Performing Modernity through Birth: Exploring High Rates of C-Sections in São Paulo, Brazil

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ABSTRACT

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Performing Modernity through Birth: Exploring High Rates of C-Sections in São Paulo, Brazil

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Since the 1980s, Brazil has had the highest rate of c-sections in the world. While existing research has provided a number of factors for contextualizing the phenomenon, this research argues that the high rates of c-sections could be due to connections between the history, geography, and culture of the Brazilian nation, especially in regards to notions of modernity, development, and what it means to be Brazilian. This research adheres to a critical theory approach to qualitative methodology, using interviews and ethnographic field notes to analyze the data within a context of larger economic, political, cultural, and ideological structures. Findings present implications for birth procedures in Brazil, and globally in the face of climbing c-section rates.

Approved: _____________________________________________________________

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract .................................................................</td>
</tr>
<tr>
<td>Acknowledgments ..........................................................</td>
</tr>
<tr>
<td>List of Tables ..................................................................</td>
</tr>
<tr>
<td>Chapter 1: Introduction ..................................................</td>
</tr>
<tr>
<td>Chapter 2: Birth: A Nation’s Gendered Performance ..............</td>
</tr>
<tr>
<td>2.1 The Role of the Maternal Body alongside Modern Medicine and the State</td>
</tr>
<tr>
<td>2.2 Development: A Gendered Process that Defines Women’s Reproduction</td>
</tr>
<tr>
<td>2.3 Ceasarean Section Birth as a Gendered Performance of Development</td>
</tr>
<tr>
<td>Chapter 3: The Brazilian Context: Brasilidade and Reproduction</td>
</tr>
<tr>
<td>3.1 Creating Brasilidade ..................................................</td>
</tr>
<tr>
<td>3.2 The Modern Medical System in Brazil and Reasons for High Caesarean Rates</td>
</tr>
<tr>
<td>3.3 Conclusion ..................................................................</td>
</tr>
<tr>
<td>Chapter 4: Methodology ....................................................</td>
</tr>
<tr>
<td>4.1 Before Stepping Into the Field ....................................</td>
</tr>
<tr>
<td>4.2 Gaining Access ..........................................................</td>
</tr>
<tr>
<td>4.3 Placing the Researcher and the Interviewee in the Data Collection Process</td>
</tr>
<tr>
<td>4.4 Data Analysis ............................................................</td>
</tr>
<tr>
<td>Chapter 5: C-Section Birth as a Performance of Modernity ....</td>
</tr>
<tr>
<td>5.1 Taking Advantage of Modernity ....................................</td>
</tr>
<tr>
<td>5.1.1 Sterilization ...........................................................</td>
</tr>
</tbody>
</table>
5.1.2 Rural/Urban Binary .......................................................... 74
5.1.3 Popular Media .............................................................. 80
5.1.4: Birth as a Performance of Modernity ................................ 83
5.1.5 Technology .................................................................. 87
5.1.6 Wealth ......................................................................... 90
5.1.7 Choice ......................................................................... 92
5.2 Implications of the Modernity Discourse ................................ 96
5.3 Conclusion ........................................................................ 108
Chapter 6: Conclusion: Implications and new contributions ........... 110
References ............................................................................. 116
Appendix A: Interview Questions for Women In English and Portuguese .......... 128
  Appendix A.1: Portuguese Translation ........................................ 129
Appendix B: Interview Questions for Doctors .............................. 131
  Appendix B.1: Portuguese Translation ........................................ 132
LIST OF TABLES

Table 1: Total Fertility Rate in Brazil ................................................................. 43
CHAPTER 1: INTRODUCTION

On the popular Brazilian soap opera *Cabocla*, set in a rural village of Brazil in the year of 1918, the main character Emerenciana undergoes the process of a painful natural birth with a midwife, only to deliver a still-born baby. The scene is dramatic, sad, and it portrays natural birth as painful, dangerous, rural, and old-fashioned. Other Brazilian soap operas that portray natural birth in this way are *O Profeta, Terra Nostra, Pantanal, O Tempo e o Vento, Chocolate com Pimenta, A Muralha, JK*, and *A Casa de Sete Mulheres*. Several of the births portrayed on these soap operas even show women giving birth in a barn with only a midwife present. On the other hand, the soap opera *Laços da Família*, set in an urban city in the present year, shows the character Helena as giving a happy, peaceful, and loving cesarean section (c-section) to a healthy baby boy in a hospital, accompanied by her husband and doctor. Several soap operas that show this portrayal of caesarian section, or c-section, birthing, which seems happy, urban, peaceful, and surgical are *Ti Ti Ti, Por Amor, Paginas da Vida, Morde e Assopra*, and *Viver a Vida*. Is it possible that Brazilian television’s portrayal of these births, as being set in specific settings, eras, and following certain cultural prescriptions are symbolic of an idea of birth that reflects larger ideas and attitudes within Brazilian society in regards to birthing? This thesis investigates this possibility, especially in regards to Brazil’s high c-section rates.

While c-sections are a useful tool in having a safe pregnancy when vaginal birth is not a viable option, there is a body of research which suggests that the procedure should be used with caution. At present, the procedure is used for the following medical
reasons: dystocia, fetal distress, cephalopelvic disproportion, breech, repeat c-section, placenta previa, multiple births, existence in the mother of HIV or herpes, high-blood pressure, and heart conditions (Churchill 1997, Shearer 1993). The WHO (2001) recommends that c-sections should be used only if a particular case presents a medical condition, such as one of the birthing complications mentioned above, due to the risks of the procedure for both mother and baby. Risks for the mother include: difficulty healing from surgery, postpartum hemorrhage, re-hospitalization, feelings of guilt, failure, anxiety, and alienation from the baby, a desire for fewer children, pelvic pain, bowel obstruction, and a higher risk for subsequent births (Affonso and Stichler 1980, Carlisle and Suthers 2006, Declercq 2006, Garel et al. 1990, Herishanu-Gilutz et al 2009, Tulman 1986). The operation poses an equally long list of risks associated with caesarean birth for the baby: respiratory problems, less likely to breastfeed due to a difficulty to suck, separation from mother after delivery, malformation of the head or body, and central nervous system injuries (Cohen and Carson 1985, Carlisle and Suthers 2006, Richards 1983). These are very serious risks that put the mother and the baby’s life in danger and lead to health problems and post-partum complications; therefore it is clear why there is a growing concern for understanding high c-section rates at varying scales.

As of 2003, Brazil had the highest c-section rates in the world (Béhague and Barros 2002, Gomez et al. 1999, Finger 2003). After a campaign launched by the government in the 1990s, the high rates of c-sections were lowered in public hospitals from 50% to 35% (Diniz 2005, Tornquist 2003). However, in private hospitals c-section rates remain at 80%-90% (Béhague and Barros 2002, Gomez et al. 1999), and in the field
work for this research, I visited some hospitals with a 99% c-section rate, or in other words, they no longer performed vaginal births. The reasons for such high rates have been explored by a number of researchers that seek to provide evidence to shed light on this worrisome trend. While existing research has provided a number of reasons contextualizing the phenomenon, this research explores the connections between high rates of c-sections and the history, geography, and culture of the Brazilian nation, especially in regards to notions of modernity, development, and what it means to be Brazilian.

From existing research, it has been established that ideas about nationhood are connected to manners of giving birth. In particular, researchers have argued that there is a symbolic quality to 1) the woman as a reproducer and 2) to her manner of giving birth, both of which reflect and define a nation’s identity (Casper and Moore 2009, Duden 1993, Fraser 1995, Kukla 2005, Lindgren 2006, Longhurst 2008, Mayer 2000, Martin 2000, O’Neil and Raupert 1995). However, the specific procedure of caesarean section and how it connects to nationality has not yet been explored.

This thesis seeks to address this gap in the literature by investigating the following questions. First, is there a link between nation building in Brazil and high rates of c-sections? If so, how is this link manifested, or in other words, through what processes does it appear? Second, does Brazil’s position as a developing and post-colonial country influenced birthing procedures? If so, how? These questions provide a starting point to investigate the connection between c-sections and notions of nationhood, which could also have implications of the climbing rates of c-sections globally, as well as
provide theoretical contributions to the literature on gender and development and
gendered performances.

Before reading the following pages of this thesis, it is important to define certain
terms that may present confusion within the text. First, while the caesarean section birth
procedure may seem obvious, its increased use of the practice as normative should first
be made clear. A “caesarean section”, often referred to as a “c-section”, is a surgical
procedure in which one or more incisions are made through a mother's abdomen and
uterus to deliver one or more babies. The term caesarean section comes from the Latin
word ‘caesaru’, meaning ‘to cut’, while the Latin ‘seco’, or section in English, means
‘incision’, but can also be interpreted as ‘opening’. Thus, the English translation is to
‘cut open’. The classic c-section uses a longitudinal incision, which allows a larger space
to deliver the baby. Currently, a lower uterine segment section is the procedure that is
most common because it results in less blood loss and is easier to repair and for the
woman to heal. This procedure involves a transverse cut above the edge of the bladder.
A “vaginal birth” refers to giving birth to a child through the vaginal canal. There is an
assumption that this birth is carried out in the medicalized setting of the hospital, and
intervention, such as an epidural or inclusion of hormones, may or may not be used in
this understanding of birthing. A “natural birth” is a method characterized by the absence
of intervention, in which the expectant mother may or may not use special breathing and
relaxing exercises to deliver. The view behind this technique is that the woman is the
primary agent in the birthing process and she is only accompanied by a doctor or
midwife. Finally, a “normal birth” is the most controversial term and is subject to debate,
but it is generally used to refer to a birth that is done vaginally. In this research, I will use the terms as specified, however, it is important to highlight that my informants use the terms natural and normal birth to refer to a vaginal birth. This different use of terminology, which does not distinguish between “vaginal birth” and “natural birth” highlights the already problematic context in of how birth is understood in Brazil.

Besides the above technical terms, it is also necessary to define other concepts I use frequently that may cause confusion. First, when I use the term “nation”, “nationhood”, or “nation-building”, I am referring to Benedict Anderson’s (2006) idea of an imagined political community, as discussed in his book *Imagined Communities*. He theorizes nation as imagined because it is not based on everyday communal interaction with other members, rather, the community, or nation, is a mentally and socially constructed identity. It is created through media or propaganda, which give people an emotional connection to people of the same imagined nation. Second, I use the terms modernity, modernization, and modern as they have been understood in modernization theory, which came from the Enlightenment Era. According to this theory, modernization in societies follows an evolutionary transition from “traditional” to “modern” in which science and rationality will lead us to ultimate knowledge and reason, creating a more just social order. The underlying philosophical approach to modernization is positivism, which is an epistemological perspective adhering to the idea that authentic knowledge is based on experience and positive verification according to the scientific method. The terms modernization and modernity are understood as processes
of urbanization, industrialization, and rationalization, all markers of positive verification that is necessary to achieve modernity and leave behind a traditional society (So 1990).

This thesis is organized as follows. Chapter 2 will provide an overview of the gender and development literature in regards to women’s reproductive rights, as well as lay a foundation for how I place the maternal body and birth in relation to modernity, development, and nationhood. This section will not only give this research a background, but will also explain how the theoretical underpinnings of this investigation are understood. In this chapter, I argue that the pregnant woman and her choice in birth procedure is an expression of identity, particularly national identity. Chapter 3 will give a geographical and historical context for the specific case of Brazil in order to explore how notions of development and modernity are understood within this national context, as well as explore previous research on the cause for high-c-section rates in the country. In this chapter, I argue that nation-building in Brazil has been affected by an international push for development and modernity, which has had an affect on how people understand birth. Chapter 4 will explain the methodology used, give a background for how research questions were explored in the field, and provide detail on how the data was analyzed.

Chapter 5 will explore and discuss my findings. I will argue that the larger discourses of modernization and development in the Brazilian national context has given geographical, historical, and cultural meanings to the practice of birth, which influences women’s and doctor’s decisions in choosing the caesarean procedure, adding to a high c-section rate. A final concluding chapter will summarize this study’s main findings and discuss the
implications of these findings in regards to the climbing rates of c-sections at the global scale as well as at the national scale in the Brazilian context.
CHAPTER 2: BIRTH: A NATION’S GENDERED PERFORMANCE

Our embodied self is a representation of who we are - our nation, race, and gender.
(Sundberg 2002:18)

Our gender, race, nationality, social class, job title, and familial role all constitute performances or roles that we play according to what society deems appropriate. How we perform our roles is dependent upon history, geography, and cultural rules that affect our thoughts and behaviors from birth. As Butler (1990) states in regards to our performative selves:

Acts, gestures, enactments, generally construed, are performative in the sense that the essence or identity that they otherwise purport to express are fabrications manufactured and sustained through corporeal signs and other discursive means. That the gendered body is performative suggests that it has no ontological status apart from the various acts which constitute its reality. This also suggests that if reality is fabricated as an interior essence, that very interiority is an effect and function of a decidedly public and social discourse. (136)

In other words, our actions create and at the same time are created by who we define ourselves to be. We perform our identities but at the same time, our identities can cause us to “perform” in specific manners, which we may or may not be aware of. For women, birth can be understood as a particular type of a gendered performance. The treatment of a pregnant woman, the birth procedure she chooses, the location where the baby is born, who is allowed to be present during birth, and the interventions used to aid in the delivery are all part of the birth performance that has been defined by our society and culture.

In this chapter, I draw on both empirical and theoretical studies to explore the birth performance and the role of the pregnant woman as an expression of a nation’s culture. In particular, I focus on how birth can be understood as an indicator of development and modernity and how notions of development and modernity in a national context influence birth. This will provide a context for my research, which addresses the
connection between the high rates of c-sections in Brazil and larger discourses of development and modernity related to Brazilian nationhood.

This review will first trace the role of the maternal body alongside the evolution of modern medicine and the state, showing how national discourses have encouraged the monitoring of women due to their symbolic importance as a reproducer. This section will provide the connection between the maternal role, birth, medicine, and the nation. It will also discuss case studies in which ideas about development and modernity have influenced choices in birth procedures. Second, I will define how my research understands “development”, not only as a definition, but as a gendered process that influences a woman’s rights to her own body and how she does or does not give birth. While this second section does not directly relate to my research on birth choice and birth performance, it demonstrates how the institution of development has played a role in influencing reproductive trends, as well as lays groundwork for how ideas about development and modernity have influenced women in national and international contexts. Finally, I will conclude that further research needs to be done that explores birth as a gendered performance of the discourses of development and modernity in national contexts.

2.1 The Role of the Maternal Body alongside Modern Medicine and the State

Two different models of childbirth can be applied to our current understandings of the birth performance. The first one, which has been called “medicalization”¹ (Franklin

¹ The term “medicalization” entered academic and medical discussion in the 1970s through the works of sociologist Irving Zola, medical sociologist Peter Conrad, ad psychiatrist Thomas Szasz. They argued that
“the biomedical paradigm” (Davis-Floyd and Sargent 1997, Jordan 1978, McClain 1982), and “hospital birthing” (Longhurst 2008), views birth as a condition to be treated by a doctor. Every case is a possible risk that must be monitored, requiring medical control over the birthing process. This model gives authoritative knowledge to doctors and healthcare professionals. It is associated with a larger "modernizing" project of western culture, which seeks to control and harness natural processes through human intervention according to the use of technology (Browner and Press 1995, Davis-Floyd and Sargent 1997, Franklin 1995, Ginsburg and Rapp 1995, Jordan 1978, Kukla 2005, Kukla 2008, Lindgren 2006, McClain 1982, Smeenk and ten Have 2003, Teijlingen et al. 2000). The second model of childbirth, often referred as “traditional” (Jordan 1978, Teijlingen et al. 2000), or “natural”, sees birth as a normal process, natural to the physical state of the human body. This model believes that the majority of women will have a normal childbirth, and that risk and complications, while possible, are not common and will show up only in a minority of birth cases. In the traditional model, the woman giving birth is in control and the midwife is seen as a facilitator and assistant (Davis-Floyd and Sargent 1997, Jordan 1978, McClain 1982, Smeenk and Have 2003, Teijlingen et al. 2000). Currently, it is the medical model which is the dominant one in our western society (Davis-Floyd and Sargent 1997, Franklin 1995, Jordan 1978, McClain 1982, Teijlingen et al. 2000). The medical model is backed by the power of technological intervention, medical and scientific concepts and knowledge of the doctor, and finally, it has the backing of the medicalization is a process by which natural human conditions become defined as medical conditions, allowing the authority of health professionals to study, diagnose, prevent, and treat a particular condition.
legal system at the local, state, national, and international levels, where legislation and legal standards exist that require medical school and training (Davis-Floyd and Sargent 1997, Teijlingen et al. 2000).

The medicalization of childbirth has its origins in eighteenth century England and France, as doctors became increasingly involved in childbirth, and midwives became increasingly pushed away from the birth process. Midwives were either prosecuted as being witches (Lowis and McCaffery 2000) or legally removed from the profession due to their lack of specific credentials and education on “expert” knowledge (Barney 2000, Jordanova 1995, Kukla 2005). During this time, the number of births attended to by physicians instead of midwives greatly increased and successful c-sections with no maternal or fetal death were recorded in great detail. There was an increase in the number of articles being written on birth, the pregnant woman’s anatomy, and the development of the fetus (Churchill 1997, Jordanova 1995, Kukla 2005).

The evolution of this obstetric care was accompanied by a changing view about the pregnant body and the role of the mother (Duden 1993, Kukla 2005, Teijlingen et al. 2000). Kukla (2005) explains the evolving notion of the mother and her pregnant body was heavily influenced by the ideas of the philosopher Jean-Jacques Rousseau, whose work centered around the idea that morality was a “natural” state, but that it had to be controlled and harnessed through self-restraint and careful education about civility. His ideas about human development were largely concerned with the place of the mother in relation to her children. Her moral responsibility was akin to the moral responsibility that a nation had for its citizens. Weiner (1995) and Petchesky and Judd (1998), explain that
these ideas go as far back as Plato and Aristotle, where women were seen as being good citizens in performing their role as reproducers. These ideas justified the evolving notion that the entire process of pregnancy and birth had to be monitored due to central concern for the nation’s future. It became the pregnant woman’s duty to be carefully overseen by a physician, her family and friends, and herself (Duden 1993, Kukla 2005, Teijlingen et al. 2000). According to Casper and Moore (2009) these expectations continue to exist, as the pregnant woman has become a “container” or “a showcase” (Duden 1993) for the baby inside of her. Because of her pregnant state society, her doctors, her friends, her family, and even she herself all have a justification to monitor her engagements, her diet, her doctor, her birth plans, and her activities (Casper and Moore 2009, Duden 1993, Fall 2006, Kukla 2008, Longhurst 1997, Longhurst 2008, Lyerly et al 2009). As Casper and Moore (2009) state, “it is women’s (not men’s) bodies, behaviors, habits, employment, relationships, choices, and practices that are seen to determine whether their babies will live or die” (72).

A number of scholars writing on the topic of the disciplining of the pregnant body employ Foucault and his concept of “biopower” (Casper and Moore 2009, Duden 1993, Fall 2006, Franklin 1995, Kukla 2005, Lonhurst 1998, Longhurst 1999, Longhurst 2008, Mayer 2000), which is made up of two components: “disciplinary power” and “regulatory power”. Disciplinary power sees the body as a machine to be molded, which it carries out in the spaces of schools, hospitals, prisons, and modern day institutions. It includes rules and regulations that dictate how people should behave in society. Regulatory power consists of the institutions and their scientific discourses that guarantee
control in society, one example being government policies and their implementation. Fertility policy, such as how many children a couple can have, according to state rules or benefits, is one example. Biopower is an invasive form of social control because it is self-reinforcing, in other words, people are disciplined to enter a process of self-surveillance so that they eventually become those that do the surveilling. People can be active agents, actively seeking to define, create, or resist, but often their definitions and creations reinforce the status quo.

Biopower is a mechanism to understand the relationship of the pregnant body to the nation (Casper and Moore 2009, Duden 1993, Kukla 2005, Mayer 2000, Martin 2000). Kukla (2005) cites Foucault to argue that medicine has become institutionalized in close relation with the state through public benefit programs, government oversight of hospital and medical schools, and medical jurisprudence. According to Foucault, medicine, along with other systematized institutions like schools or prisons, serve as a link between individual people and the moral state of the nation. This link is self-reinforcing through biopower, both disciplinary and regulatory (Foucault 1979).

Martin (2000) demonstrates an example of disciplinary power through her case study in Ireland that discussed what happened when a 14 year old girl was raped, resulting in pregnancy. Wanting an abortion, the girl and her family tried to go to England to have the procedure done, since it was illegal in Ireland. However, for the nation of Ireland, this was a highly contested issue in the national media because the pregnant girl “symbolically represented the purity and tradition of the country” (67). The case went to the justice system, and it was ruled that she would not be allowed to leave
for England to have her abortion. For the Irish, the death of the girl’s baby was synonymous with the death of the nation and its ideals.

Casper and Moore (2009) and Duden (1993) explain how regulatory power functions through the use of demographic aggregate data, which furthers the agenda of the state by instilling fear into women about their pregnancies. Percentages, numbers, and pie charts provide data showing the increases and decreases in fertility rates or infant mortality, providing impersonal scientific information that is presented as facts. There is no personal care and women are treated as statistics, and their medical treatment reflects this treatment. Duden (1993) gives the example of Maria, a pregnant Latina woman over 35 years of age, who enters her consultation joyous and happy to be pregnant. Maria is given a graph of how women over 35 have increased risk in pregnancy. She looks at the doctor confused by the graph, not understanding why she should worry about these statistics. The doctor tells her that since she is part of the demographic on the graph, she must worry about the state of her body and take extra measures to control her diet and health during her pregnancy. Duden concludes that “by being told to worry she is being reminded about her contribution to the fetal population, which summons normalcy. She depends now on being told” (29).

One important aspect prevalent in the western nation-building projects is that technology supposedly represents the absolute truth and the means to our salvation, therefore it is a woman’s duty to have trust in her doctor and medical system (Browner and Press 1995, Kukla 2008, Lindgren 2006, Longhurst 1997, Longhurst 2008). Electronic fetal monitors (EFMs), epidurals, and tools for cesarean surgery are all
readily available in the medical model in case of need. Before the birth, there is 

systematic pressure to have a pre-natal screening (Browner and Press 1995) and an ultra- 
private health-care systems may even get a financial subsidy for these services (Browner 
and Press 1995). The images created by the ultrasound has been one of the key sites of 
struggle over the female body and reproductive freedom because the images create the 
impression of a human life already in existence, giving the unborn fetus its own legal 

The medical system also disciplines and regulates through its placement of bodies 
in terms of risk (Browner and Press 1995, Ginsburg and Rapp 1995, Kukla 2008, 
unpredictable dangers of modern life that should be minimized through both human and 
technological intervention. Since pregnancy is always viewed in terms of risk, the 
woman must minimize any chance for her birth to go wrong. Lyerly and colleagues 
(2009) show how concern with risk often causes a woman and those around her to have 
“magical thinking” that turn a sip of beer, a cup of coffee, the smell of paint, or a bite of 
raw fish into poison or contamination, irrationally believed to be detrimental to the life of 
the fetus. Longhurst (1997) and Fall (2006) show that women withdraw from public 
spaces due to their supposed irrational, emotional, and overly forgetful states, which they 
feel may put their fetus in greater danger. While pregnancy and birth do present an 
element of risk, preoccupations over how a woman should behave and be disciplined at 
every moment can go from conscientious to paranoid, augmenting her feelings of
In addition to pregnancy, the birth performance is also controlled and disciplined due to its symbolic quality (Duden 1993, Ginsburg and Rapp 1995, Fraser 1995, Longhurst 2008, Martin 2000). Longhurst (2008) provides an example in her case study of Nikki, a pregnant pornography star. Nikki decided to have her birth filmed for a pornography movie that documented a pregnant woman’s sex life, with the climactic moment being the live birth of the baby. When a documentary aired in New Zealand explaining Nikki’s decision to film her birth for the movie, there was a national moral outrage because “coupling pregnancy and especially birth with sexual gratification challenges mainstream notions of pregnant birthing women as modest, motherly, and focused completely on their infant” (75). People responded by calling the birth an “outrage”, “an affront to mothers”, “an insult to health professionals”, “a degradation”, “a bizarre saga”, and “a repulsive sleaze” to contest the porn birth. Responding to the controversy, the Ministry of Health stepped in to ban the filming of the birth. This case illustrates how the institutional medical and state structures intervene to create and enforce norms and regulations about the role of the pregnant body according to the normalized social and cultural practices which society expects. Nikki could perform her birth, but only in a culturally appropriate fashion.

The debate between a medicalized birth and a traditional or home birth has become salient in regards to culturally appropriate notions of birth performance. In northern Canada, Inuit women are forced by the government to have hospital births due
to national regulations on birth standards, despite their insistence on using a local midwife (O’Neil and Raupert 1995). In New Zealand, women are called irresponsible when they chose to have a home birth because any incidence when a home birth goes wrong is typically portrayed in the media as being a dangerous and culturally unacceptable place to have a baby (Longhurst 2008). This is also true for the US (Kukla 2008) and Sweden (Lindgren 2006). Giving birth according to the traditional model, by using a midwife, is seen as "backward" and is often associated with a practice in developing countries (Teilingen et al. 2000). In twelve states in the US, as well as in some European countries, it is illegal for a midwife to engage in childbirth at all (Devries 2000).

Fraser (1995) shows how the midwife is symbolic of an uncivilized and “pre-modern” past. She cites the example of Green River, Virginia, where the gradual decline of the African-American midwife in the 1950s symbolized a shift into the medical model, which signified progress and modernization to the local community (Fraser 1995). Attached to midwife was the stigma of race as well as feelings of shame due to primitive birthing methods. One woman recalled in horror about how her daughter decided to have a homebirth to reconnect with her African-American roots. For her, the midwife was linked to a meaning that opposed upward mobility, status, and pride. She could not understand why her daughter would oppose all the positive qualities she associated with the medical model of birthing.

These cases demonstrate the link between birth performance and identity, both at the local level, as Fraser (1995) demonstrates, but also at the national level as several of
the above cases have shown (Kukla 2005, Longhurst 2008, Martin 2000, Mayer 2000, O’Neil and Raupert 1995, Lindgren 2006). How one defines the nation becomes important for how one gives birth, and vice versa. The understanding that the woman is a vessel, in which the male familial line passes through, gives the woman’s body great importance as a symbolic carrier of nation’s identity. Jolly (1994) notes that this idea was present in ancient texts in which the woman was likened to the land and the man to the seeds that had to plant the land so it could become pregnant. Thus, the nation and its boundaries are symbolically reproduced through the female body. The scenario for acting upon this notion varies according to context, but the fact remains that a birth in our present society is much more than just a birth, it is a symbolic act of nation, culture, and identity. How that birth is performed has become a crucial element in who we are and how we see ourselves.

2.2 Development: A Gendered Process that Defines Women’s Reproduction

Birth’s symbolic connection to nation influences birth choice at international scales, especially in regards to westernized projects of development. Development projects are standardized internationally in what they promote, reinforce, and discourage. In the case of birth, development promotes the “medical” model of birthing and influences reproduction by implementing population control measures that affect women’s reproductive behavior. This section will analyze how development has been understood in the western context and explore how it has affected women’s reproduction.
As stated in the introduction, most of our ideas about development and modernization in society stem from the positivist model, which was essential in creating the “enlightened democracy” that western political systems and nations are built upon. This form of positivism, known as Comptean Postivism, was developed by August Comte (1798-1857), who like Rousseau, was also a French philosopher whose ideas came from the time of the French Revolution. His ideas became influential in Europe, the US, and Latin America as individual countries strove to implement political democracies with “rational” societies, free from the hindrances of religion and focused on science as a way of knowing and being. Comte stated that society had to undergo three stages of evolution to reach the last stage, the positive stage, in which scientific progress and technology would cure societal problems. Comte’s works have greatly influenced our current notions of modernity and development, especially as they pertain to Latin America, and most specifically Brazil, whose national motto of “Order and Progress” came specifically from Comte’s positivist motto “l'amour pour principe et l'ordre pour base; le progrès pour but” or “love as a principle and order as the basis; progress as the goal”. It is important to define positivism in regards to this research for two reasons: 1) positivism was foundational in Brazil because of the type of “development” project that it pursued, and 2) “development” as we understand it in Brazil as well as globally, has its roots in the Eurocentric positivist thought (Lenzer 2009).

Following Escobar (2002), this research understands “development” not as a condition, but rather as a discourse subject to analysis. Escobar (2002) defines the development discourse as “a process through which social reality comes into being.
through the articulation of knowledge and power” (39). This process happens through “the systematic creation of objects, concepts, and strategies” (40) created over time by a dominant group, which in this case is the US and Western Europe, the creators of western Eurocentric thought. The origins of this discourse can be understood within the context of Post-World War II history, which is traced out of a need to 1) expand growing post-war markets of the west, 2) a geo-political agenda stemming from a fear of communism, and 3) a positivist optimism in science and technology. In light of this historical context, the need for “development” of the peripheral countries was clear, and as Escobar states, two thirds of the world was “transformed into poor…almost by fiat” (23).

With the creation of the United Nations, World Bank, and International Monetary Fund, “development” was institutionalized (Escobar 2002, Hartmann 1995, Pieterse 2000, Rist 2003). Besides acting as experts, these institutions often supplied the capital needed in the form of loans so that “developing countries” could buy new technologies from transnational corporations to pursue “development”. Money was allocated to these countries to overhaul their medical, educational, political, and economic systems in order to teach “modern” values (Escobar 2002, Ferguson 1994, Pieterse 2000, Rist 2003).

During this time-frame, besides the fact that Europe was de-colonizing across Africa and Asia, three other important phases were happening simultaneously that served as the main reasons for the urgent need of the institutionalization of “development”. First, economically, the US needed a place to expand its growing post-war markets, and Western Europe, in light of the Marshall Plan, needed a constant supply of raw materials for reconstruction. Second, geopolitically, the Western World was afraid of communism, thus the Cold War acted as a justification for the interference of Western Influence of the countries in Asia, Africa, and Latin America, territories serving as a battleground for wars between the Soviet Union and Unites States. Finally, culturally, there was optimism in science and technology, as growth and modernization theories, following Comte’s positivist ideas, demonstrated. Following the “stages of evolution” countries would become economically, socially, and psychologically modern (Escobar 2002).

By “modern”, I am referring to Western civilization’s definition, created during the enlightenment era, which believed that science would lead us to ultimate knowledge and reason.
According to a number of scholars, this entire process privileged European values and subordinated women (Benería and Sen 1981, Escobar 2002, Mohanty 2004, Narayan 2007). This affected women adversely because these development programs “made women invisible in their role as producers and has tended to perpetuate their subordination” (Escobar 2002: 43) showing how “gender” intertwines with the institution of “development” to uphold the dominant value system. Like “development”, “gender” is also a discourse. Gender is not inherent but rather it is a process that is performed. Joan Acker (1992) explains that the process of doing gender and subordinating on the basis of gender can be understood through the divide between reproduction and production, which “constitutes the gendered understructure of society’s institutions” because these institutions “are organized on the assumption that reproduction takes place elsewhere and that responsibility of reproduction is also located elsewhere” (567). The institution of development is an example on one such institution that disadvantages women on the basis of gender, especially in regards to their reproductive rights (Goldberg 2009).

Reproductive rights are the rights to decide one’s own fertility, which includes starting, stopping, spacing, planning pregnancy (Benería and Sen 1981, Pillai and Wang 1999), and while not mentioned in the literature, choosing how a woman will give birth. Many feminist scholars argue that the basis of women’s rights starts with her ability to control her reproduction, because without this basic right, her equal participation in society, both socially and economically, is limited (Freedman and Isaacs 1993, Freeman 1990, Ginsburg and Rapp 1995, Goldberg 2009, Hartmann 1995, Petchesky 1995,
Petchesky and Judd 1998, Pillai and Wang 1999, Smyth 1998). However, a woman’s control over her reproduction and birth choice has been ignored in the development context due to power struggles between larger patriarchal political and economic institutions, which seek to delineate reproductive rights for the individual woman (Ginsberg and Rapp 1995, Goldberg 2009, Hartmann 1995, Newland 1991, Petchesky and Judd 1998, Postel-Coster 1993). It is important to understand how this historical process has occurred because it has sought to promote population control through reproductive health as a means of development.

The establishment of the U.N. Commission on the Status of Women (CSW) in 1946 brought reproductive rights to the international arena as a topic for debate. Reproduction became especially relevant in the late 1950s, when population control was seen as essential to western national security in the fight against communism (Goldberg 2009, Hartman 1995, Jackson and Person 1998, Pillai and Wang 1999). The popular 1954 doomsday book entitled *The Population Bomb*4 by Hugh Moore stated that as more people were born in developing countries, where population was increasing, there would not be enough food and resources to support this population. Therefore, these people would become desperate, poor and hungry, and would be more susceptible to communism and violent revolt. Convinced by these ideas, John D. Rockefeller founded the Population Council in 1952, which instilled birth control programs throughout the world (Goldberg 2009, Hartman 1995, Smyth 1998).

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4 This book was followed in 1968 by the best seller *The Population Explosion* by Paul R. Ehrlich and his wife, Anne Ehrlich, both Stanford professors at the time.
With the support of the Population Council, family planning, contraception, and planned abortion all became part of US policy abroad as millions of dollars went to set up clinics through USAID in support of population control. The United Nations Population Fund (UNFPA) was created in 1969 under the United Nations Development Fund to encourage population control through reproductive health for the purposes of development. In 1970 Nixon started the Commission on Population Growth and the American Future to further combat population problems. There were, and continue to be, a number of problems with the population policies implemented by these development organizations. First, especially important for the case of this research, traditional midwives were forbidden in most development contexts because it was determined that they did not have proper training (Hartmann 1995, Morsy 1995), despite the fact that often the absence of midwives led to higher rates of maternal mortality (Morsy 1995). Birth was to be carried out in a medical context because other manners of birthing were “backward” and underdeveloped. Second, development workers in the entire developed world, faced with fertility goals and demographic targets from above, bribed and even forced people to accept birth control, sterilization, and abortions (Correa 1994, Goldberg 2009, Hartmann 1995, McLaren 1990, Pillai and Wang 1999, Smyth 1998). Third, birth control clinics were improved while the other healthcare clinics were left with unacceptable health conditions (Goldberg 2009, Hartmann 1995). Fourth, family planning programs commonly ignored local contexts (Hartmann 1995). Fifth, data taken from specific national contexts would be used to implement fertility targets in other nations (Hartmann 1995). These are just a few of the many problems found to be
associated with the “development” approach to reproduction, of which Brazil and all other developing nations were part of.

It is important not to focus all of the debate on an east vs. west or a “developed” vs. “developing” issue because the debate over reproductive rights exists within the borders of dominant western countries that claim “developed” status. In many countries reproductive choice for women remains limited (Freedman and Isaacs 1993, Freeman 1990, Ginsburg and Rapp 1995, Goldberg 2009, Hartmann 1995, Petchesky 1995, Petchesky and Judd 1998, Pillai and Wang 1999, Smyth 1998). Examples include illegal abortions in Ireland and Belgium (Hartmann 1995, Martin 2000), unpaid maternity leave in the US (Goldberg 2009, Hartmann 1995), or restrictive abortion laws (Goldberg 2009, Hartmann 1995). Certain rights that restrict women’s reproductive freedom that women in many countries lack are the rights to economic security to have the means to care for their families (Goldberg 2009, Hartmann 1995), the right to a safe workplace so that women are not exposed to hazards affecting their reproduction (Hartmann 1995), the right to sex education (Hartmann 1995), the right to have (or not to have) access to contraception (Hartmann 1995, Goldberg 2009), and especially important for this research, the right to choose how to give birth (Hartman 1995, Longhurst 2008). However, through the development agenda at the international scale regulatory and disciplinary power reinforce existing norms in regards to women’s reproduction. Women must comply with what western society has deemed as modern and developed manners or reproducing.
Women’s reproductive rights continue to be contested and have become the battleground for culture wars internationally due to politics, religion, culture, and morals (Goldberg 2009). However, another reason this debate is causing such an international stir among institutions concerned with development and population is because white European descendants are dwindling. In 2000, only 12% of the world’s population was of European descent and by 2100, only 5.9% will be (Goldberg 2009). The demographic decline of the white European and the threat of incoming immigrant cultures in the US and Europe has created unequal societies and discrimination, and countries are responding by outlawing abortion and developing a strong conservative rhetoric that women need to assume their traditional role as mothers within the home to maintain cultural ideals and national traditions (Chesnais 1996, Coleman 1992). According to Goldberg (2009) the idea of birth and reproduction is becoming patriotic. While Brazil does not struggle with a dwindling white population, the notion of birth as an expression of patriotism is important for this research because it establishes a lens for birth to be viewed as a performative expression of the Brazilian nation that seeks to uphold ideals of “development” and “modernity”.

2.3 Ceasarean Section Birth as a Gendered Performance of Development

This chapter has established that there is a link between the role of the pregnant woman’s body, her birth performance, and how it connects to notions of nation, development, and modernity. However, while scholars have addressed the issues of medicalization of birth and birth choice with respect to these themes, the specific topic on
the high rates of caesarean sections has not yet been studied within the context of this literature. This gap in the literature has become important to fill, especially with the alarming rate at which c-section births are rising globally. That no research has contextualized the climbing c-section rates within this development context leaves an important space for new insights to be gathered and concluded to draw awareness to this important issue.

In 1965, the United States had a c-section rate of 4.5% (Taffel et al. 1987), while today c-section rates are at 30% (US Department of Health and Human Services 2000), and arguably, have already risen to 40% (Snow 2007). Chile, South Korea, Taiwan, and Italy all have above 30% c-section rates, while Canada, England, Australia, and Mexico all have above 20% (Taylor 2007). According to a large body of literature from the 1990s and early 2000s, nowhere are rates higher than in Brazil, with 80% (some have put the number at 90%) of all births in private hospitals being c-sections, and 35% in public hospitals (Béhague and Barros 2002, Gomez et al. 1999, Finger 2003). This data, when compared to the World Health Organization’s (WHO) recommended rate of 15% for c-sections (WHO 2001), is surprising because recent studies confirm the WHO recommendations about optimal caesarean section rates. The best outcomes for mothers and babies appear to occur with caesarean section rates of 5% to 10% and rates above 15% do more harm than good (Althabe and Belizan 2006).

This thesis seeks to explore if these high c-section rates are an example of birth being a gendered performance of a nation’s expression of “development” and “modernity”. It will focus on the context of Brazil where a specific set of conditions are
present. First, Brazil has been a model for the implementation of Comptean positivism during its creation as a republic. Second, its status as a “developing” nation means that it has been included in the development model, and programs through the international development organizations, as well as through western political interference in the name of development, have all occurred within its boundaries. Finally, it is a country with one of the highest rates of c-sections in the world, providing us with an exaggerated case of the c-section birth performance. By looking at c-section rates through the lens of the Brazilian context, the question can be asked: is how we give birth symbolic of who we are as a nation and as a people?
CHAPTER 3: THE BRAZILIAN CONTEXT: BRASILIDADE AND REPRODUCTION

Brazil is an especially unique place to study high caesarean rates due to the exaggerated use of the procedure and the existence of a strong positivist discourse of “order and progress” within the framework of a post-colonial state and context of “development”. In this chapter I argue that nation-building in Brazil has been affected by an international push for development and modernity, which has had an affect on the high rates of c-sections in the country. I present this argument as follows. First, I discuss what it means to be Brazilian and how this meaning has been created throughout Brazil’s history. This is important to lay a foundation for how my informants understand meanings of birth and how birth links to nation and ideas of development and modernity. I will also explore how reproductive policy has been treated in the national context to provide an understanding of how the institution of development has functioned in Brazil, as well as to explore important cultural elements essential to understanding my findings. Finally, I will discuss the current birth rates for Brazil and the existing research for why the country currently has among the highest c-section rate in the world.

3.1 Creating Brasilidade

Brasilidade is translated as “Brazilianess” and in the popular imagination it encompasses what it means to be Brazilian. It includes how you think, behave, speak, dress, and what you eat as a Brazilian person and as someone belonging to the nation of Brazil (Page 1995). Understanding Brasilidade lays a foundation for the interpretation of
the point of view of my informants in relation to birth, development, and modernity, therefore it is essential to lay this groundwork. Brasilidade was consciously defined and created in the politics and culture of Brazil’s early nation-building projects, when centralization and unification of all Brazilians were essential to create a country on even footing with the modernity that was occurring in Europe, the US, and the rest of the world. As Philippou states, “the quest for modernity was parallel to an intensified quest for brasilidade” (245).

This quest began after Brazil became a Republic in 1889. The country’s transition from a monarchy, which had still maintained significant ties to Portugal, to an independent republic was carefully planned in 1889 by the Brazilian-Portuguese monarch, Don Pedro II, who saw Brazil as old-fashioned and out-of-touch with the Enlightenment and positivist ideas shaping Europe, the US, and other newly forming countries of Latin America. Don Pedro II considered himself more Brazilian than Portuguese, and as a world traveler and self-declared modern man, he wanted to see Brazil take part in the same modernization that was happening in the rest of the world. Under Don Pedro II and in collaboration with the Brazilian military, Brazil transitioned into an independent republic that looked towards Europe and the US as models of nation-building under positivist ideals, as it sought political, industrial, and technological equality (Butler 2000). Ordem e Progresso (order and progress) became the only words displayed across the country’s newly adopted flag, the same flag that the country uses today. This came specifically from Compte’s famous positivist motto “l’amour pour
principe et l'ordre pour base; le progrès pour but” or “love as a principle and order as the basis; progress as the goal”.

Order and progress became a driving ideology for the country as it pursued a project of modernity (Butler 2000). According to Butler (2000), “Order”, in the context of Brazil, refers to the social order of relationships, which in Brazil is the system of patronage. It emphasizes hierarchy, the importance of social connections, paternalism, dependency, and control. “Progress” refers to biological and environmental determinism, which was accompanied by the idea that technology and planning could make Brazil “modern” (Butler 2000). Through the historical changes, such as the Vargas Era in the 1930s and 1940s or the return to democracy in the 1980s, the motto of “order and progress” and been a constant driving force for Brazil’s national image creation.

However, Brazil, as a former colony with an “underdeveloped” economy that relied heavily on exporting raw materials, not to mention a racially diverse population, could not mimic the US and Europe in matters of wealth, international clout, racial segregation, nor technological advancement (Butler 2000). As Velloso (1993) states in her article discussing Brasilidade during the early 1900s, “the idea of a grand community that self-regulates with perfection, equally distributing order and progress, is unmasked. Brazil stands face to face with its own problems” (89). The country’s solution was to look inward at its own underdevelopment, and how to solve it culturally, politically, and economically.

One of the ways Brazil attempted to reconcile this divide in the early 20th century was through mass media, both in literature and through the medium of radio. Mass
media was a way to reach out to the entire citizenry of the country, so everyone could participate, shape, and be shaped by the modernizing nation. It was a conscious effort, with the government calling for intellectuals and people everywhere to “stop talking about yourselves and talk about the Brazilian nation” (Velloso 1993:90). The eventual result of this urging was the intertwining of high-culture and popular culture in mass media that created a unified national Brazilian consciousness that sought to define itself in the face of the foreign dominance it desired to imitate, at times resist, and always negotiate through what it saw as its own limitations as an underdeveloped nation (Butler 2000, Dunn 2001, McCann 2004). Thus, the awareness of the dichotomy between the nation’s reality and the European ideal it sought to become has been a part of the national consciousness since its formation as a republic.

In the 1920s, as mass media became more prevalent, there was an explosion of ideas and movements in both high and popular Brazilian culture that sought to define what this duality of culture meant to the nation and its people. Below is a quote from McCann (2004), who wrote extensively about Brazil’s nation-building through popular music and literature:

Determining the cultural content of Brazilianness, and discovering the best ways to cultivate, express, and preserve it, became an overriding concern. Artists, authors, bureaucrats, popular composers, and, to a surprising degree, everyday Brazilians, shared in an investigation of Brazil’s identity – an investigation that in itself became a process of reinvention and reconstruction…describing a transition from one set of national myths and symbols, based on a high cultural vision of the marriage of European and indigenous elements to another, based on Afro-Brazilian roots and modern, popular cultural forms (2).

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5 This was done in a national public magazine called A Revista do Brasil that was popular in the early twentieth century.
Nationally important samba lyrics like *O Guarani to Guarana* in the famous song *História do Brasil*, or the movie *Hello Hello Brazil* demonstrate Brazil’s awareness and concern over its dichotomy of a nation seeking modernization yet at the same time “underdeveloped”, and as McCann states, “they are part of a common store of cultural knowledge. As markers of Brazilianness, they are as pervasive as *feijoada*” (3).

This binary was solidified in the popular imagination in important movements in the 1920s, such as modernismo, anthropofagia, and repeated with important cultural movements in the 1960s and 1970s, most notably Tropicalismo (Dunn 2001), all

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6 *O Guarani* is Brazil’s most influential nineteenth century nationalist piece of literature, written by José de Alencar in 1857, which tells the tale of a Guarani Indian, who must give up his culture to the European Portuguese settlers, but whose spirit is adopted into the European way of life. This piece of literature ignored the African influences of Brazil, and exalted the Indian, which was safe to exalt at this time, since the Guarani had been defeated. However, it is a significant example of Brazil’s culture of mixing and miscegenation, which has been a cornerstone of its national identity. Guarana, on the other hand, is a specifically Brazilian modern commercial soda pop made from a berry in the Amazon that has become an important beverage in the Brazilian diet. It’s mass-produced and commercialized quality, bottled by the powerful corporations of Brahma and Antártica, makes it a symbol for the “democratically consumable Brazil” (McCann 2004: 3). The juxtaposition of *O Guarani* to *Guarana* in Lamartine Babo’s samba “ushers out the old, refined, elitist Brazil, and welcomes in the new, mass-produced, democratically consumable Brazil” (3).

7 The title in Portuguese is Alô Alô Brasil, and it is about a man who travels from rural Brazil to the city of Rio de Janeiro to meet his favorite famous singer. He becomes starstruck with the city as has many glamorous experiences with famous Brazilian singers. The plot shows the urbanization and modernization of Brazil in the city as juxtaposed with the countryside.

8 *Feijoada* is the national dish of Brazil.

9 Modernists sought out the artistic, intellectual, and popular modernization of Brazil by incorporating the artistic tendencies of Europe with an authentically Brazilian tradition. It sought to define how modernization was to take place in an under-developed nation, and how to define a national identity under this dichotomy. It was an effort to construct Brasilidade through the school curricula, national heOlivialiage, carnival, music, radio, film, and literature.

10 Anthropofagia refers to a type of cultural “cannibalism” that served as a metaphor in art and culture for Brazilians digesting all of their cultural influences simultaneously. It specifically referred to Tupi natives eating and digesting the culture of the Europeans. It was a “modernist quest for intellectual autonomy from Europe; as a diagnostic of a society traumatized by colonialism; and as a therapy for counteracting the legacy of this trauma through satire and humor” (Dunn 2001).

11 Tropicalismo is a movement from the 1960s that included music, theatre, art, and poetry. The name exalts Brazil as a tropical paradise and it was heavily influenced by the modernismo and anthropofagia movements, especially in its desire to “digest” or mix together different kinds of cultural influences to make something specifically Brazilian. Musically it mixed Brazilian, European, African, and rock n’ roll rhythms to create something unique to Brazil. It was once again, a movement that sought to define, question and identify Brasilidade.
engagements seeking to make peace with the cultural struggle between western thought and Brazilian reality.

Brasilidade and the search for definitions of nationhood in a western context has driven all aspects of society, one being the medicalization of health (Amador 2008, Butler 2000). This is especially important for this research because this model of medicine has affected the way women give birth. In the early 1900s up to the 1920s, known as the “era of sanitation”, Brazilian Health Officials claimed that a standardized struggle against sickness and disease would create a better and more evolved citizenry and collective society (Amador 2008). It was during this period that healthcare was centralized under the federal government, while being privately funded by outside donors for improved infrastructure, one of which was the Rockefeller Foundation (Amador 2008). In 1934, under the new constitution of the *Estado Novo* (The New State), the populist president Getúlio Vargas granted healthcare reform to the entire population, giving all citizens in Brazil an equal opportunity to have access to “modern” medicine. During this period, there existed three health subsystems: the private sector, the public sector that served everyone else, and the social security system which tended to the old and the disabled. The latter contracted the private system to provide services (Falleti 2009). These two phases were reflections of what was happening in the industrialized world, demonstrating how Brazil was a part of the international project of modernization. The era of sanitation was a reaction to the western germ theory of disease, and the expansion of hospital based medicine was part of an international push to expand this model along with a culture of industrialization.
A stronger push for widespread medicalization occurred during the military dictatorship in 1964, when the creation of several bureaus, such as the Fundo de Assistência ao Trabalhador Rural or FUNRURAL, extended health services to the rural population and strengthened them in urban areas (Faria 1989, Martine 1998). The dictatorship, focused on national security in an era when communism was a threat, saw universal healthcare and medicalization as a means to quell possible subversives, maintain control to all areas of the nation-state, and infiltrate areas where rural workers and organizers could be meeting (Falleti 2009). Stronger medicalization meant healthier workers for the industry that was contributing to the “economic miracle” of the time. The number of physicians and healthcare facilities more than doubled during this period (Faria 1989). However, this policy focused on the expansion of a technical and hospital-based medicine that favored surgical procedures and allopathy over preventative medicine. This is a legacy that remains in Brazil today, highlighted by the fact that Brazilians have a strong trust in surgical procedures and medicine. This is also reflective of the positivist ideals Brazil is built upon which favor technology and intervention in natural human processes. Furthermore, the extension of widespread medical care to the population often took place through the private sector of health care, which proved a means whereby public funds could be transferred to the private sector. This left the private sector with a stronger influence in the medical arena to make decisions about procedures and norms (Faria 1989). This is evident when researching c-sections in Brazil since the procedure first became widely used in private hospitals, serving as a model for
the public sector of maternal medicine in the country (Béhague et al 2002, Tornquist 2003).

According to Faria (1989), characteristics of this medicalization of Brazilian society meant the following: 1) the responsibility for healthcare was taken out of the hands of the Catholic Church and a new secularization of norms in regard to healthcare was generated, 2) the control of the medical authority was strengthened because of their scientific knowledge, 3) there was an increase in medical appointments to discuss intimate problems, which the authority of the solution would be with the doctor, 4) the legitimacy was granted to the doctor in all biological processes, 5) the normalization of medical standards of health and body care became widespread, and 6) the efficacy of the procedures of medical intervention such as surgery became a dominant belief. In sum, it weakened the traditional authority of the church and family and legitimized the authority of medical professionals, paving the way for a technology-based medical care that favored allopathy, surgery, and western concepts of medicine.

Currently within Brazil, there remain three systems of healthcare, which closely mirror how the system has been structured since the 1940s. The private sector attends to 20-30% of the wealthier sectors of the population, the public sector attends to everyone else, and social security is extended to the elderly and disabled citizens, although this sector is still contracted under the private sector. Private healthcare is considered the best, although public healthcare in wealthier areas such as Rio de Janeiro and São Paulo is also considered to be good, despite waiting lists according to a need basis. Healthcare in rural areas and shanty towns is still very poor, and maternal and infant mortality
remain among the highest in Latin America despite Brazil’s high income per capita (Dixon-Mueller and Germain 1994). Due to such high levels, as well as Brazil’s constant fertility decline since the 1960s, it continues to have a pro-Natalist policy on birth.

Brazil’s pro-Natalist policy began during the military dictatorship, since they saw a larger population as a means to expansion and progress. However, despite the policy and the government’s pro-Natalist intentions, it was this period that marked the beginning of Brazil’s fertility decline (Burquó 1998, Kaufmann 1998, Martine 1998). Between 1970 and 1990 the total fertility rate fell by more than fifty percent (see Table 1).

Table 1: Total Fertility Rate in Brazil

<table>
<thead>
<tr>
<th>Years</th>
<th>TFR in Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960-65</td>
<td>6.00</td>
</tr>
<tr>
<td>1965-70</td>
<td>5.75</td>
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<tr>
<td>1970-75</td>
<td>4.97</td>
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<tr>
<td>1975-80</td>
<td>4.17</td>
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<td>1980-85</td>
<td>3.37</td>
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<tr>
<td>1985-90</td>
<td>2.82</td>
</tr>
<tr>
<td>1990-95</td>
<td>2.48</td>
</tr>
</tbody>
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Martine (1998) and Diniz et al. (1998) explain this 30-year decline as being due to a variety of actors and non-actors, which include the government, international development agencies, the Catholic Church, women’s groups, health-care professionals, and a changing society and culture geared towards modernization and urbanization.

First, Brazil was one if the primary targets of concern for international development agencies and the United States with regard to rapid population growth in the 1970s (Fonseca 1993). Since the Brazilian government was pro-Natalist, the strategy of
the population establishment was to provide aid to make agreements with private family planning organizations, to which the government allowed due to oversight and lack of internal funds and staffing (Fonseca 1993, Hartmann 1995). The two most influential actors that participated in population and development programs in Brazil have been the sterilization industry and family planning NGOs (Martine 1998). The main family planning agency in Brazil is BEMFAM (Bem-Estar Familiar no Brasil), which is the Brazilian affiliate of International Planned Parenthood. In the 1970s BEMFAM received funding from USAID and other donor agencies to distribute the birth control pill, however there was not adequate counseling or follow-up care, and the most effective birth control method became sterilization, despite its illegality (Hartmann 1995, Martine 1998, Burquó 1998). Through BEMFAM, who signed agreements with local governments to sterilize in public and private hospitals, 44% of Brazilian women between the ages 15 and 44 were sterilized by 1986, due to lack of other contraceptive technologies (Hartmann 1995). Often this sterilization was completed legally in private institutions through a loophole in the law, which stated that sterilization could be done after a caesarean section, adding to the already high c-section rate (Burquó 1998, Diniz et al 1998, Martine 1998). Also, because the government was primarily concerned with economic and industrial growth, its Ministry of Health did not have the funding or the resources to overlook the extensive use of the sterilization procedure (Martine 1998). This was the beginning of a culture of two c-sections followed by sterilization, which is a legacy that has carried into Brazil’s present.
Second, in 1986, feminist organizations saw their chance to improve women’s family planning methods and reproductive rights because the government was transitioning from the military dictatorship into a democracy (Burquó 1998, Diniz et al 1998, Dixon-Mueller and Germaine 2010, Martine 1998). Prompted by feminists, the government officially legalized contraception, since it had not yet done so, and the Ministry of Health adopted PAISM (Program of Integrated Assistance to Women’s Health). Through providing education and other options of reproductive technology, PAISM has been effective in some areas, however due to issues of resource allocation and social expenditures it has not been effective everywhere. By the end of the twentieth century, many women throughout Brazil, lacking access to other contraceptive technologies, still relied on sterilization (Diniz et al 1998). This continues today with sterilization being Brazil’s main form of contraception, especially when it is performed after a c-section (Diniz et al 1998).

Third, the Catholic Church has had a strong influence on issues of reproductive health, staunchly opposing contraception and family planning of any kind (Berquó 1998, Dixon-Mueller and Germaine 2010, Martine 1998). Due to its strong influence on government policy, supporting official pronatalist agendas, contraception was not legalized until the late 1980s due to pressure from the international population and development agencies (Martine 1998). The Church’s insistence on opposing contraception (it now makes an exception for natural methods) has paradoxically contributed to higher rates of sterilizations and unsafe abortions, since abortion still remains illegal in Brazil (Berquó 1998, Martine 1998).
There have been several non-social actors that have also led to Brazil’s fertility decline. First, widespread education about fertility and reproduction due to increased medicalization has given women increased information about their options (Martine 1998). Second, rapid proletarianization and urbanization due to increased industrialization during “the economic miracle” drew much of the labor force into the money economy and removed the advantages of larger families (Martine 1998). Brazil was urbanizing and people were rapidly moving to the city. Brazil was becoming a predominantly consumer society, meaning that there needed to be a focus on purchasing goods like cars, appliances, or clothes, forcing the cost of child-bearing to go up. Rational economic calculation became a means to familial well-being and smaller families made better financial sense in the city (Faria 1989, Faria and Potter 1994, Martine 1998). The gap between “the rural” versus “the urban” in cultural values and standards began to grow larger. Finally, the spread of mass communications, which was promoted as a means of social control during the military dictatorship, has been influential in changing reproductive behavior (Faria and Potter 1994, Martine 1998). Besides promoting consumption, most television programs and popular novelas\(^\text{12}\) (soap operas) portray small consumer-oriented families and an entire urban culture that accompanies this modern lifestyle, which includes a modern and urban tradition of c-section birthing. All of these factors led Brazil to achieve one of the most impressive fertility declines in the world (Martine 1998).

Within the government and among feminist organizations, there still remain two main concerns in regards to reproductive activity. The first is the high rate of maternal

\(^{12}\) As of 1991, 80% of household watched the nightly novelas (Martine 1998).
mortality (Burquó 1998, Diniz et al 1998). Diniz and colleagues (1998) report that WHO and UNICEF have put the national ratio at 220 maternal deaths for every 100,000 births. Unsafe illegal abortions, hemorrhages often due to caesarean sections or the precarious state of blood banks, toxemia, and hypertension are responsible for 90% of these deaths (Burquó 1998, Diniz et al 1998). Within this research, the legacy of maternal mortality has weighed heavily on the minds of the Brazilian population, often serving as a reminder for concerns over Brazil’s position as a developing and modern nation. The second concern is the subordinate position of women, both in the home and at the workplace (Burquó 1998, Diniz et al 1998, Dixon-Mueller and Germain 1994). While this second concern is much less important for my research, it is still an important factor for understanding a woman’s desire to plan her birth. Both of these topics will be further explored in findings and analysis in Chapter 5.

Also of concern in regards to reproduction is the high rates of caesarean sections in the country, which pose health concerns for women and babies and are expensive for the public sector of the Brazilian health care system (Diniz 2005). There is an existing body of research that seeks to understand these high rates in the Brazilian context in order to help correct the phenomenon. The existing research on this topic is important for understanding specific causal factors that have led to high rates, and while they do not take into account larger discourses, they do provide explanations that better help to comprehend the phenomenon. The next section will explore this literature.
3.2 The Modern Medical System in Brazil and Reasons for High Caesarean Rates

Each year in Brazil there are 2.5 million births, of which 88% are attended by the public sector, or the Sistema Único de Saúde (SUS), which has a 28%-35% cesarean rate (IDEC 2008). The remaining births take place in the private sector, where 80% of births are done by cesarean, and numbers can reach 90% depending on location (IDEC 2008). This brings Brazil’s total cesarean rate to 44% (IDEC 2008), which is where it is today (IDEC 2010). Currently, the government advocates vaginal births. In the 1990s, when the government of Brazil learned of its financial loss in the increased use of c-sections in its public hospitals, it started a project called *Maternidade Segura*, which was aimed at making birth safer, more “humanitarian”, and more “natural”. It encouraged less intervention in the birth process, particularly discouraging the use of c-sections (Diniz 2005). This program received a fierce backlash from doctors who not only felt offended and attacked that their birthing practices were not considered humanitarian, but also felt resentful of the fact that birth needed to be “humanized”, since they saw c-sections as an already more humane method of birthing. They disliked the romantic idealism the government was associating with the natural birth, and they thought the idea that a woman should be autonomous was wrong. Some doctors retorted that like birth, “death is natural too” (MacCallum 2005: 225) and people should not follow certain practices simply because they are “natural”. For them, cesarean sections are clearly the “modern”, and therefore, the best method to deliver babies, and according to existing research they are very vocal and upfront about this bias (Souza 1994).
In the public hospitals, where the practice is controlled by the government, c-sections have decreased from 50% to 35% (Béhague et al. 2002), however, in the private sector, where doctors have the control, the rate remains between 80%-90% (Finger 2003). Many scholars have attempted to understand the phenomenon of high c-section rates. A variety of causal factors have been pinpointed, all in the place-specific context of Brazil, which fall under the three main categories of: 1) characteristics the modern medical system, 2) cultural perceptions of birth and the female body, and 3) economic imperatives under capitalism.

In Brazil, there are three main characteristics of the modern medical system that contribute to the high c-section rates. The first is technology and intervention. The technology used in the medical model is implicated as a primary factor in increasing the c-section rates, both in Brazil (Finger 2003, McCallum 2005), as well as globally (Churchill 1997, Teilingen et al. 2000). When labor is prolonged, medication is given to the woman to accelerate contractions. This causes stronger contractions, requiring the increased use of analgesics, leading to decreased sensitivity and no urge to push the baby out, which causes fetal distress, and ultimately leads to a c-section. The chance of c-section becomes exacerbated due to the definition for fetal distress as being very vague, subjective, and always changing (Churchill 1997, Teilingen et al. 2000). Furthermore, devices called electronic fetal monitors (EFMs) that have been designed to detect fetal distress in a standardized manner, actually double a woman’s chances of c-section (Marieskind 1979, Inch 1985) because they increase the chances of fetal distress being diagnosed (Churchill 1997). While fetal distress is a concern, the fact that it is vaguely
defined means that it can be easily diagnosed and can often be used as a justification for an unnecessary c-section. The second characteristic is lack of doctor training in vaginal birth. Evidence has pointed to the fact that some medical schools in Brazil lack funding and time to train doctors in all types of birthing techniques (Finger 2003, McCallum 2005). Under these circumstances, doctors are trained in what is perceived as the hardest techniques first to ensure that they understand what to do in worst case scenarios. Easier methods are only introduced briefly, if at all, time and funding allowing (Diniz 2005).

Additionally, a belief in the medical profession that caesarean presents a better outcome adds to its perpetual use. Potter and colleagues (2001) found that doctors often do not discuss other options with women because they believe caesarean is the superior method to ensure a perfect birth, as well as a more convenient option that fits into their busy schedules. Hopkins’ (2000) research found that doctors gently encourage patients to do a c-section by offering vaginal birth as something they can “try”, however at the first sign of the slightest complication, a c-section is performed.

In addition to characteristics of the modern medical system, there are a number of cultural imperatives influencing this trend. First, cultural perceptions of birth and the female body add to its acceptance. One way is the dissemination through the media that c-section is better and more acceptable. Victoria Beckham, former singer of the popular band the Spice Girls, and wife of the soccer super star David Beckham, had a c-section, stating she was “too posh to push” (Wagner 2004, Klein et al. 2006). The slogan was widely covered in the Brazilian media, accompanied with c-section stories of celebrities like Elizabeth Hurley, Claudia Schiffer, Angelina Jolie, and Christina Aguilera who were
also “chiques demais para fazer força” (Folha 2009, Farandulista 2009). This concern stems from a worry over image, both social and physical, as women (and men) are afraid of disfiguring the vagina and hips. Brazilian women have a strong preoccupation with their appearance. Research shows that women have internalized the construction of the “sexy Brazilian”, feeling pressure to maintain this stereotype (Adelman and Ruggi 2008, Beserra 2007). Of primary concern for women is that their hips will not return to the normal size and their vaginas will become mutilated (Althabe et al. 2002). An additional common cultural concern is the fear of pain during birth. There is a wide-spread belief that vaginal birth is more painful than cesarean birth (Barbosa et al. 2003, Faúndes et al. 2004, Hopkins 2000, Potter et al. 2001). Hopkins (2000) found that doctors encourage women to have a c-section by reminding them of the suffering and the painful experience of a vaginal birth (Hopkins and Potter 2001, Osis et al. 2001, Tornquist 2003). Finally, the Brazilian law on sterilization only after c-section is a major cultural factor in high c-section rates. The influence of the Catholic Church to define a women’s reproduction still plays an important role Brazilian society (Dixon-Mueller and Germain 1994, Martine 1998). By banning contraceptive methods, women are more likely to get a sterilization, which can be done ethically and morally following a c-section and becomes legally mandatory in Brazil after three c-sections (Barrows et al 1991). This reason for this law is due to valid medical concerns that a repeat c-section put women at higher risk for placenta accreta and other medical complications.

The idea of a “modern” birth and a “modern” female body can also be understood in the context of Brazil as a highly unequal society, where divisions between rich and
poor vary greatly. Socio-economic status plays out in two different ways. First, upper and upper middle-class women are having c-sections because they believe it is “chic” and “modern” (Tornquist 2003). They see c-section birth as something that requires little effort and pain, as well as the fact that rich and famous women are doing it. Second, Béhague and colleagues (2002) found that socio-economic inequalities within the public hospital system led to antagonistic relationships between doctors and patients that caused an increase in c-sections. According to some poor women, the overcrowded public health system means that they must fight for attention, especially because their lower social standing deems them less important with public health doctors, who often need to first establish a reputation in public health before they can move into a private practice. These women believe that they must scream and moan to receive the proper attention and care from doctors, hoping that by doing so, they may be chosen for a c-section.

Economic imperatives are also a driving force in high c-section rates. Both doctors and hospitals seek to benefit financially in several ways. First, they receive more money by performing caesareans since it is a major surgery (McCallum 2004, Potter et al. 2001). Second, in their already busy schedule, doctors can maximize their time by having a scheduled birth, which frees them from waiting during labor, waking up in the middle of the night to deliver, and having to come to work on the weekends for a delivery (Potter et al. 2001). Evidence of this is also reported by Bergeron (2007), who states that most c-sections occur on a Friday between 6AM and 6PM. Third, the maximization of hospital beds is not dependent upon the recovering woman, but rather on the extraction of profit a hospital can get from that woman. In this way, a c-section is more ideal because
the recovery time is longer, meaning that the woman will pay more for her bed (McCallum 2004). Profit maximization means that there is a lack in proper staffing, and often there is no obstetric nurse present (McCallum 2004). Without an obstetric nurse, the doctor has no one available to assist through labor, which can take long, so a c-section is the more convenient method (Osava 1996). Economic concerns also enter the life of women, who must schedule their birth around their holiday or vacation time, or when their workload at their job is less hectic (McCallum 2004, Wagner 2004). This not only allows them to have the convenience to know when they will be absent for their job, but it also gives their boss more assurance for how to plan for their absence.

3.3 Conclusion

To summarize, vaginal birth is no longer perceived as being compatible with modern technology, a modern and attractive female body, and an economically viable birthing practice in Brazil. While this research contextualizes the procedure as being influenced by individual factors, it also recognizes that these factors fail to uncover that technology, culture, and economics all fall under the western model of modernization and development, which this research explores as the larger discourses influencing this trend. Also part of these larger discourses is Brazil’s quest for defining Brasilidade in the face of westernization. This pursuit has shaped national projects such as the medicalization of health, and it has encouraged the drive to urbanize, industrialize, and modernize, as well as allow international development agencies to promote unhealthy fertility campaigns that encourage sterilizations. Yet, how do these discourses manifest in Brazil to shape
cultural ideas that influence birth, specifically c-section birth? Through the understanding of Brasilidade as a term created out of a desire to modernize, this thesis will investigate this question.
CHAPTER 4: METHODOLOGY

This research adheres to a critical theory approach to qualitative methodology, which means that it takes a critical stance towards the meanings participants attribute to the topic at hand, and analytically places these meanings as being subject to analysis in light of larger economic, political, cultural, and ideological structures, which may go unacknowledged in other approaches to qualitative methodology. This approach requires more autonomy from the research participants, as well as from the researcher, who recognizes the need for interpretation of informant responses, while at the same time being cognizant that responses as well as interpretation are constructed within the space of the research being conducted. Therefore, the use of this approach means that there is a social stance that the research takes, and that the research outcomes are informed by the researcher and the research participants, as well as the larger social systems and power relations in which both subjects find themselves within the space of the research. This approach to methodology stems from a post-modern tradition and it encourages a reasoned analysis, rigor, the cross-checking of data, and an attention to detail and balance through the exploration of a variety of perspectives of informants and field observation (Denzin and Lincoln 2002).

In order to carry out my research, I conducted a five week investigation of c-section birth in São Paulo city, where c-section rates are the highest in the country (IDEC 2008), during July and August of 2010. In order to understand how discourses on birth, modern medicine, birth techniques, and women’s bodies disseminate through people’s thoughts and behaviors, I conducted structured and unstructured interviews, as well as
compiled daily field notes. I used a purposeful sampling strategy in order to conduct a total of 22 interviews with women between the ages of 25 and 50, who had experienced at least one caesarean birth. Interviews with five doctors were also conducted. These interviews consisted of two obstetricians, one general family physician, one anesthesiologist, who specializes in c-section birth, as well as one acupuncturist, who was a pediatrician for 20 years prior. All interviews, except for one, were recorded using a digital device. In addition to interview transcripts, I have approximately 15 handwritten pages of field note data taken from observations and informal conversations I had during my time in Brazil, as well as 10 pages of single spaced field notes on the computer.

4.1 Before Stepping Into the Field

Adhering to the critical approach at the outset of creating my methodology, I was aware that the questions I chose for the interviews and the lens through which I viewed my research was informed by a social stance. For personal and academic reasons I am uncomfortable with the idea of unnecessary c-sections, and while I respect other women’s opinions, I am aware that my research opposes climbing c-section rates. Therefore, it should be made clear that my research is motivated by a concern for unnecessary cesarean sections and the questions\textsuperscript{13} that I crafted for my interviews thus reflect certain discourses and beliefs that I hold to be true. Nevertheless, upon creating my initial interview questions, which served as the framework for my ethnographic fieldwork, I attempted to ask my questions in a manner that would not influence the

\textsuperscript{13} Refer to Appendix A and B for my interview questions.
informant’s responses in regards to my views, as my goal in this research was not to present my opinion, but the experiences and perceptions of those with whom I spoke.

When choosing what my sampling procedure would be I was aware that my research was not intended to generalize the opinions of all women or doctors in São Paulo, but rather to be an exploration into contextual meanings that were produced in regards to my initial research questions, which were centered around my research questions as presented in the introduction of this thesis. In order to best explore these questions given the limited amount of time I would have in the field, I proposed to use structured and unstructured interviews with 20 women 1) who have had a c-section, 2) who were between the ages of 30 and 50, 3) who were from a middle class background, and 4) had their birth in the private sector of the Brazilian health system. Additionally, I set out to interview 5-10 doctors, specifically gynecologists and obstetricians, who worked for the private system. My aim was to isolate my exploration of birth around the middle class and privately hospitalized culture of c-section birthing in order to make my sampling, and thus my results, more manageable and congruent. As my next section will explore, due to research limitations, this was not entirely possible, however, the sample in which I actually obtained influenced my results in unexpected ways.

4.2 Gaining Access

At my fieldwork site of São Paulo city, I already had contacts and a support base from which to begin my research due to my three years of living and working in the area between 2003 and 2007. My comfort with the language and the culture was already
solidified due to time spent living in the region, as well as prior experiences I had with Brazilians. I already had access to a variety of women of different ages and different socio-economic statuses that offered to help me with my research. Twelve of the women I interviewed were either existing contacts or friends of existing contacts. These interviews were conducted at the homes of the informants or at restaurants they chose. The other ten women I interviewed I met at one of three places, each of which I selected due to the presence of a large number of women that fit my interview criteria as well as the proximity of the locale to my place of residence during the fieldwork.

The first was a Catholic nursery school in the neighborhood of Ipiranga, where children attended school and their mothers could be found between 3:00 and 4:30 to pick up their kids. I was informed of this site by an existing research participant and I returned to this nursery for several days in the hope of finding informants. I met a woman who agreed to an interview, and after feeling comfortable in our interview, she introduced me to two of her friends whose children also attended the school. The second site I found informants was at a McDonald’s restaurant in the neighborhood of Mooca. I discovered this research site because it was the location for an interview with a woman I had met at the nursery. As in the US, children in Brazil love McDonald’s because of the Happy Meal toys and the indoor playground. I discovered that dinner time, between 5:00 and 8:00 PM, were ideal times to be at a McDonald’s to find women with children, many who had experienced a c-section. Returning to the McDonalds everyday for three days with my informant from the nursery, I was able to find three more informants. I soon realized that dinner time at this restaurant was ideal for my interviews because mothers
had an opportunity to talk to me while their children played on the McDonald’s playground with other children. Since the mothers had nothing else to do but watch their children, eat dinner, and talk to other mothers, they were free to talk to me openly. Finally, a popular park, called the Museu de Ipiranga, was a weekend destination for families. On Sundays there were clowns, music, and candy being sold, and mothers would watch their children as they played on the slides and swings. Four of my interview informants were women that I approached at this locale, which I randomly discovered on my first day in Brazil when I accompanied a friend to the park. Again, while children played on the playground, I found an open research space with mothers, with whom I could talk openly about birth and conduct my interview questions.

These sites ended up being ideal locales because they were spaces where mothers felt safe and were in a relaxed environment, where they could talk freely about their ideas. While the nursery presented a logical starting destination to find informants, the existence of the playgrounds at the McDonalds and the park meant that I could have the woman’s full attention since her child was playing in a secure space and as a result she could talk to me while she waited for her child. In all of these places, women who had had c-sections were easy to find, perhaps easier than if I had been looking for women who had vaginal births, further demonstrating the commonality of the c-section practice. While it was not always easy to find women that agreed to set aside time for the interview, the majority of women that I approached in all three of the areas primarily consisted of women who had c-section births.
All of my interviewees were between the ages of 25 and 50, who had experienced c-sections. They were from a varied social class status. Angela and Benedita both worked in the cleaning service, while Susana, Raquel, and Leticia were all secretaries or performed duties similar to a secretary, and finally Melina was a telemarketer. Gloria was a stay at home mother for her seven kids, as well as her two grandchildren. These women were all lower class women who had no college education and had given birth in public hospitals. Natalí, Luisa, Lourdes, Marta, Dolores, Daniela, Claudia, Renata, Fátima, Agnes, Alda, Ana, and Thaís were all college educated middle and upper middle-class women that were working mothers. Two of them were small business owners and the rest had careers in architecture, sales, teaching, government administration, and nursing. Olivia, the only anomaly, was a manicurist, who had experienced middle class status during her marriage, but had dropped to a lower class financial status after her husband left her to care for herself and her three children. In two of the interviews, there was a third person present. Fátima brought her sister Bruna, and a mutual friend of Olivia and I, Rosa, stayed during our interview. Their responses and opinions were also recorded in the interview and used for my data analysis. The unintended variation in the social class status of my sampling came about due to time constraints coupled with the fact that lower class women were more responsive and timely in providing me with an interview. With my middle class informants, there was a social process that had to be followed that consisted first of conversation, lunch, or dinner, followed by the interview. Therefore, these interviews took much more time, in some cases as much as half a day, and had to be scheduled at least a few days ahead of the actual interview. Almost all of
them had to be done on the weekend. On the other hand, women from the lower social classes did not set aside this time for the interview, rather, they allowed me to interview them whenever there was a chance. Often my interviews with these women were done at their work place, on their walk home from work, or spontaneously occurred after they invited me to dinner.

Much more difficult to interview were the doctors. For my first three weeks in São Paulo, I was unable to have a single interview with a doctor. After scheduling an interview with Dr. Maria, an OB/GYN, through a friend, I used the snowball technique to gain access to Dr. Selma, followed by Dr. Melina. Dr. Sergio, who was a practicing acupuncturist that had twenty years of experience in the field of pediatrics, agreed to an interview during my fourth week, although it was in between patient visits, and was unrecorded. Finally, Dr. Bela, my former doctor in Brazil, who was not in São Paulo at the time of my field work, provided me with an interview through e-mail and Facebook chat in October of 2010 and has been in communication with me in regards to the topic since that time.

Besides corresponding with Dr. Bela, I also used the internet to join a virtual community forum centered on the debate over the use of the caesarean section procedure in Brazil. The site is called Orkut, which is sponsored by Google and dominated by Brazilian users. This virtual space has proven useful to me in qualitative research collection in the past because it has open public access to community forums and provides for easy communication among users. I included conversations from the forum in my field notes, and also met a woman named Susana, who took the time to correspond
with me about her ideas in regards to c-sections. However, I have decided to only use this data in my field notes and not include Susana as an interviewee, since our correspondence was short and did not follow my interview topics.

In sum, I conducted 27 interviews in my exploration of how people view c-section birth and its relationship to ideas of development, modernity, nationhood, and pre-existing research. Qualitative research, especially when it is conducted through a critical theory tradition, aims to gather an in-depth understanding of a behavior and its reasons, trying to answer the questions of why and how. Therefore a smaller and more focused sample is used as opposed to larger samples, thus putting an emphasis on the meaning of responses in regards to larger social forces, in contrast to frequency of a particular answer that does not recognize context. Due to the personal nature of these interviews and the understanding that the knowledge that results from them is constructed through a relational context, it is important that both informant and researcher positionality be highlighted. The next section will explore this area of the methodology.

4.3 Placing the Researcher and the Interviewee in the Data Collection Process

All of my informants knew about my position as a graduate student researcher from the geography department of Ohio University before the interview started and they gave me informed consent through a standard that was approved by an Institutional Review Board. The interviews followed the format of a structured, semi-structured, and un-structured interview style, meaning that in some I followed the prescribed set of interview question chronologically, in some I followed these questions but became
conversational when necessary, and in some I used the protocol as a topic outline, but the interview became completely conversational in nature. The nature of the interview in regards to these styles did not follow any specific pattern, but was created in the context of the interview and depended on the level of comfort and rapport I had with the informant. All of my informants were willing to be interviewed about birth, therefore nearly all of my questions were addressed in some form during the interview process. The length of the interview depended on the informant and the time she had to talk. My longest interview lasted 3 hours, and my shortest interview was ten minutes, while most interviews lasted approximately one half hour. All of the interviews were recorded and transcribed.

The affinity with particular informants over others followed no specific pattern, and while I was more at ease with my existing contacts, I also conducted interviews with new contacts that were in-depth. By far, the most useful aspect of my identity in doing this research was the fact that I am a woman. It gave me grounds to relate to my informants, as well as feel a sense of solidarity. Women talked with me easily about their birth story and thoughts and opinions of the topic, and I enjoyed listening and talking to them about this issue.

Because I had previous living experience in the country, I did not feel like a “foreigner” and on the contrary, I was surprised with the ease with which I as able to relate to people, especially in regards to the research. Nevertheless, my identity as an American did make some people feel curious about why I wanted to study Brazil for my case study, and I always had to be cautious about relaying the idea that I was not a
foreigner trying to highlight Brazil’s problems, but rather I was simply academically curious. Because I was aware of the possibility of offending people in this context, as I know Brazilians can be sensitive about this, I was careful about asking one of my research questions, which asked whether women thought there was anything specifically Brazilian about their birth. Only in two interviews did I feel like this aspect of my identity caused tension, and on the whole, my informants felt comfortable that I chose Brazil as my site of research.

My position as a student researcher from a North American University often gave me credibility, however, I do not think it caused the women to be reluctant as they were answering my questions and telling me about their birth experience. I did notice however, that conversation with the lower class women did not flow as easily in some cases. These women often gave me short answers, and I felt like I had to put a lot of effort to make them feel comfortable to answer my questions in greater depth. One interview with a woman named Benedita, a low-income woman that worked as a maid, made me realize why this could have happened. At the end of our interview Benedita started crying. When I asked her why she was crying she said it was because she felt stupid answering my questions because she was a simple woman. This made me question if the short answers I got from some of my lower class informants was due to the fact that they did not feel themselves entitled to answer my questions, not even when I actively told them how important their personal experiences were to my research. While this was not the case with all of my lower-class informants, I do feel like this
perceived relationship of power and status could have affected the way some of my informants reacted during our interview.

In addition to obtaining interviews, I also engaged in observation of society’s attitudes as they pertained to my research topic. This included a daily examination of people’s general opinions on the topic of caesarean. Brazil is a society in which engaging in conversation is relatively informal, and engaging my research topic was easy because one of the first questions people would ask me was why I was visiting Brazil. Through these conversations in the field, I heard about many birth experiences, often told to me by a third person, and discovered many attitudes on the topic of high c-section rates in Brazil.

The main challenge for me in data collection in the field was time. Due to a problem I had with my visa prior to leaving for Brazil, my initial seven weeks of allotted research time was reduced to five weeks. While I was able to gather a significant amount of data in Brazil, I feel like I could have better met my initial research criteria, as well as interviewed more doctors, if I had had more time in São Paulo to fully carry out data collection. This affected my results, especially in regards to isolating the responses of middle class women. On the other hand, it gave me the opportunity to obtain data on how class affected people’s perceptions of c-sections, which is highlighted Chapter 5 in my discussion of the rural versus the urban dichotomy in Brazil, which became an important finding that the difference in class status emphasized. Despite the opportunity to analyze public versus private hospital care that this inconsistency in class status allowed for, the possibility of this finding was not discussed, largely because it did not
arise in the interview questions since the majority of my informants were in favor of c-sections.

4.4 Data Analysis

After transcribing all interview data, I used the interpretive technique of open and focused coding of interviews, field notes, and other documents and materials (Emerson et al 1995). From this process, I assembled themes on the topic of caesarean section, why women were doing it, how the phenomenon was linked to discourses of development and modernity in the Brazilian national context, as well as repetitions of findings from previous research. Through focused coding, I was able to use the themes to create categories, under which I gathered the pertinent data. Thirteen categories emerged from this process, they were “why I got my c-section”, “opinions on c-section”, “caesarean section is modern”, “fear of pain/normal birth/death”, “the disciplining influence of culture”, “no dilation and no passage”, “a trust in the doctor”, “the doctor not explaining the birth process”, “normal birth has better recuperation time”, “caesarean section is more convenient”, “caesarean section is a typical Brazilian birth”, “the body does not influence birth decision”, “a fear of getting fat”, “portrayal of normal birth on television”, and “getting my birth filmed”. These categories were grouped into larger categories in regards to my initial research questions on birth, development modernity, and nationhood, which developed into the following topics in my results: 1) rural versus urban constructions of development and how these discourses affect Brazilian society’s opinions about birth, 2) performances of birth and what they mean to being a woman in a
“modern” nation, 3) how notions of technology and wealth have influenced women’s choice in birth procedure, and 4) choice and what it means to choose one’s birth, either c-section or natural birth, in the Brazilian context, and 5) the systematic implications of birth choice. These themes will be highlighted in my next chapter.
CHAPTER 5: C-SECTION BIRTH AS A PERFORMANCE OF MODERNITY

This section will explore the findings of my interviews and field work, as well as provide an analysis for their interpretation. I will argue that a larger discourse of modernization and development in the Brazilian national context has given geographical, historical, and cultural meanings to the practice of birth, which influences women’s and doctor’s decisions in choosing the caesarean procedure, adding to a high c-section rate.

The reasons for the high rates of c-sections can be summarized from previous research as follows: 1) technology and the desire to use the most up-to-date and modern methods, 2) lack of doctor training, 3) a belief that caesarean sections present a better outcome, 4) the dissemination through the media that c-sections are better, 5) fear about disfiguring the vagina and hips, 6) sterilization, 7) fear of pain during birth, 8) socio-economic status, 9) financial gain for doctors and hospitals, 10) lack of staffing in hospitals, and finally 11) the ability to plan a c-section around the work schedule. While my research supports many of these findings, I argue that none of these reasons can be understood as the single cause for such high c-section rates. Rather, these factors both give meaning to and are the expression of a larger discourse of ideas about modernity, development, and nationality which can be understood as an underlying determinant of how birth is being “performed”.

I specifically use the word “performed” because, as discussed in Chapter 2, in this work I see birth as a gendered performance of an identity, which in the case of this research is the Brazilian identity, or Brasilidade. As Judith Butler states in *Gender Trouble* “identity is performatively constituted by the very expressions that are said to be
its results” (1990: 25). In other words, gender and certain expressions of gender, which in this case is birth, are a performance of what women do at particular times to express something about themselves, which in this case is their Brasilidade. This is an important notion because, according to Butler, these ideas can take a hegemonic hold that may seem natural, but actually are created and socially constructed over a time and space, and as in the case of my research, become normative. My case study is an example of a performance becoming normative and hegemonic, because, as stated in Chapter 3, Brasilidade seeks to follow a modern path of “order and progress” and these notions extend into birth choice, as this chapter will demonstrate.

Of my twenty-two informants, only six stated that they would have liked to have a normal birth, each of them for the reason that they thought normal birth would have a faster recuperation time. The other sixteen women all stated that they wanted a caesarean section, and while the medical explanation they gave was that they had no dilation and no space for the baby to pass through the vaginal canal, my interviews revealed that these reasons are formed in a context of larger discourses that influence how birth is discussed and understood. Of the five doctors I interviewed, two were strongly in favor of c-sections, two were strongly against, and one was in favor of both c-section and normal birth, depending on her client. These doctors all spoke to me about the social pressure as doctors to perform a c-section, the complications in the medical system that allow and even stimulate the use of the procedure, as well as the cultural acceptance of the procedure as common.
This chapter will simultaneously explore my research in relationship to previous findings, lay a foundation for the interpretation of my informant’s views about birth and modernity, and develop my main argument of how modernization discourses have influenced birth. In particular, in the first section, I will analyze notions of: 1) rural versus urban constructions of development and how these discourses affect Brazilian society’s opinions about birth, 2) performances of birth and what they mean to being a woman in a “modern” nation, 3) how notions of technology and wealth have influenced women’s choice in birth procedure, and 4) choice and what it means to choose one’s birth, either c-section or natural birth, in the Brazilian context. My second section will analyze high c-section rates as a systematic problem, where both doctors and women have been disciplined into choosing certain birth procedures, in which choice is presented in the vacuum of the medicalized model of childbirth. This section will discuss the implications of these larger geographical, historical, and cultural discourses of modernization and development to conclude that choice in birth procedure has become limited and more awareness needs to be cultivated about birthing in the face of high and climbing c-section rates in the country of Brazil but also on a global scale.

5.1 Taking Advantage of Modernity

In my field work, I visited hospitals with 99% c-section rates, or in other words, these hospitals no longer perform natural birth. They are in nice areas of São Paulo that
showcase wealth in the form of nice cars, beautiful buildings, good kilos,\textsuperscript{14} shopping malls, and accessible subway stations all within walking distance in an intensely urban setting that is often compared to Manhattan. It makes one feel a sensation of modernity and urbanity that is inescapable. To live in São Paulo is to take advantage of all of the positives and negatives that our urban and modern life offers. In the case of this research, “taking advantage of modernity”, as one informant of mine explained, also means to have a c-section birth. Every single friend, colleague, family member, informant, and acquaintance I had in the area had all had c-sections, and I talked with doctors that attempted to no longer perform the natural birth procedure. It seemed that to live in São Paulo and have a baby meant an unyielding commitment to a c-section. My exploration into this phenomenon both agreed and disagreed with previously existing research, but one aspect became clear, each of the causal reasons for the high rates of c-sections were influenced by cultural perceptions of modernity, development, and nationality, at least in São Paulo.

5.1.1 Sterilization

My first example of how modernity and development have influenced reproduction is the case of sterilizations, which occur largely due to the fact that women only want to have two children due to the busy and expensive lifestyle that

\textsuperscript{14} Comida por Kilo is a Brazilian type of a Brazilian restaurant in which you help yourself from a buffet and weigh your plate. You pay for the weight of the portions you chose. Kilo restaurants usually serve varied, home-style Brazilian food: beans, rice, meats, vegetables, pastries, casseroles and salads.
industrialization and modernization require. Prior to doing my fieldwork there was research done showing that sterilizations added to higher c-section rates because it was illegal except after a c-section (Burquó 1998, Diniz et al 1998, Martine 1998). Therefore, in order to have a sterilization after two children, women would have the c-section procedure performed so they could legally have the sterilization. Since the sixties, sterilization remained, despite its illegality, one of the main contraceptive technologies, forcing c-section rates to climb because it was only legal after c-sections (Diniz 1998). While sterilization has now been legalized, my findings support previous research which sees sterilization, and subsequent c-sections, to be a consequence of the modern and urban lifestyle that led to Brazil’s fertility decline in the sixties and seventies (Faria 1989, Faria and Potter 1994, Martine 1998). Because women are working more, they have less time, less money, and less incentive to have large families. Furthermore, children are expensive, especially in the urban environment of São Paulo, where everything is costly.

Paulista women take pride in their careers, and see their work and earning power as symbols of being a modern woman. All of my informants, while full-time mothers, were also engaged in a full-time profession, and in São Paulo, Benedita, an informant that worked as a maid stated “work is life, work is serious, here in Sao Paulo, we are in a professional machine”. My informants were all proud of their jobs and this was as much a part of their identity as being a mother. While interviewing Angela, she mopped the floor and dusted the walls, and for her it was a matter of pride in her work to clean every inch to her fullest potential. Both of us took time to admire her job well done after she
finished. Due to professional importance, no one I talked to had more than two children, since it meant more work and less money. As Doctor Maria told me:

A second reason why c-section rates are high is because of a financial question. Women have a maximum of two children. So generally it’s a plan for two children and two c-sections and in the second c-section we perform a sterilization.

However, the legal procedure of two caesareans followed by sterilization has become a culture. This is reflective of a legacy from the increased use of sterilizations through BEM-FAM as promoted by the US and international development agencies in the 1970s (Fonseca 1993), as well as the Catholic Church opposition to contraceptive technologies which made sterilization the main method of birth control (Berquó 1998, Dixon-Mueller and Germaine 2010, Martine 1998). At least ten of my informants had sterilizations after their second c-section, and Dr. Maria and Dr. Selma both stated this was a common practice. This culture was something very specific to the urban and modern setting, as it is still different in rural areas of Brazil. Dr. Melina told me that:

Women come here and they are planning two children. It’s different if you go to other parts of Brazil and you have patients that are having eight, nine, or ten kids. Are you going to even mention a c-section in this situation? No, it does not make sense. But here with only two kids, with a sterilization afterwards, why not? Our infection rate is really good, there is anesthesia 24 hours a day, and we have the most modern technology. That is the way it is here, that is our population. Understand? One thing is for us to discuss c-section here in São Paulo where women only have two kids, and another is to discuss it in other places of the country.

Sterilization, like c-sections, are markers of a modern and urban woman. They have become more than a method of contraceptive technology and are now synonymous with a modern lifestyle. Her statement also highlights a rural versus urban binary that is important for understanding this research. This rural versus urban theme re-emerged often within my interviews, with the city as being a center for modernization, technological advancement, power, wealth, culture, and status, all qualities associated
with the western ideals of advancement and positivism. On the other hand, the rural is associated with danger, poverty, old-fashioned ways of life, dependency, disempowerment, and underdevelopment.

5.1.2 Rural/Urban Binary

The words “urban” and “rural” become loaded with significant spatial and historical meaning, which have consequences for current views about life-style, and for the purpose of this research, ways of giving birth. The urban is synonymous with modernity, which having a c-section birth exemplifies, while the rural equates backwardness and is associated with natural birth. This dual reality was, and continues to be, expressed in popular culture geographically through portraying the differences between Brazil’s rural and urban areas, like in the iconic book, which became a movie and a samba song, *Macunaíma*, or in the popular novel and later soap opera, *Tieta do Agreste*. This binary is also expressed by McCann (2006) as “morro and cidade”, based on the same ideas, but in reference to the spatial and socio-cultural separation between the slums and the city. The rural versus urban duality is one that is found throughout Latin America, and was first defined in the iconic book entitled *Facundo*:

15 *Macunaíma* is a specifically Brazilian character in that he/she is a hero without an identity. The plot of the story is about Macunaíma’s quest from the countryside to the city of Sao Paulo to retrieve a sacred amulet that was stolen. Also relevant to this research is that the artistic cover of Macunaíma is a natural birth that takes place in the backlands of Brazil.

16 *Tieta do Agreste* is a novel written by Brazilian author Jorge Amado in 1977 about a woman who moves to Sao Paulo, the rich urban center, and then returns to her native Bahia, a state in the northeast, to visit the small town where she grew up. Tieta is a hero who can negotiate both spaces, unlike the characters around her. The plot highlights the differences between the urban capital the the Brazilian northeastern countryside.

17 *Cidade*, or city in English, stands for the working and middle-class, white, and mixed race neighborhoods of the downtown, as well as the recording studios, restaurants, and cafes. The morro refers to the favela, or slums, composed mostly of blacks.
Civilization and Barbarism by Domingo Faustino Sarmiento, which first explained the parameters in nineteenth century Argentina about ideas of development, modernization, power, and culture. For Sarmiento, civilization was identified with northern Europe, North America, and urban centers, such as Buenos Aires, while barbarism was identified with Latin America, Spain, Asia, the Middle East, and the countryside. As Sarmiento states:

The inhabitants of the city wear European dress, live in a civilized manner, and possess laws, ideas of progress, means of instruction, some municipal organization, regular forms of government, etc. Beyond the city everything assumes a new aspect; the country people wear a different dress, which I will call South American, as it is common to all districts; their habits of life are different, their wants peculiar and limited. The people composing these two distinct forms of society do not belong to the same nation. (86)

The fact that my research site was in São Paulo holds special significance since it is the largest urban center in Brazil and was coined during the modernization movement of the 1920s as “the symbol of modernity and Brasilianness” (Velloso 1993). A repetitive theme in my field work was the dichotomy between São Paulo as an urban center of modernity, juxtaposed with rural areas, particularly the northeast, an area of the country famed for its underdevelopment and poverty. A magazine Papel e Tinta, important during the 1920s, explains the sentiments about the city, “a burst of energy that drives the rural arm of the interior to greatness… and a center of progress and wealth” (92). The exaltation of São Paulo as an urban center of modernity and optimism causes it:

- to be compared with the large European capital cities. Its public gardens, avenues, theaters and cinemas don’t owe anything to Paris; the construction of the cathedral in the center of Sé follows the model of the cathedral of Vienna; its people are exceptional. Overall, the city represents the example of modernity, progress, and the image of the future of the country (93)...It becomes the land of work, the spirit of pragmatism, and of responsibility and seriousness. (94)

With Brazil lagging behind economically in an international market, São Paulo’s urban industrial power symbolized the order and progress that Brazil was seeking, and in the
words of a famous modernist intellectual of the time “the poetry of our economic richness must predominant our new Brazil. This Brazil is represented by São Paulo, a center of work and of practical activities that are useful and intelligent” (96). It became a beacon of modernity for the country.

Ethnographic observations during my time in the city suggest that the self-image of Paulistas has not changed. They are proud of their city and many people have boasted to me about how they have the highest literacy rate in Brazil, that they are the richest city in the southern hemisphere, and that they have more millionaires in their city than any other in Latin America. I know from my own personal experience that to travel to other parts of Brazil and say that you live in this city already connotes wealth and status. The city has more shopping malls than any other urban center, was named the World Capital of Gastronomy for several years in a row, one of the major fashion centers of the world, as well as the Cultural Capital of Latin America (Lonely Planet 2007). Despite São Paulo’s issues with poverty, favelas, and pockets of underdevelopment, the city is perceived as a place where one can become wealthy and climb the social ladder of status, wealth, power, and prosperity.

Recognizing the rural versus urban cultural construction does not negate that there is a cultural difference between these two areas, however, the ideas that are shaped about life-style and more specifically, birthing methods, often carry a cultural weight that influences women’s decisions to get a c-section. Aggregate data shows that São Paulo is where c-section rates are the highest in the country, in comparison with rural areas, where natural birth is the most common birthing method (IDEC 2008). Exemplifying the
cultural weight of the urban versus rural dichotomy were the responses of my informant Gloria, who was from a poor family in the northeast of the country, a region where she had given birth to six children, all naturally. When she and her family moved to São Paulo, she gave birth in a hospital through a c-section at her request. She said that she preferred natural birth because the recovery time was much faster, and the c-section was more painful for a longer amount of time. She complained about how after the c-section she had difficulty walking, holding her baby, and doing things around the house. However, when I asked her which birthing method she preferred, if she were to give birth again, she stated that she preferred the c-section:

I’m in São Paulo and I like doing the c-section. Here all I have to say is that I have some pain and they’ll give me a c-section. If I had to do it again, I would do a c-section because I have the possibility here in São Paulo. When I lived in the North, I basically had my children in the bush, and when I came to São Paulo I thought it was so good, so cool, that I could have my baby in the hospital.

For Gloria a hospital meant already meant a c-section. Despite the fact that Gloria preferred natural birth and its benefits in comparison to c-section, she preferred to have a c-section, and this preference highlights the fact that women have c-sections for cultural motivations associated with something beyond medical reasoning. First, her c-section gave her empowerment because in São Paulo she had the choice of which kind of birth to have, and this choice gave her, using her own words, “possibility”. Second, in the northeast, her birth was in the “bush”, but in São Paulo she had the modern setting of the hospital, and this option was, as she stated, “cool”. Gloria recognized that c-sections were harder on her body, but the procedure meant a status that was associated with empowerment and modernization that she could have in São Paulo, but not from the northeast, a region of the country associated with poverty and underdevelopment.
Ideas about birth in rural areas are something that many of my informants shared, and these ideas extended beyond preoccupations about birthing methods. Angela was an informant from Maçéiô, a poor state in the Northeast of the country, who had moved to São Paulo in her early twenties, after marrying her husband. According to Angela, in São Paulo she could have her own life in matters of work and independence. During the day she was a janitor at the apartment complex where I stayed, and at night she went to night school to earn her high school degree, something she could not do in Maçéiô due to her social and economic status. She did this while maintaining a family, a home, and helping to put food on the table alongside her husband. Her plans for the near future were to go to college and become a physical therapist. Her ideas about São Paulo as a modern city of opportunity extended to her birth choice, and for her birth in Maçéiô was something rural. She even compared it to animals stating that “my mom had a normal birth. She seemed like a sheep in the way that she gave birth.” For her, natural birth in a rural area was something that was associated with animals, farms, poverty, and overall, it represented a lifestyle she was trying to leave behind. She often told me:

I love Sao Paulo, here I can achieve something. I try to associate myself with people that are going to make me better. That is why I am friends with Renata and that is why I try to talk to people in this building. It is so good for me to talk to you too. These are opportunities for me. I don’t want to go home to live except to visit my family. I want to eventually bring my family here because there are more opportunities.

She was happy that in São Paulo she was able to have her baby in a hospital in a “modern” fashion. I understood her ideas about birth as being shaped by the social geography of each place, as well as her own ideas about underdevelopment and modernity that she shared with many of my other informants.

18 Also one of my informants, Renata was Angela’s best friend, and a woman from an upper middle class family.
Natural birth as an animalistic procedure was an association that repeated in my interviews. For some of my informants, it was a geographic association, connecting rural areas with this “animalistic” method of birthing, but for other informants, it was a historical association, and I heard it described once in an interview with Thaís as a “prehistoric” way to give birth. Susana, who worked as a nurse said the following:

I get so mad to hear women talking about normal birth, if it can even be called normal, as if it was better. The dignity? The pain? I chose to have a c-section and it was the best thing. Seriously? Hours suffering to have a baby? This isn’t something of humans, this is something animal. For all of those who say that they learned a lot with the pain they felt. What? I’m not native and I’m not a slave. We’re in 2010. C-section needs to be the way to give birth.

Her quote associates c-sections with the present, with 2010, while natural birth is something that is animal, it lacks dignity, means suffering, and is associated with the past, even comparing it to the legacy of slavery. Her reference to slaves and natives suggests that natural birth is a procedure of birthing that happened during a past Brazil that was under-developed, not something modern that expresses what it means to be a Brazilian woman in 2010. Her statement reflects the sentiment that natural birth is attached to a time period of Brazil that is no longer up to date with modernity.

This dichotomy of rural versus urban birthing can be attached to models of childbirth already explored by researchers. As discussed in Chapter 2, hospital birthing (Davis-Floyd and Sargent 1997, Franklin 1995, Jordan 1978, Longhurst 2008, McClain 1982, Smeenk and ten Have 2003, Teijlingen et al. 2000) is part of a larger "modernizing" project of western culture that is associated with technological advancement, and it is what my informants viewed as typical São Paulo birth. On the other hand “traditional” (Jordan 1978, Teijlingen et al. 2000), or “natural” birth (Smeenk and ten Have 2003), where the woman giving birth is in control and a birth assistant or
midwife is present, is associated with the rural. It is the medical model that is the
dominant one in our western society, therefore it is not surprising the views that my
informants held about birth in rural versus urban areas of Brazil.

This rural versus urban theme that emerged in my field work is the geographic
expression of the debate between a “medicalized” or a “traditional” birth that has
become salient in regards to culturally appropriate notions of birth performance that was
discussed in Chapter 2. Women that give birth according to the traditional model are
“backward”, pre-modern, primitive, and associated with areas of underdevelopment
(Fraser 1995, Kukla 2008, Lindgren 2006, Longhurst 2008). This demonstrates how
birth procedures, seen in this research as performances, make us and are made by us; they
are linked to our identity and how we see ourselves.

5.1.3 Popular Media

Geographic and historical discourses about birth are expressed and reinforced in
the pop-culture medium of the telenovela,\(^{19}\) popularly called the novela, which is
important and unique to Brazil. Through their portrayal of the discourses discussed in the
previous section, novelas emphasize and support a culture of modernization in the
lifestyle of Brazilian society. Telenovelas are the most up-to-date means of national
unification, spoken of by Page (1995) as a “glue that binds together the disparate
elements of Brazilian society” (447) or “the great aspirin of Brazil” (447). These novelas

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\(^{19}\) Roughly translated as soap operas, although this is misleading. They are shown six nights per week over
an eight month time span and have a clear beginning and end. They are romantic, tragic, or comic and they
often deal with contemporary or historical themes.
unify the rich and the poor, the young and the old, and “frontier towns in Amazônia and high-rise apartments in São Paulo” (447), and have been noted as a “televisual democracy” (447). Despite their power to unify the country and generate a common social awareness, they are also criticized as being a means of social control. It is now public knowledge that Rede Globo,\textsuperscript{20} which attracts 60\%-90\% of the nation’s viewers, was a staunch supporter of the military dictatorship, working with the government in the 1960s to create the simultaneous transmission of TV signals across regions, and in the 1970s to help the government finance low-interest loans to low-income homes so TV could become a method to promote political unification (Page 1995). Laws have been created to limit their political influence, but novelas are still used by the government as a means to educate and create awareness about different national and international issues.

In 1995, 90\% of the population watched novelas, and as Page states, “it has reached out to almost every town of Brazil. It has shaped the way Portuguese is spoken throughout the country, the way people dress, and the way people behave” (173). The novela’s direct influence on people’s attitudes about birth became clear in my interviews. I asked women why they wanted to have a c-section and three of my informants initially stated that what they saw on television was a main reason for their choice. The following quote is by Bruna, a middle class woman born and raised in São Paulo:

\begin{quote}
Television shows normal birth as being birth on a farm or in a slum. They show normal birth on a plantation when they have historical soap operas. They show the painful side, the suffering of the birth, with the help of a midwife, and not even with a doctor. No, it’s not even with a doctor, it’s with a midwife and they don’t even have anesthesia. It’s like that. Television shows birth as suffering.
\end{quote}

\textsuperscript{20} Rede Globo is the most popular Brazilian television network. It is the largest producer of soap operas in the world and fourth largest TV commercial network globally. It was created by media entrepreneur and industrialist Roberto Marinho in 1965 in association with Time Warner.
In this quote we see her understanding of the farm, the slum, or the plantation, as being 1) historical and something of the past, 2) as being old-fashioned without the use of the modern figure of the doctor or technological assistance like anesthesia, and 3) as being something of suffering. Her idea about natural birth on TV is the same as the popular geographical and historical imagery discussed in the previous section. The rural holds a negative and old-fashioned meaning as a birth space and natural birth equates suffering.

In direct opposition to Bruna’s answer was Fátima’s, who explained how birth was portrayed positively on television; however, unlike Bruna, in her answer she was referring to c-section birth and not natural birth, showing how TV wields its power to influence people’s opinions about this topic. During our interview, she responded to my question about television’s portrayal with the following answer:

On television the portrayal of birth is very close to reality. I don’t see a difference, no. The only thing is that the mom that is having caesarean on television is beautiful, her make-up is perfect, her nails are done. It’s not quite like that even if you go to the beauty salon first, right? But television is close to the reality. I think television portrays birth close to reality.

Fátima, who enjoyed, encouraged, and was a firm supporter of c-section birth saw television’s portrayal of c-section birth as being something positive, which is a contrast to how Bruna and several of my informants saw natural birth portrayed on television in rural areas. Fátima told me how on TV women are in a nice hospital room, all the family is present, and it is a special moment. Their answers support the reproduction in popular culture of natural birth being associated with the rural versus c-section being symbolic of the urban. These cultural associations make birth a performance that carries a meaning that extends beyond bringing a baby into the world. In my field work, I found that birth in Brazil, especially c-section birth, is literally seen as a performance.
5.1.4: Birth as a Performance of Modernity

Birth as a performance of modernity is not only expressed in popular culture through novelas, but is also present in individual birth performances. Performing the birth in front of a film camera, like on television, is common during the c-sections of middle and upper middle class women, who document their birth with a video made by the hospital. I argue in this section that this is a birth performance of modernity. Women prepare for it in a culturally appropriate fashion, such as by going to the beauty salon, so they can look good as if in a novel, and as in the novel, the c-section symbolizes their modern and urban lifestyle, also culturally suitable.

Births are planned specifically for the preparation of the filming because it is a marker of pride and a memoir of an important rite of passage for women and their families. In the most private maternity hospitals there is a film department, which takes care of the birthing videos that women have made of their birth performance. Two of my interviews with doctors were conducted in the film sector of the maternity hospitals, and as I waited for the doctor to visit, I heard the secretary taking many calls about how and when to schedule the filming and what aspects of the birth they wanted filmed. Things that the secretary discussed were who would be present on film, who would assist in the baby’s first bath, and which little lullaby or musical song parents wanted to accompany the video. I saw two women, both dressed in nurse’s scrubs prepare their cameras, large professional filming cameras, in order to go to the birthing room to film a birth. Several of my informants scheduled their birth to invite friends and family, and it is common for
middle class women to go to the beauty salon before their birth is filmed in order to beautify themselves for the camera. Five of my informants told me that they had done this and they were all women that could be considered middle class. The following quote is by Fátima:

It’s normal to go to the beauty salon before your birth. I went one day before my birth, I got my hair and nails done, and since it was a birth I had to use clear nail polish, natural hair, and in the hour of the birth I just put some lip gloss on my lips and that was it. I had to look good for the film, right? I had to be beautiful to receive a beautiful baby. In the pre-birth room the filming starts, and you have to go there already beautiful because they film you in your robe, with your hospital hair net, and you have to be all nice looking. They film you before and after. It’s really cool. It’s a beautiful film and they know how to show the beautiful moments of the birth. Mine is really cool, really well done.

According to this quote, the performance of c-section birth is so common that there is even a prescribed set of rules that accompany the make-up and how one must look for the camera: nail polish needs to be clear and the hair and lip color need to be natural.

Daniela, another informant, even told me that one should get waxed before-hand. For Fátima, Daniela, and several other informants it was important to look beautiful for the births, and they felt they could better do this by being prepared rather than being taken by surprise for a natural birth that could take hours. It was also important for them to be calm and composed, and since they could not feel anything during the c-section on account of anesthesia, they thought it would be better than if they were yelling, crying, and screaming due to the pain that natural birth can bring.

I was able to view one of these filmed births after my interview with Natalí, a mom of two boys that also worked full time as an architect. I recorded the details of the birth in my field notes as I watched, and after seeing the birth I took some time to write about the experience. The video began with an introduction of lullaby music that showed the outside of the hospital. Then it cut to a shot of Natalí. She smiled at the camera as her
stomach was being cut open by her female obstetrician, along with her team of doctors. In then changed scenes to a cartoon stork, flying to the hospital. She asked me if I was able to see how pale she was as we watched the video. She said that she was suffering. Indeed, in the video, her smile looked forced and she looked very uncomfortable, although she insisted she couldn’t feel anything. The camera kept panning in on her face, which at this point in the operation was giving a forced smile as she lay on her back and the doctors continued opening her stomach. The camera panned to her husband Ibrahim outside of the room, behind the glass, with his parents looking in the room at the operation. Finally, the camera shot to an image of her stomach as the baby was pulled out, bloody and crying. The umbilical cord was cut. The camera then shot to the baby for a few seconds showing him from all angles. It then shot to her reaction, and the reaction of her family outside the room. The family all looked happy and surprised. The camera shot to Natalí and she looked tired, and gave a forced smile. She told me again that she was trying to be happy for the camera, but that she was tired and not feeling very good. The video then showed the baby getting his first bath, assisted by her husband Ibrahim. Meanwhile the camera returned to show Natalí in the operating room getting her stitches, while the baby was down the hall getting his first bath with his nurse and the doctor. Towards the end after a few scenes of the cartoon it showed the stork leaving the hospital, Natalí and Ibrahim were shown in the birthing room, both standing with their newborn son Danilo. Something that struck me was that Natalí looked exhausted in the scene in comparison to her happy and smiling husband. They then cut to a scene of the baby sleeping peacefully in the nursery, in a small plastic crib, around other babies, all
lined up in rows. Footage of Ibrahim and Natalí holding Danilo was portrayed, and finally the video ended with Natalí taking her first post-birth steps and the three of them leaving down the hall together, Natalí in a wheelchair and Ibrahim holding Danilo, walking down the hospital hall with a light at the end.

As a witness to the video as it was happening, it didn’t seem strange, and in all actuality, the video was sweet, cute, and touching. It was an endearing experience to watch this video with her and Natalí even cried a bit after we watched it together as she had not seen it in 5 years since her son was born. It was not until returning to the US, and reading through my field notes that I realized the metaphor of birth being a performance, and in the case of my research, c-section birth being a performance of modernity. This finding reflects previous research on the symbolic quality of birth (Duden 1993, Ginsburg and Rapp 1995, Fraser 1995, Longhurst 2008, Martin 2000). Like Longhurst’s (2008) discussion of Nikki, the pregnant pornography star discussed in chapter 2, these women were performing their birth in front of a camera in a symbolic fashion, however, unlike Nikki, it was culturally appropriate because it was seen as a reflection of their modernity.

This phenomenon was synonymous with performing the birth appropriately, not about appearance, as previous literature might lead me to hypothesize. Surprisingly, especially in reference to the above discussion of going to the beauty salon for the filming of the birth, one finding my research did not support in regards to previously written research was that women have c-sections in order to preserve their physical appearance and stay sexy. Contrary to Adelman and Ruggi (2008), Beserra (2007), and Althabe et al, 2002, my informants were not afraid of the physical changes their hips or
vaginas would go through, they did not see it as disfigurement, and they report that they
did not feel any pressure from their husbands and society in regards to this issue. Almost
all of my informants stated that this was not an issue, as Fátima said, “I have big hips and
I see this as a good thing, it doesn’t influence my decision in anything, anything,
anything”. Most of my informants were aware that their hips and vaginas would
eventually return back to normal size. The only preoccupation with regards to
appearance that appeared with frequency in my interviews was a fear of getting fat.
Women in favor of natural birth and c-section both reported feeling this fear. However,
suggesting that among my respondents, a preoccupation about physical appearance did
not influence birth choice.

5.1.5 Technology

In addition to the birth performance, technology is also a factor of the
modernization discourse that influences c-section. In Natali’s interview she told me in
reference to her birth, “with all the technology we have, I think we have to take
advantage of modernity”. For her, along with many other women, the fact that c-section
is technologically more advanced already made it better, and made it something that
needed to be “taken advantage of”, even if it may not have been medically necessary.
That she had a c-section, using the most up-to-date modern medical technology made her
feel good.

In the case of the majority of my informants, their choice to have a c-section
provided them with a sensation of ease and pleasantness, as if the technology did the
work for them and they did not have to do anything but lay calmly on the operating table. Having a technologically advanced birth was important for most of my informants. This desire is reminiscent of the positivist underpinnings that Brazil is built upon that herald the medical model of child birthing, where technology is praised as something that is going to improve the human condition and make life easier, more pleasant, and more productive, even in birth (Browner and Press 1995, Davis-Floyd and Sargent 1997, Franklin 1995, Ginsburg and Rapp 1995, Jordan 1978, Kukla 2005, Kukla 2008, Lindgren 2006, McClain 1982, Smeenk and ten Have 2003, Teijlingen et al. 2000). This is clear in Dr. Selma’s comment:

In this hospital we have a 95% c-section rate and the infection rate is so small, smaller than it is in the US. With such a small rate of infection, why not have caesarean, as it ends up being the better option. Now we have the technology for this type of procedure. It’s the culture of our population. We trust in caesarean because it’s a more modern method.

For Dr. Selma c-section was better because it was technologically more advanced, and since this “modern” method could now be done safely, it was the better choice. Dr. Selma was aware of national and international medical studies showing natural birth to be the better option for women and for babies, and she was also aware of the campaign of the Brazilian government to bring down c-section rates, a movement that disseminated studies to doctors about the benefits of natural birth. However, Dr. Selma saw c-section birth as being a less risky and less complicated manner of birthing since the level of risk was low in the hospital where she worked. Furthermore, because the infection rate in her hospital was well-managed and the majority of c-sections were done successfully, she saw c-section birth as being a better option, despite the benefits of natural birthing post-partum. For her, as a doctor, less risk and birth success is a benefit of advanced
technology and modernity. However, her definition of “risk” in regards to post-partum infection is limited, since she ignores the list of medical risks associated with the procedure, as was discussed in the introduction. This reflects previous research which found that technology is a main cause for high c-section rates in Brazil (Finger 2003, McCallum 2005), as well as globally (Churchill 1997, Teilingen et al. 2000).

I received responses in reference to technology that made clear the preoccupations Brazilians have now and had in the early 1900s, during early nation-building, when they compared their own technological prowess to countries that seemed and still seem more technologically advanced. As Olivia said “in countries that have more advanced technology, caesarean must be the typical way to give birth”. For her, technological advancement, associated with developed countries, meant c-section birth, and this was a positive connotation for her, as Olivia was an advocate of c-sections. Her statement also links birth to nation. Some informants stated ideas about birth that were linked to culturally informed ideas about international development. As Gloria told me:

In Europe the standard of hospital care must be so good, like in Santa Catarina, a really good hospital here on Paulista, but in Africa, you will suffer. I don’t think birth is good in Africa, it’s more complicated. I’m sure there is more caesareans in Europe and not so many in Africa. There are more cesareans where there are more resources.

The geographical divide in maternity healthcare that Gloria speaks of by comparing Europe to Africa is the same as the rural versus the urban construction, only on an international scale. Stereotypically, the African continent symbolizes backwardness, while Europe is a beacon of modernity and western culture. Her statement demonstrates the popular knowledge that in an “underdeveloped” region of the world birth means

21 Paulista Avenue is the most important and most central avenue in Sao Paulo city. It is a business and commerce center where a person can find almost anything: food, shopping, banks, cultural activities, hospitals, and the headquarters of many important corporate businesses.
suffering, backwardness, and is done naturally. On the other hand, a developed region means good standards of health care, positive treatment, and c-section birthing. She links the developed region of the world to c-sections and “resources”, a word used in Portuguese to express financial capital. These ideas reinforce the idea that c-section birth is a performance of nationhood, in this case what women see as a modern nation. When I asked Gloria if she thought c-sections were a typical birth in all of Brazil, or just in São Paulo, she stated, “I would like to think that c-sections are a typical birth in all of Brazil, just like here in São Paulo”. She knew that they were not, however, due to the status and technological “progress” of the procedure, she said she liked the idea of her country being associated with this manner of birthing.

5.1.6 Wealth

Not only is technology important, but the link between wealth (resources) and caesarean was also a common association in my interviews, as demonstrated by Gloria’s comment in the above section. The importance of individual wealth is the economic aspect of the modernization discourse influencing this trend. Women often made an association to wealth using place as an example, as Dr. Selma stated, “in areas where people have more money the c-section rate is higher. If you go to New York, I’m sure the c-section rate is higher because people have more money. It’s like that here in Sao Paulo”. Linking c-sections to wealth was also done by comparing people of different socio-economic statuses within Brazilian society. Olivia is an interesting example because she experienced both types of birth procedures as well as both social classes,
both middle and lower. She was married to a wealthy man and during her marriage she could afford a c-section. However, her husband abandoned the family and she had to become a full-time manicurist to pay the bills and raise her children. She told me that “if I had had the (financial) conditions, I would have had a c-section. Natural birth in a public hospital is something horrible”. Another informant, Daniela was a hair stylist and owned her own hair salon. As a business owner, she had a good financial situation, but she told me how some of the women that worked for her were not. She felt bad that they could not afford to have a c-section. She stated:

In the public hospitals they are encouraging natural birth, but it ends up being the least favored women that go to the public hospitals. It’s the neediest women that really depend on public services, right? It’s because they don’t have (financial) resources, so they end up choosing natural birth because they don’t have resources. They majority of women that I know have some (financial) structure so they are in a condition to have a birth that is better and organized, so they prefer to have a c-section. But I know some women that cannot afford this. I feel bad for women that have to go to public hospitals because they are not in a position to decide what is best for them.

For Daniela natural birth is something that the “least favored” and “neediest” women need to “depend” on because they don’t have the wealth to empower them in their choice, whereas women that have the financial possibility can chose a c-section birth that is “better” and “organized”. For her, as well as several other informants, c-section is less about the birth procedure and more about the fact that she can make the choice to get a c-section. This is reminiscent of previous research that found that women want to have c-sections because it is a status marker representing a modern woman who has financial status (Tornquist 2003). C-sections connotes choice, wealth, and status, and these meanings occur and are reproduced at the individual, national, and international scales.
5.1.7 Choice

Daniela’s concern with choice in her birth is reflective of the debate about elective c-sections that is happening in Brazil, as well as in the US and internationally. There is an argument that a woman should have the right to elect to have a c-section. By using the language of empowerment that comes from liberal feminism, choice is demanded as a women’s right. The media exacerbates the liberal feminist cries for power and “choice” by portraying famous, admired, and glamorous women that had c-sections, one example being the “too posh to push” slogan discussed in Chapter 3. The problem with their view of choice is that it is presented in a vacuum within the medicalization model, since "choice between the current norm and surgery may not turn out to be much of a choice at all" (Wagner 2004:16). Choice in this context is a commitment to technological intervention in childbirth, since women are not informed of other options, such as the traditional model of childbirth and the midwife. This is not surprising since the profession has been nearly eliminated internationally due to its inability to survive amidst power structures and discourse that considers it "backwards", or an "improper place for women" (Donnison 2000). This happens internationally, but it is exacerbated in Brazil because of the cultural preoccupations and dissemination through the media about the “urban versus rural”, or the “developed” versus the “underdeveloped”, associated with each respective birthing method.

I asked women what they thought about other ways of giving birth, such as giving birth in the home with a midwife, and indeed, the lack of knowledge or automatic assumption about these types of birth are backward were common responses. Some
women could not understand why I was asking, demonstrating how far removed the idea is from their reality, while other women were horrified at the idea. Natalí responded by saying the following, “with all the technology we have, I want to have my baby in the hospital, there is no reason to do it at home”. She sums up the sentiments I felt from other informants, which is that there is simply “no reason” for other models of giving birth in the Brazilian “modern” context. As Claudia stated:

My sister-in-law had her baby in England and her birth was so different from mine. She had a midwife and she was in labor for three days. They didn’t do any exams, nothing. She was just waiting and the baby is close to being born? No. Now? No. She had to be in labor and stay waiting and waiting. There was no ultra-sound and no hormones were given. Okay, it was normal, but even though it was normal, they should have given her something to stimulate the birth, right? It was so much suffering. Three days of suffering for what? With all the technology they have there? Why would they make her go through that? It wouldn’t happen here. Here we are caring.

Claudia saw c-sections in Brazil as something caring. It is important to be clear that my informants that had and supported c-sections did not actively do so out of a quest for modernity, but rather for loving and caring reasons, demonstrating that there is a space needed for elective c-sections. Most women I talked to expressed positive experiences during their c-sections and enjoyed the procedure. They felt that their power to choose gave them the ability to be more caring and humane. As Claudia stated:

I’m so glad that I’m in Brazil and I have the resources to choose my birth. I don’t know if it is because of the hospital or my team, but it’s so human the way I gave birth, very loving. It’s not something cold as if I was in a public hospital, where you go, suffer, and it’s done. No, I think my birth was very Brazilian, very human and loving.

For her c-section birth was not about being modern or technological, but rather, it was Brazilian because it was loving. This is a reflection of Brazilian nationalism that is caring, communicative, warm, friendly, loving, and accepting. This side of Brasilidade was also cultivated in the Brazilian national consciousness, especially as it sought to resist foreign dominance that seemed to oppose human ideals of love by exalting the
gread of economic success (Dunn 2001). For many of my informants, while not directly
connected to Brasilidade, c-sections were an expression of a loving and kind way to give
birth, as well as a proper way to treat a woman and her baby, as Olivia stated:

I think birth is a moment that is so beautiful when you’re there having a c-section. You’re awake
but you’re not feeling anything, you have contact with your child, you have affection, not that
horrible thing. Normal birth is something that is pain. You’re nervous. This is not a way to have
a baby. I don’t want pain. It’s shame to treat a woman this way nowadays. They don’t put
anesthesia on the woman, God forbid.

For Olivia, like Claudia, having a c-section meant an affectionate birth and was a moment
that was beautiful, whereas natural birth and the pain that accompanied was nerve-
racking and “horrible”. For Daniela natural birth was stressful, and could even cause
trauma:

I have colleagues at work, people who work for me, they stay suffering for up to two days, and
then at the last minute they have to rip out the baby. Why? This is my question, why does a
woman have to suffer so much this day in age in order to have a baby? There is no why. I think
birth should be a moment of happiness, so you can’t let birth be a stressful process because you
can repeat the stress of birth in life, as you care for you child. This can cause you such a trauma
and you won’t like your child or you won’t want to have another child, ah, so I don’t even want to
know about normal birth, to suffer so much I don’t even want to hear about it. You suffer too
much, the child suffers too much, you can’t run the risk nowadays.

Her intense fear of suffering and trauma in natural birth as demonstrated in this quote is
something that was repeated with frequency.

I tried to explore with my informants why they felt this way in our interviews, and
there were three main reasons for their fears. The first was a fear of suffering during
natural birth. To hear stories of friends and family talking about their painful labor
experience during natural birth is an incentive to choose the c-section option. Second, the
pervasive influence of television shapes women’s perceptions the experience of natural
birth. As Rosa stated:

What I think of normal birth, from what I’ve seen on television, I’m sure I wouldn’t do it because
I am a wimp when it comes to pain, you understand? I wouldn’t do it. I want a c-section because
what we see on television is horrible. But it’s not just Brazilian television, it’s American television too. There is a program on Discovery Health, a program only about births, the women yelling, screaming to have a child. I wouldn’t have a child that way.

As discussed earlier in this chapter, natural birth is rarely portrayed positively on TV, and as this quote shows, it not only extends to associating the procedure to a way of life associated with the past and rural, but also to the intense suffering that women experience to have the baby. The third reason for the fear of natural birth is women’s own experiences in witnessing this procedure. Angela stated the following about the natural birth she witnessed in the hospital.

Why do I prefer c-section? From what I saw in a birthing room when I went to the hospital, the births that I witnessed. There was one woman who was having a c-section and not feeling any pain, and then there was a woman having a natural birth that was crying and screaming. My gosh it must have hurt. She was so red, and I felt agonized to see her like that. I thought, is my birth going to be like that? I saw her in that situation and I was so scared. She was pushing with such force and killing herself. I was relieved to have the c-section and my birth was so different, it was calm.

Witnessing the moments of a real and live natural birth, which does involve pain, screaming, and crying, can be so intense for some women that they prefer the c-section. However, most women think of the moment of the birth procedure, and many did not pay attention that the aftermath of natural birth has an easier recovery time. My informant Alda, who had experienced both natural birth and c-section birth, expressed it in the following way:

The pain of natural birth that we speak of is real. The contractions are terrible. The pain is inexplicable. I had terrible contractions. You can’t imagine the pain. But the pain finishes. Five minutes after the baby comes out it finishes. It’s born? Then you don’t have any more pain. With caesarean no, you stay suffering a long time afterwards. I’d have 10 kids with natural birth. Easily, because you have allot of pain, and that’s it, you don’t have anything else afterwards. You suffer, but a few hours later, you get up, you take a bath, you walk, you arrive at home and you can move around. You’re not going to do anything too physical right away, but you would have conditions to. With c-section, you can’t even get out of bed without help. You are afraid to pee. I was afraid to pee.
Alda was a well-educated middle class woman who not only was well-informed about the c-section versus natural birth debate, but who also felt from personal experience that natural birth was better due to the easier recovery time. The fact that she was well-informed about the debate, as well as the benefits of natural birthing were important information that all women should receive prior to giving birth. However, due to cultural ideas about natural birth and what women see on TV, hear from friends, and see for themselves often informs their decision to get a c-section before they become educated on the benefits and drawbacks of each birthing procedure. It is important that these opinions be informed by giving women more knowledge on birthing, because often women allow cultural meanings, informed by history, geography, and society form their final birth decision. I felt that my informants lacked this information, and thus, truly lacked choice. Their views of c-sections as loving and caring were already opinions created within a specific cultural context and a national consciousness that strives for modernity in the international arena.

5.2 Implications of the Modernity Discourse

That women are not entirely informed of their birth options and educated about birth procedures is a problem that is often blamed on doctors (MacCullum 2005). However, this research sees this blame as being too simplistic, especially in light of my argument that geographical, historical, and cultural meanings about modernity, development, and nationality have shaped the practice of birth. This section will explore the implications of these discourses, especially in regards to the doctor/patient
relationship and the doctor’s choice in the birth procedure. It will conclude that due to
the normative use of the procedure, there is very little choice in the birth procedure,
making change, such as the lowering of c-section rates, a near impossible task.

In all cases, my informants did express a strong trust in their doctor, often
actively giving up their choice in what kind of birth to have. In the case of Natalí, she
preferred for her doctor to decide for her because “I have complete trust in my doctor. I
actually didn’t decide anything but who decided was the doctor”. On the other hand,
Melina, a lower class woman who gave birth in a public hospital stated, “you have to
listen to your doctor, it doesn’t matter what you want. I confided in my doctor because
there was no other way”. She felt she had to trust her doctor because she did not have the
medical knowledge to know the difference, and she did not have the financial conditions
to choose what doctor she could go to. This supports previous research that found that
based on western thought’s positivist leanings and trust in technology, it is a woman’s
duty to have trust in her doctor and medical system (Browner and Press 1995, Kukla
2008, Lindgren 2006, Longhurst 1997, Longhurst 2008). This trust is a consequence
from Brazil’s intense development period during the military dictatorship during the
“economic miracle”, discussed by Faria (1989) as a time when medical expert knowledge
became a predominant paradigm for good-health. Brazilians today have strong trust in
medical knowledge and surgical procedures that has replaced more traditional or natural
views of medicine (Faria 1989).

However, there is a general blame game that happens within the c-section debate
in Brazil in which doctors are rebuked for the high c-section rates by society and
researchers, and they in turn, implicate women for insisting on elective c-section (MacCallum 2005). While only a small part of the problem of high c-section rates, it cannot be denied that doctors often have no incentive to do a natural birth. Three of them discussed this with me during our interviews, even explaining that they get paid at least R$1000.00 more by insurance companies when a c-section is performed, supporting the claims made by previous studies (Bergeron 2007, McCallum 2004, Potter et al. 2001).

Doctor Maria, a doctor that performs both natural birth and c-section depending on her patient’s preferences, explained to me, “the professional prefers to do a c-section. Why? Because the insurance pays little for normal birth, so it’s better for them to go and resolve to do a c-section without giving all the time to go through labor. It’s practical for us.”

Similarly, doctor Bela, a doctor strongly against c-sections, admitted the same thing. It starts with the fact that the amount paid by insurance and SUS\textsuperscript{22} for cesarean is much higher than normal birth. And marking the day and hour of the birth without having to go through labor day and night makes everyone want to do a c-section. And don’t forget that culturally the women are already convinced that c-sections are better because they don’t want to feel any pain. But it’s an illusion, to escape pain.

Dr. Sergio also stated that he believes the reason c-section are so high is because the doctors get paid more. Interestingly, it was the three doctors that were more in favor of natural birth that were the ones who admitted to me that they got paid more by insurance companies to perform a c-section. This fact was never mentioned by the two doctors in favor of c-section. I believe that these doctors did not talk about this because one, they were employed on account of the c-section procedure, especially in the case of Dr. Melina, an anesthesiologist, who needed women to have c-sections to perform her job.

These doctors were benefitting from the procedure. Also, they understood that this could

\textsuperscript{22} SUS stands for Sistema Único de Saúde (Unified Health System) and this is the public sector of Brazilian health care.
be seen as their main motivation for advocating c-sections, further supporting the blame they experience as causing the high c-section rate in the country.

However, according to my findings, it is too simplistic to blame doctors and women, and while both are part of the problem, the high rates of c-sections and fact that women lack choice about other options is part of a systematic problem within Brazilian medicine, which I see as an underlying issue heavily influenced by cultural perceptions about development and modernization. Both women and doctors are forced to make a decision on a birthing procedure under an intense social pressure from family, friends, and colleagues. As Angela said, “everyone told me it was a bad idea to have a normal birth, everyone said to me to do a c-section, even my grandmother said ‘do a c-section. Please.’” Sometimes instead of outright pressure, there was a persuasion to do a c-section merely by example. In the case of Daniela “my friends had a c-section, my clients all had c-sections, and they were all calm births. So, when it was my time to have a baby, they had already helped me form the idea as to what type of birth I would have.”

According to Doctor Melina:

This is something that the doctor can no longer control, because we now have medical knowledge, but we have to respect our patient’s knowledge. If someone has 5 friends and all of them had elective c-sections in good hospitals, and nothing bad happened, then they already have a predetermined non-medical idea that c-sections are safe.

This social pressure on both women and doctors is an example of Foucault’s biopower, which becomes self-regulating through social and cultural mechanisms that the individual can no longer control. This example supports previous research (Casper and Moore 2009, Duden 1993, Fall 2006, Franklin 1995, Kukla 2005, Lonhurst 1998, Longhurst 1999, Longhurst 2008, Mayer 2000) that shows the woman’s body has become “a docile
body” and has become disciplined for the greater modernizing project of society. In the case of this research the body in disciplined to perform a specific birth procedure.

According to Foucault (1979), when biopower is present, there is a link between individuals and the nation. As stated in Chapter 2, medicine is now institutionalized through government regulation and oversight of hospitals and medical schools. Medicine, like education or disciplinary reform, links individual people to the moral state of their nation.

In my research Foucault’s “regulatory power” was present when I witnessed informants discussing the pressure they felt to do c-sections by being reminded of Brazil’s past struggle with maternal and infant mortality, especially in regards to its status as a developing country. According to Doctor Melina, the maternal mortality rate in the sixties and seventies was 20-30 deaths for every 100 births, which made it the country with the highest maternal mortality rate in the world. While her data is exaggerated\(^{23}\), the point is not about accurate data, but that people remember their country as having this serious problem, especially in comparison to other countries. A statement Daniela made exemplifies this, “in wealthier countries with lower infant deaths there is more caesarean sections… because they have the control and the structure”. This was a frequent issue in my interviews. Dr. Selma explained:

Thirty or forty years ago the infant mortality rate was too high, and as there were more caesareans that occurred safely, it seemed like a more trustworthy method to give birth for people who could afford it. Along all these years this gradually started happening, so what happened? When you have a complication in birth, this complication, unlike in your country, becomes questioned if you did not do a c-section. People ask ‘why didn’t you do a c-section?’ But if you have a complication with a c-section, this isn’t something so questioned than if you had one in a normal birth.

\(^{23}\) As discussed in chapter three Diniz and colleagues (1998) report that WHO and UNICEF have put the national ratio at 220 maternal deaths for every 100,000 births.
Doctor Selma, while an advocate of c-section birth, also explained to me that she no longer felt comfortable as a medical professional doing natural birth, because of the social pressure she would face from friends and colleagues should anything go wrong. She explained the c-section procedure as defensive medicine for a doctor that is constantly afraid of being sued or of being blamed by patients and colleagues. However, 90% of current cases of maternal mortality are due to illegal abortions, hemorrhages, toxemia, and hypertension, and have nothing to do with natural birth (Burquó 1998, Diniz et al 1998).

Dr. Maria, who was in favor of both c-sections and natural births, stated that she did more c-sections because often her patients came in her office insisting on them, and she knew that she would lose patients if she did not provide them with this service. She felt a social pressure, and her case, this pressure enforced her to perform a procedure to survive at a private practice in her profession. This is another example of how biopower functions to make c-section birth normative, in which no one, not even the doctors, actually has choice.

According to four doctors with whom I spoke, women wanted to do c-section birth because of several reasons, one being the need to plan the birth. Dr. Maria told me:

I like to do normal birth and when it is possible I prefer to do normal birth. But nowadays women don’t have the patience for a normal birth. They arrive here wanting an operation, and they don’t even want to hear about normal birth. I think it is a problem of the big city, the timing of the people, and that it is easier and faster. They want to arrive in the hospital, have their baby, and they don’t want to have pain or to take the time to go through labor. They want something immediate and exact, so they get it and the baby is there.

This supports one of the main findings of the 2004 documentary Born in Brazil (Nascendo no Brasil) as well as research done by Wagner (2004), which found that
culture and society do not allow for the time of an unplanned birth that could last hours or even days. This is one of the ways the economic aspect of society, especially in regards to modernity, order, and progress functions as also being a factor influencing the rising c-section rates, as well as choices in reproduction. Since capitalism does not take women's reproductive role into consideration, most women tend to be overwhelmed with having to make time for pregnancy, as well as their other productive responsibilities. Additionally, in order to plan their reproductive role, which is considered secondary, around their productive one, which is the most important, women must schedule their birth around their holiday or vacation time, or when their workload at their job is less hectic. In the case of some of my informants, I found this to be true. As Claudia said, “I loved the fact that I could plan it. I let my students know, and I knew the exact week I would be gone. Everyone knew the time I would be giving birth, I thought it was cool to have this control”. The ability to mark the birth, go to the beauty salon and plan everything made something chaotic seem more manageable to their busy lifestyles. This control symbolized the mark of a modern woman, who has resources to take care of herself and plan her life, while those that could not have this same control were subject to nature and chaos by means of their natural birth. Recently, a friend of mine, Renata, wrote as her Facebook status, “people, little Theo is going to arrive Friday, the 2nd, at 4:30 in the afternoon. Afterwards we are going to celebrate, a barbecue at home!” While she was probably joking about the barbeque, this quote demonstrates the need for planning an exact time and place to let everyone know when, where, and how the birth will happen.
As Daniela told me “I think the woman of today needs to plan, prepare, have things organized, have a nice pre-natal experience, and know what is happening in the day by day with her body. It’s really important to know what is going on because you don’t want to have an experience of sadness, trauma, and that is why it should be planned.” Lack of time, pressure to get things done in an ordered and controlled manner, and the desire to make friends and family aware of the time and place of the birth, is another example of biopower functioning to discipline women into the c-section birth procedure.

While an uncommon response, another reason one informant gave me for planning her birth through a c-section was so she could choose the day: “I wanted him to be born on the same day as his father, which was the 25th of February. He was anticipated to be on the 27th, but I went ahead and marked my c-section for the 25th”. There were few Brazilians that planned their birth due to the significance of the day, however research on the rising rates of c-sections does show this to be a problem in the US as well as parts of Asia and Southeast Asia, where people chose specific days for astrological or historical reasons (Ellington 2010, Mukherjee 2006).

Dr. Melina explained to me that c-sections also give doctors control, and an ability to plan for complications. She stated the following:

I went to a congress in Europe, in Copenhagen. There, most births are natural and 90% of natural births are without anesthesia, and this demonstrates the cultural differences. It’s cultural. Because in Denmark, first, there is no miscegenation. Here in Brazil we have Africans, whites, Indians and everyone has lived and mixed together through our history. But if you go to Denmark, the phenotype of the patient is constant. Everyone is 1 meter and 80 centimeters, blond, and blue-eyed. So what does that tell you? They know what to expect in the birth. Here, no, because of these cultural problems that we have, you never know how the baby will be, if you will need forceps, or if there is going to be some sort of complication. These are cultural problems, and there is a lot of risk involved here.
While her quote was in reference to planning, other interpretations can also be taken from this statement. Dr. Melina reflects the upper class Brazilian attitudes about race in Brazil, demonstrating the “myth of racial democracy” that exists in the country. While people in Brazil do not have outward proactive discrimination, racial tension is a hidden notion, expressed at the most subtle of levels. For Dr. Melina, caesarean section is a result of Brazil’s “cultural problems” that a medical procedure can give her control over. While in social science we view race as a social construction, in medicine there is a recognition that genetic variation will lead to unexpected outcomes, and in Brazil, a diverse country in matters of phenotype, the size, weight, and type of baby that will be born is unexpected. The c-section procedure gives the illusion to doctors of having more power over this aspect.

Harnessing the natural in a controlled method makes doctors feel in control and gives them a false impression of order over every aspect of the patient and seems to make Brazil’s racial diversity more manageable. This is reminiscent of previous research that discusses the importance of monitoring what seems to be a chaotic, unplanned, dangerous, and risky act, that is always spoken in terms of danger, risk, and suffering (Browner and Press 1995, Davis-Floyd and Sargent 1997, Franklin 1995, Ginsburg and Rapp 1995, Jordan 1978, Kukla 2005, Kukla 2008, Lindgren 2006, McClain 1982, Smeenk and ten Have 2003, Teijlingten et al. 2000). Birth is unpredictable and dangerous. Natali’s statement highlights these sentiments:

I remember some women had a c-section because they were suffering and the baby was suffering and this is dangerous. You can’t allow the labor to continue because it means there is a problem with the baby. For this reason I don’t think caesarean section is so bad. Before, where there weren’t so many c-sections, people lost their babies, and many of them died. My aunt had a baby and it was lost because it was such a big baby during birth. She lost it because they didn’t have
the technology like they to today. There are still cities where people have their baby in this type of way and it is dangerous. You suffer.

As shown in Natali’s statement, and in several other above quotes by informants, suffering is a big theme that repeated with frequency in my field work, and something that was mentioned by everyone I interviewed. This supports previous studies on Brazilian birth that found that there is a wide-spread belief that vaginal birth is more painful and equates suffering (Barbosa et al. 2003, Faundes et al. 2004, Hopkins 2000, Potter et al. 2001). This perception of suffering was maintained by informants and concerns over risk were upheld by doctors even when it is medically proven that vaginal birth is less risky, which is evident by the law that a sterilization must be performed after three c-sections. Nonetheless, the discourse of natural birth as “high risk” are so powerful that many women, besides liking c-sections for cultural reasons, were also terrified of natural birth. Thus, as Doctor Maria and Doctor Bela told me, doctors can no longer control or assuage this fear.

Dr. Bela and Dr. Maria, both advocates of natural birth, tried to talk to women about the procedure. Dr. Bela was frustrated with women stating that:

They have lost their confidence to give birth naturally and there is no convincing them. It’s impossible. But it’s an illusion to escape the pain and suffering of birth because with c-section, after the operation there is a lot of pain, it takes a long time to return home, and the women can have pain for months. It limits her ability to walk and do activity after the birth, she needs help to drive for a week, there is a scar, a risk of infection, not to mention future problems with ruptures and other issues. But it’s impossible to convince them, they think it is dangerous, the suffering.

Her statement is evidence that not all Brazilian doctors encourage women to do c-section, and this finding does not support what was found in previous research by Hopkins and Potter (2001), Osis et al. 2001, and Tornquist 2003. In my field work, I found that doctors no longer control how women view natural birth. Women and society see it as
dangerous, reminding women of the possibility of death, something from Brazil’s past when mortality rates for mothers and babies in birth were higher. Fátima exemplifies women’s preconceived notions about birth that women have before they arrive at the doctor’s office pregnant:

I already knew I wanted a c-section before I went to my doctor because I knew that with caesarean section there is no danger. You go, get cut, take out the baby and da da da. With normal no. In normal birth the child is born, but once it goes there is no way to push it back. So, if it gets caught, or turns, or gets strangled by the umbilical cord, it can die. The difficulties and the risks are much more in normal birth because in normal birth they have no way to know how the baby and mother are going to react.

If a woman comes in to a doctor’s office with a mindset like Fátima’s statement demonstrates, a doctor has no choice to perform a c-section, unless he or she wants to lose a client. Like choice for women, a doctor’s choice on birth procedure is limited by existing discourses, informed by societal perceptions that were molded by culture, history, and geography.

Because birth is often discussed in terms of risk and danger, and in spite of the fact that c-sections are elective, both doctors and women felt like there needed to be a medical justification for the procedure. The common explanation that all but two of my informants gave was that there was no dilation and no space for the baby to pass through the vaginal canal and this was a problem because the due date had either already passed, or two weeks before the procedure it was already clear that a c-section would be necessary due to the lack of dilation. This response consistently confused me and I would ask women repeatedly why they didn’t wait for dilation. Below is a conversation I had with Rosa about this issue.

Rosa: I would die if I don’t have the c-section because I don’t have dilation.

Jill: Yes, but dilation takes time. Once you go into labor, it occurs with time, naturally.
Rosa: Yes, but you don’t just have dilation, it just doesn’t open for some women and this is why c-sections are necessary.

Jill: But if you wait through the labor you will begin to have some dilation.

Rosa: But if you are not dilated by the due date there can be complications.

This conversation was a common one I had with my informants, and for them, if they were not dilated by the due date, it simply meant that a c-section was necessary. It was interesting that both women having had the c-section and doctors, especially those that were openly in favor of the practice, felt that they still needed to justify the procedure with a medical explanation, as if they were searching for a biological explanation to justify their social and cultural birthing perceptions. Furthermore, Dr. Melina’s above comment about doing c-sections on account of Brazil’s diverse population is another biological justification that reflects the underlying medical uneasiness about doing so many c-sections without medical indication. According to Dr. Samual and Dr. Bela, increased c-sections were not on account of the lack of space or dilation in the woman’s vaginal canal, but on the structure of the medical system and society. As Doctor Bela stated:

> Understanding that we need to lower the rates is not enough. The whole medical scheme needs to be changed and people need to be changed because it’s partially cultural. We need well-trained nurses and midwives on the floor with the doctors to give support. There needs to be a doctor full-time in each maternity ward responsible for a birth team that accompanies labor, instead of turning to a surgical procedure due to lack of time. But we are far from resolving our basic medical system here in Brazil. We have all the technology, but we don’t have the right training and people don’t want to hear about it.

While her quote demonstrates the problem with the medical system, this research seeks to show that this is a problem about society’s concerns with modernity and development, and the medical system can only be changed if these underlying notions that shape cultural perceptions are recognized.
5.3 Conclusion

This chapter has sought to demonstrate that to have c-section in Brazil is to be modern and is symbolic of what it means to be a person living in a modern developed country. What does that mean to a woman’s body and to her baby’s health and what does that say about one of the most natural practices we share in together in humanity, that of natural birth? To reiterate Narayan, what can be adopted as nationalist and what cannot is “extremely selective” (22), and while many of the women praise certain Brazilian traditions, not necessarily considered modern, they criticize others, in this case natural birth. Some of the same women that abhorred natural birth as something prehistoric and ugly, something from the legacy of slavery, sat down with me to a plate of feijoada, extolling how delicious it was and how a real and delicious feijoada was specifically Brazilian. However, feijoada, made of rice beans and pig leftovers (tongue, hoof, and knee), was a dish that the slaves created from the leftovers their masters gave them. Both traditions associated with slavery, yet feijoada is praised while natural birth is unacceptable. It would be easy to say that someone is benefitting from this selective adoption of cultural correctness; however, this research sees this as a systematic problem that evolved over decades as a country sought modernization, order, and progress in an international world dominated by western cultural values.

This research does not seek to point a finger at Brazil and analyze this only through a lense of a “developed” vs. “developing” issue. Brazil is merely a country with an extremely high c-section rate. Brazil and Brazilian women are a model for the rest of
the world because the c-section rates are rising internationally, and the country gives us a chance to analyze how cultural ideas of modernity and development have influenced birth everywhere. It becomes a global feminist issue, and the idea as stated in Chapter 2 that an affront to women in one country is an affront to women everywhere (Freedman and Isaacs 1993, Freeman 1990, Ginsburg and Rapp 1995, Goldberg 2009, Hartmann 1995, Petchesky 1995, Petchesky and Judd 1998, Pillai and Wang 1999, Smyth 1998), is synonymous that an affront to mothers is one country is an affront to mothers everywhere. What is important is the woman and her baby’s well-being. While there is a space for c-sections in birthing, its usage and its option in choice need to be better analyzed by our society.
CHAPTER 6: CONCLUSION: IMPLICATIONS AND NEW CONTRIBUTIONS

This thesis argues that the high rates of c-sections are a result of the discourses of modernization and development in national and international contexts. Despite the serious risks associated with the dangers of unnecessary c-sections, the discourse of modernity in Brazil is strongly maintained through themes of wealth, status, race, geography, history, and culture to uphold the procedure as normative. Several findings from this research highlight my conclusion.

The first of these findings is the issue of sterilizations. Sterilizations were made illegal, unless they were performed after two c-sections. This law was created in Brazil due to the scientific evidence that birth becomes dangerous for the woman after her second c-section. Therefore women, who wanted the sterilization procedure, had c-sections. Sterilizations were convenient for women living in São Paulo because they often only wanted two children, due to their hectic work schedule, as well as higher cost of living in the urban setting. This costly and hectic lifestyle is a consequence of the urbanization and industrialization of our modern society, showing how modernization is the overarching discourse influencing this trend.

Second, ideas about modernization have influenced perceptions about the urban and rural geography in Brazil. Rural areas are associated with backward and traditional ways of life, the antithesis of the modern city, and notions of birthing procedures are attached to perceptions of each of these places. Natural birth is associated with rural areas, and it is a procedure associated with backwardness, danger, and traditional ways of life. On the other hand, the perceived modern and technological c-section procedure is
associated with the urban, an area of wealth, growth, and modernization, which are positively perceived traits in Brazilian society. To have a c-section equates the status, wealth, and social standing of a modern woman and a modern family, therefore the procedure is identified as desirable.

The media, my third theme, especially the Brazilian novela, highlights and emphasizes this trend. As stated in this thesis, the novela is an element that connects all Brazilians from the north to the south and it is a facet that influences notions of Brasilidade to make the Brazilian nation cohesive. Therefore, what is portrayed in novelas influences people’s perceptions about lifestyle. Typically, novelas have portrayed vaginal birth as being a backward and dangerous procedure associated with poverty and low social standing. Conversely, c-sections are portrayed as a positive, happy, peaceful, and calm manner for birthing that are typically done in the modern setting.

Fourth, to have a c-section is to perform Brasilidade appropriately, according to notions of modernization, and the fact that women get their births filmed, highlights the idea that birth is a performance of what it means to be modern. The filming of the birth is a performative act of urbanity, wealth, status, and power. Therefore, it is not surprising that women view c-sections as a choice they may make due to their middle income economic reality, making wealth the fifth theme of this work.

It was also important for my informants that they were having a technologically advanced birth, making technology the sixth theme. The importance of technology in Brazilian society comes from the positivist notions of that the nation was built upon,
since its creation as a Republic. These positivist underpinnings come from Brazil’s adoption of the values of modernization that originated during the Era of Enlightenment, when technology was thought to be a solution to human suffering. The fact that a birth is technological allows it to be perceived as appropriate according to positivist philosophy, which is one theoretical foundation for modernization. To have a technological birth is to perform modernity appropriately.

The modernization discourse is so powerful in the context of Brazil that it overwhelms a clear conception of choice in birth procedure. To perform a vaginal birth in Brazilian society is already an act of rebellion and to have a natural birth in the home is something that is counter-culture. The phenomenon is something that Brazilian society no longer controls because it has become self-regulating through culture, which is informed by meanings of place that are imposed on notions of birth procedures. Both women and doctors are socially disciplined through “biopower”. The irony is that there is an overwhelming amount of risk associated with c-section birthing that is proven by medical researchers in Brazil, as well as internationally. The contradiction between perceived and actual risk, however, is negotiated precisely through reference to the discourse of modernity, which relies on all of the themes discussed above. This finding could be useful for the Brazilian government, which has attempted to lower the rates since the 1990s through ineffective educational campaigns like *Maternidade Segura*. While the efforts of this campaign lowered rates in the public sector by 15%, in the private sector rates continue to climb. How can something so embedded in the national consciousness be changed?
One place to begin to make change is through popular media. As this thesis has shown, the phenomenon of high c-section rates is connected to ideas of Brasilidade that have been disseminated through popular literature, radio, and television over a period of 100 years. To reverse this change, it will take time. However, two important changes in the media have already been noted. The first was the existence of two vaginal births that occurred on the recent soap opera *Caminho da India*. The portrayal of these births was positive, happy, and peaceful. That being said, these scenes reproduced stereotypes about birth in a rural and developing India, as well as vaginal birth in hospitals, which includes intervention. Nevertheless, these scenarios present a place to start changing attitudes in regards to birth. The portrayal of these births was so different than what the public is accustomed to that it was even noted in several blogs and debates on the internet among Brazilians. The second important occurrence was when the popular national figure as well as the most requested and well-paid supermodel in the world, Gisele Bündchen, had a natural birth at her home in New York City. This occurrence was noted in the Brazilian media, magazines, and the news. One magazine even posed the title: Is it possible that the “fashion” of natural birth will catch on (Será que a “moda” do parto natural pega?). I actually discussed Gisele’s natural birth with several of my informants, and they were perplexed by her behavior. It is important to note that due to the level of respect she has earned, she was not criticized, rather, people were mostly baffled by her choice. A popular national icon having a natural birth is a good beginning for change. If media campaigns were to portray natural birth done by other glamorous and well-respected female figures, perhaps society’s attitudes would begin to change.
It must be kept in mind that this is a process that is not going to change rapidly. If birth is symbolic of nation, as I have argued here, then a nation’s attitudes about how it will define itself as a modernizing country are also important for change. Brazil is in an economic boom and will continue as one of the most influential countries of this century due to the might of its economy, technology, and natural resources. In the face of this rapid modernization, the country has the opportunity to set an international example for a series of issues, birth being one of them. How it uses the 21st century to define Brasilidade will have an impact, among other issues, on birth procedures.

Theoretically, this research reinforces the existing body of literature that argues that national ideals influence, discipline, and control a woman’s choice, or lack of choice, in regards to her pregnant body, abortion, or how to give birth. However, my research is important for further studies in regards to the climbing c-section internationally because almost every country in the world has been influenced by modernization, therefore the discourse attached to this process may function similarly in other contexts. For example, my research demonstrates that the institution of development has also promoted the usage of c-section birth and added to the high c-section rates. First, by promoting the medical model of birthing and casting the midwife as a legacy of underdevelopment, “modern” hospital births became the norm and midwifery became stigmatized. Second, due to development’s concern with over-population, its implementation of sterilizations as the main contraceptive technology has promoted subsequent c-sections, a pattern which fits perfectly into a modern and urban society where couples find it difficult to afford more than two children. Thus, the discourse of development, also a part of modernization, has
added to the high c-section rates. It is my assumption that this occurs on an international scale as well, especially when considering the climbing rate of c-sections globally.

While Brazil has its own historical, geographical, and cultural processes that link c-section birth to a nation’s concern over modernization, connections between caesarean section and development should be established for other countries with climbing c-section rates; examples include the United States, China, Mexico, Australia, and South Korea, all countries with rates above 30% and climbing. This is a problem of the international political economy and each country needs to be analyzed contextually to explore how discourses of modernity, which are shaped by westernization, influence unnecessarily high c-section rates. Without exploring this root cause contextually, country by country, change will be superficial and short-sighted.

However, this thesis has serious implications about notions of modernity and how it influences our perception of what is acceptable for how we treat our bodies and how we treat newborn babies. If a discourse of modernization can have such a powerful effect on something so intimate and universal to the human experience as birth, influencing people to make choices that are potentially risky for their well-being, then we need to question how we understand this notion of modernization. It is a fact that we live in a society influenced by modernization’s ideals, yet what aspects of it should we accept and which should we discard? By allowing c-section rates to climb according to a self-regulating discourse, we are surrendering our health and well-being of ourselves and our children.
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APPENDIX A: INTERVIEW QUESTIONS FOR WOMEN IN ENGLISH AND PORTUGUESE

1. What is your age?
2. What is your occupation?
3. How many children do you have?
4. What are their ages?
5. Can you tell me about your experiences giving birth?
6. Where did you give birth?
7. What do you remember most about your birth experience?
8. What kinds of decisions did you feel like you needed to make when preparing for your birth?
9. Why did you choose to have a c-section?
10. Did you consider having a vaginal birth?
11. Did you consider having a c-section prior to giving birth?
12. Did your family, friends, and doctor support or encourage you in your decision?
13. Do you think your birthing experience is typical of the way most women give birth in Brazil? If so, why, if not, why?
14. Do you think there is any similarity of difference between birth in Brazil and birth in other countries?
15. Do you see anything about your birth as being particularly Brazilian?
16. How do you imagine the birth of women from other countries? (probe for specific countries here)
17. In my research, I found that Brazil has some of the highest c-section rates in the world? Why do you think this might be?
18. What did you imagine birth to be like before you had a child?

19. How do you see birth as being portrayed on television?

20. How do you think your doctors portray birth?

21. How do your friends and family feel about birth?

22. How do you normally feel about your body?

23. How did you feel about your pregnant body?

24. How did you feel about your body after birth?

25. Did the way you feel about your body influence decisions you made during pregnancy, labor, or after giving birth?

26. Do you think your feelings about your body are typical for a Brazilian woman? For women everywhere?

27. Do you imagine women in different parts of the world feel about their bodies differently?

Appendix A.1: Portuguese Translation

1. Quantos anos você tem?

2. Qual é sua profissão?

3. Quantos filhos você tem?

4. Quantos anos tem os seus filhos?

5. Você poderia falar sobre suas experiencias de parto?

6. Aonde foi o seu parto?

7. O que você mais lembra sobre o seu parto?

8. Quais decisões você precisou tomar quando você estava se preparando para o seu parto?
9. Por que você decidiu ter uma cesariana?

10. Você considerou ter um parto vaginal?

11. Antes de seu parto, você considerou ter uma cesariana?

12. A sua família, os seus amigos, e o seu médico apoiaram sua decisão de fazer uma cesariana?

13. Você acha que seu parto foi um parto típico do partos no Brasil? Você poderia explicar o porque?

14. Houve algum procedimento no seu parto que você acha ter sido especificamente brasileira?

15. Como você imagina ser o parto de mulheres de outros países? (Países na Europa ou na Africa por exemplo)

16. Em minha pesquisa eu descobri que o Brasil tem as mais altas taxas de cesariana do mundo. Em sua opinião, porque isso ocorre?

17. Antes de ter um filho, como você imaginou que seu parto seria?

18. Em sua opinião, como é que a televisão retrata a experiência do parto?

19. Em sua opinião, como os médicos retratam a experiência do parto?

20. Em sua opinião, como a sua família e os seus amigos sobre se sentem sobre a experiência do parto?

21. Como você se sente sobre o seu corpo?

22. Como você se sentiu sobre o seu corpo de mulher grávida?

23. Como você se sentiu sobre o seu corpo após seu parto?

24. Como os seus sentimentos sobre o seu corpo influenciaram as suas decisões durante a gravidez, o trabalho de parto, o pos-natal?

25. Você crê que os seus sentimentos sobre o seu corpo sejam típicos de uma mulher brasileira ou iguais aos sentimentos de mulheres em todas as partes do mundo?

26. Você imagina que mulheres em partes diferentes do mundo se sentem diferentes sobre os seus corpos?
APPENDIX B: INTERVIEW QUESTIONS FOR DOCTORS

1. What is your age?

2. Where did you receive your medical training?

3. When did you finish medical school?

4. What kinds of procedures did you learn in birthing techniques?

5. How many babies have you delivered throughout your career?

6. How many babies do you deliver each week?

7. In your medical training what did you learn as a typical birth? Was it how you imagined birth to be before medical school?

8. Tell me about a typical birth that you handle on a day to day basis. (probe for whether or not the use intervention like hormones, epidural, EFM, forceps)

9. Do you deliver more caesarean births or vaginal births?

10. What is your preferred technique for delivery?

11. Are the births that you attend typically Brazilian?

12. What do you imagine a typical birth to be like in other countries?

13. Do you think there is anything different about birth in Brazil in comparison to other places?

14. How do you prepare your patients for birth? What are some recommendations or suggestions you may give them?

15. What sorts of concerns do your patients have?

16. Do women commonly worry about their bodies?

17. How do you assuage them of their worries?
Appendix B.1: Portuguese Translation

1. Quantos anos você tem?
2. Onde você estudou medicina? (OR: Onde voce se formou em Medicina?)
3. Em que ano você se formou em Medicina? (OR: Em que ano voce se graduou?)
4. Quais técnicas e procedimentos de parto você aprendeu na escola de medicina?
5. Quantos partos você já realizou em sua carreira?
6. Quantos partos você realiza por semana?
7. O que poderia ser considerado como um parto típico segundo seu treinamento médico que você recebeu? Sua percepção sobre o que constitui um parto típico mudou após seus estudos de medicina?
8. Descreva os procedimentos de um parto típico que você realiza no dia-a-dia.
9. Você faz uso regular de intervenções tais quais hormônios, anestesia peridural/epidural, forceps, monitor fetal eletrônico, ou alguma outra intervenção?
10. Você realiza mais partos cesarianas ou partos vaginais?
11. O que é a sua técnica preferida para a realização de parto?
12. Você crê que os partos que você realiza sejam típicos em seu país?
13. Descreva de um modo geral o que você conhece sobre os procedimentos de parto em outras partes do mundo.
14. Qual sua opinião sobre as condições parto em outros países?
15. Você crê que haja algo diferente sobre o parto em Brasil em comparação aos outros lugares?
16. Como você prepara seus pacientes para o parto?
17. Quais são algumas das recomendações ou sugestões que você daria?

18. Que tipo de preocupações sobre o parto os seus pacientes tem?

19. Você crê que as mulheres brasileiras se preocupem sobre os seus corpos?