of himself as victim [of circumstance]" (1969:39). An ironic telling provides emotional counterbalance, but never a complete one: "an ironist is never completely detached" (Muecke 1969:218). Marcela's shift in tone, from a high to a low point, registered the emotional weight of the event. Her humor offered an energizing counterbalance.

Although the one account was not expressly ironic and the other was, both stories employed a great deal of critical observation. Both Cira and Marcela held some critical distance from circulating ideas of childbirth. Yet both were self-critical even of their own fantasies of the moment of transition to new motherhood. It is interesting to note that in subsequent pregnancies, both Marcela and Cira were uninterested in the experiential aspects. Cira said, "The first time you have patience for the pain, because you still think you are curious, there's the business of trying to discover what is happening. The second—no more curiosity. You know what you want. You want to get it over fast, and that's it. It was the same with recovery. No patience for it." While not assuming "alienation" per se, one can still note the withdrawal from an "embodied self" (Akrich and Pasveer 2004:63–84; see also Sargent and Stark 1989:46). The final two brief examples present what counts as idyllic C-sections, both for breech presentation.

Idyllic C-Sections: One Woman Compliant, One Truant

A Secure Delivery Thanks to Family and Fictive Kin as Attending Doctors

Kátia, special needs teacher and resident of a beach-front apartment in Niterói (with a household income equivalent of US$2100), said her C-section (at age 28) for breech presentation was "really smooth" (*super tranqüilo*). Her father, himself an ob-gyn, and husband were there, and the medical team worked with her father. "So, the anesthesiologist, the doctor are my 'aunts and uncles.' I have known them since childhood, a very nice atmosphere, pleasant, I felt really secure about everything. It was really good!" Kátia also had a sense of security from her pregnancy course—taken from an "aunt" (a family friend) who had known Kátia since infancy. Family involvement assuring Kátia's security went further. While Kátia wanted to work up until her due date, her father convinced her husband that Kátia should stop in her final month of pregnancy to

avoid the risk of going into labor in transit. Kátia gave in to the pressure. Although Kátia wanted to experience labor, as her due date drew near, like Marcela she became anxious and scheduled the C-section, foregoing labor induction.

Kátia appeared to adhere to "compliance as strategy" in childbirth (Tanassi 2004). Kátia's strong relationship with the medical team was celebrated as one of fictive kinship; the childbirth became a family event. Kátia's family connections gave her a sense of security, if not autonomy or control[5] over the childbirth conditions (see also Gama Ade et al. 2009; Namey and Lyerly 2010). Although her father's agency prevailed, concern surrounding Kátia kept her center stage as a receptive protagonist.

A Fairytale Story of Improvised Beauty and Joy Bookends the C-Section

Resident of Barra da Tijuca and fashion designer (with a monthly household income equivalent of US$3800), Tatiana had a doula accompany her pregnancy at age 29. She said, "I wanted [my son] to be born by normal childbirth . . . but [it] . . . was breech." Tatiana's efforts to get the fetus to turn around through yoga and acupuncture were unsuccessful. She also said her ob-gyn "didn't think it was a good idea [*não achava interessante*], in her first pregnancy, to try to turn the baby during childbirth; it wasn't very advisable, in her opinion, and as she was someone entirely in favor of normal childbirth, I believed her, so it was cesarean, but it was great. I didn't schedule it, I waited until it was time."

On the day her baby was born, Tatiana awoke around 2 a.m., realizing her bag of waters had burst. Her husband called the obstetrician, who told them to go to the maternity ward. "I got up, got dressed, got my maternity bag ready, fixed up the baby's room a bit more. I felt some light contractions. It was about five in the morning." She then woke her husband back up, but he said, "I'm going to make an açaí juice first." Tatiana's story then took a turn. "We lived in an apartment that had a view of the sea, the day was beautiful, dawn was breaking, so he said, 'Let's take some pictures.' I was pregnant, nude, that beautiful light, so we took some pictures, without hurrying, and at about 6:00, 6:30, we left the house, and when we were on our way . . . my doctor called and said, 'Tatiana, where are you?' 'I'm in the car, almost there.' And she [said], 'You are crazy! I told you to get dressed and come to the maternity ward.' And I said, 'I thought you meant in the morning.' She and the whole team were there, waiting for me since 4 a.m. . . . When we got to the delivery room—the whole time, we'd planned on various things for the birth, that it would be in the dark, no strong lights, there would be ambient music, the sound of water, nice for the baby to be born into, the room would be aromatized—my doctor had just taken a course in the U.S. about how to improve the atmosphere for the baby—there wasn't time. Another thing we wanted was instead of the baby being cleaned up initially, that he'd come immediately to my breast, to humanize the birth. This we did. We started at 8:15 and the baby was born at 8:48. . . . The birth was great, he came right to my breast, it was wonderful, the emotion is indescribable, we cried an absurd amount, we three, the baby obviously, I did and [husband's name], it was wonderful."

Discussion and Conclusion

This work examines young middle-class Brazilian women's agency vis-à-vis others as represented in childbirth narratives. A key plot complication and focus for evaluation was the decision for the C-section. The women interviewed for this study *themselves* raised the topic of

the trend in C-sections, identified it as the preference of Brazilian doctors, and generally, but not always, as a break with a higher ideal held by them. The frequency of the commentary in the sample suggested first that my being a foreigner led women to provide this context. Second, it suggests that C-section delivery had not become a normative cultural script, but rather, was a cultural debate among the women—whatever their position. Thus a woman who chose C-section for herself vociferously criticized a friend over the age of 40 who she believed had nearly caused perinatal endangerment by attempting vaginal childbirth. Even those who were taking it as a nonissue took a position (as one said of C-sections, "I don't have anything against them"). The critical commentary on mode of delivery in personal narratives reminds us that childbirths are culturally situated.

The women represented the agency of doctors in determining mode of delivery in two ways: as pre-emptive or accomplished through a language of mutuality coupled with a language of risk. These findings align with studies on the framing of C-section deliveries in Brazil (McCallum 2005; Hopkins 2000); they extend them by indicating that the framing occurs not only during labor, but beforehand, in clinic visits. I would also suggest that the doctors' language of mutuality, where a C-section is highly probable, may have an unfortunate effect: the woman sees herself as responsible ("failing" to induce, or "failing" in the trial of labor). Few women directly questioned the reason provided for their C-section, including in relation to circumstances that are not indicators (e.g., wrapped umbilical cord) or that are in debate among obstetricians (e.g., stalled labor). The accounts suggest that the women are critically engaged in the debates on mode of childbirth without having specific understandings of valid versus doubtful reasons for C-sections. Yet even without such information, women may reasonably question (as did Regina and Cira) the doctors' skill and experience in vaginal delivery.

After registering that these middle-class women did not prevail in the form of childbirth, I considered in what ways women exercised agency to create meaningful childbirth conditions. Cira proactively sought to have a "natural" childbirth by taking educational classes for vaginal childbirth and choosing a doctor who promoted it. Others worked within the context of pre-determined C-sections. Some insisted on or considered induction of labor even if C-section delivery was predetermined. Some did and some did not schedule the delivery. Whatever direction the decision took, they all offer testimony to ways Brazilian women struggle to retain agency and meaning in their childbirths. Marcela, Kátia, and Tatiana strived to imbue C-section deliveries with value and meaning variously through an alternative childbirth by accepting familial presence in the delivery and improvising delays to ensure the delivery started and ended in intimacy and beauty. In so doing, they illustrated agency that was "nondefensive" and "creative" although without changing the broader conditions (McNay 2000:12). Regina's and Sandra's unvoiced objections to C-section delivery, and the retrospective evaluations they made in their narratives, offer a belated, moral recuperation of agency.

Attention to narrative resolution and coda as well as to dramatic genre signal a sense of the woman's perspective on the event. Regina's and Sandra's serious dramas stood out as the clearest counter narratives to idealized childbirth stories. In their accounts, critical evaluations of the doctors performing C-sections and the wrongness of C-sections themselves were central. Marcela and Cira described their own elaborate efforts to stage and enact what for them would be perfect childbirths: one conveyed disappointment (in herself and others) when her expectations weren't met; the other resolved the unexpected turn of events by accepting her decision to give up on a vaginal childbirth. Marcela's irony and Cira's phrasing of her pregnancy and childbirth as "fairytales" suggested critiques of the idea of an ideal childbirth. These

critiques were as much directed at themselves as at the context producing such idealizations. The lack of irony or critique in Kátia's and Tatiana's idyllic stories suggests that when surgery was seen as completely justified, the C-section experience was positive.

Theories of agency remind us that we can produce effects in our social fields. I found from the woman's stories that perhaps first and foremost, the effects were on themselves. The women's accounts of their agency were often quite complicated, and in some cases, seemed ambivalent. While registering the doctors' agency, the women often appeared to take responsibility for their mode of childbirth. I would argue, following Simkin, that they did not have the necessary means to prevail as "transient stakeholder[s] in the maternity care system" (Klein et al. 2006:247; see also Lazarus 1994). Simkin underscores limits to the possibilities of acts in this space, especially by separately acting social agents. The scrutiny at the individual level—a limitation of this work—brackets off the necessary community level for effective agency in relation to biomedical institutions and medical professionals. At the same time, the individual experience provides some compelling grounds for social change. Coole underscores that agents' capacities "emerge and endure within corporeal experience . . . [they] describe a dimension of power whose medium is bodily effects/affects: one that is both the site of a body politics in its own right and one that incites or inhibits the emergence of individual or collective political actors as bearers of agentic properties" (2005:131).

In closing, one hopes that the efforts of medical anthropologists and childbirth activists (Davis-Floyd et al. 2009) and new public health policy in Brazil (see Gama Ade et al. 2009) will be more effective than individuals in reversing this trend toward a majority of surgical childbirths. In the meantime, as we assess the magnitude of biomedical power enforcing surgical childbirth in contemporary Brazil, we can appreciate the strength, humor, critical edge, and creativity of these young Brazilian women as they strive to retain their agency and create meaningful celebration of the moment of transition to motherhood.

Notes

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[1] Wendland's report that considerations extraneous to the pregnant woman's bodily state determine mode of delivery, and her conclusion that the C-section is becoming the "unmarked" procedure and vaginal delivery "unpredictable, uncontrolled, and therefore dangerous, appropriate for only a select few" (2007:224) resonate strongly with research on C-sections in Brazil.

[2] Not having expertise in childbirth, I consulted a reference for doctors (Enkin et al. 2000). An ob-gyn and a nurse midwife separately reviewed the descriptions to assess whether each C-section appeared warranted. A Brazilian specialist in women's reproductive health confirmed procedures with slow labor.
[3] Wendland (2007) points out that evidence-based medicine regarding C-section delivery disregards C-section delivery risks (see also Enkin et al. 2000:362).
[4] Determination of feto-pelvic disproportion often cannot be made prior to labor. See Enkin et al. 2000.
[5] The women I interviewed did not use the term control (but see Namey and Lyerly 2010 and Sargent and Stark 1989). Phenomenological studies complicate the idea of control in accounts of vaginal childbirth (Berg and Dahlberg 1998; Carter 2010).

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