Doctors, Women and Cesareans: The construction of normal birth as "risky" and the medicalization of birth in Brazil.

Alessandra Sampaio Chacham1

ABSTRACT

In this work we investigate the reasons for the high rates of cesareans in Brazil, especially in private hospitals. We interviewed 18 obstetricians and 60 women who had given birth in the year of 1998 (30 in a public hospital and 30 in private hospitals), to understand their perceptions and preferences regarding the process of birth. Our data suggest that as result of the process of medicalization of birth in Brazil there is a growing perception of normal births as always more risky than cesareans, seen as innocuous. This perception seems to make easier for doctors to indicate a cesarean and for women to accept it, especially in the private sector. Also, we discuss as the current Brazilian obstetric assistance model (in which obstetricians are the sole responsible for assisting women during pregnancy, labor and birth), seems to reinforce the establishment of a more interventionist, technology-based kind of obstetric practice.

1. INTRODUCTION

It is a well-established fact that Brazil has very high rates of unnecessary c-sections2 (Melo, 1976; Barros, 1991; Faúndes, Cecatti, 1991; Rattner, 1996). There is also strong evidence that upper and middle class women are much more likely than working class and poor women to have a cesarean delivery although generally they constitute a group with lower obstetric risk. This suggests that other factors than medical ones are responsible for those high rates (Berquó, 1993, 1994; Rattner, 1996). Several explanations have been offered for this phenomenon. Among the most frequently cited are: social and cultural values which would generated a demand from women for c-sections, such as fear of pain or damage to the perineum during a normal birth; the chance to get a tubal ligation during a cesarean (since sterilization was illegal and not paid for the public health system or private health insurance, a common way to obtain a sterilization was through a c-section); cesareans also would be more interesting for doctors', specially for economical reasons. Doctors interests would have a strong weight due to Brazil's model of obstetric assistance where doctors are

1 Adjunct Professor at the Department of Social Sciences - Pontifical Catholic University of Minas Gerais

2 In 1996, according to the Demographic and Health Survey (DHS-96), cesarean rates reached the percentage of 41,8% in Brazil's

the only ones responsible for assisting during labor and birth (Faúndes, Cecatti, 1991).

Although there were no studies that directly asked women these questions (the discussions were based in the opinion of doctors), the women's preference for c-sections was accepted as a fact. However, recent researches made with women in different parts of the country3 raised serious questions about the validity of those hypotheses. They found that most women interviewed, both the ones who delivered in public hospitals as the ones who used the private sector, wanted to have a normal birth. The indication of a cesarean came from the doctors and the majority of women accepted it. Those results suggested that doctors were mainly responsible for the high c-sections rates, but the studies did not clarify the doctors' motivations for performing an excessive number of c-sections. Doctors' direct economic interests are the most common explanation offered, although we do not have any empirical proof this argument. At the international level, Sakala (1993) warns that there is not enough evidence to accept or refute this hypothesis, because several other factors seem to be involved. In the same way that the hypotheses about female demand for c-sections were not confirmed, the suppositions about doctors interests also seem inadequate to fully explain the complexity of this situation. For instance, it ignores women's role in this process and fails to explain why they seem to passively accept a surgery they do not want. At same time, there is some evidence that the way the obstetric assistance is organized in Brazil strongly favors the abuse of c-sections4. In the light of these considerations, in this paper we sought to discuss how several factors interact to keep cesarean rates high in Brazil, departing from women's view on their experience with pregnancy and birth.

From a theoretical point of view, the excessive numbers of c-sections practiced in Brazil can be seen as a part of a global trend to medicalize birth, which stimulates the growing use of medical technology to manage and control the birth process. This trend can be placed in a much bigger process of medicalization of the body and the increasing presence of technology in each aspect of modern life at in different levels, in

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urban areas, in several states, the percentage of cesarean births is over 50%.

3 Carranza (1994); Hopkins (1998); Perpétuo, Bessa e Fonseca (1998). In those studies, they interviewed women who had have children recently, in several states, and the results they found were very similar among them.

4 A analysis of births occurred in Belo Horizonte, 1994, shows that the kind of hospital where the women had birth, if private or public, was the most influential factor in a woman's chance of having a c-section, more than any other socio-economic

almost every country. Medicalization is the process in which different health conditions, social status and behaviors are redefined as belonging to the medical domain, and submitted to the health system to be "cured" or managed (Becker, Nachtigall, 1992). This process establishes the hegemony of medical authority and reaffirms its control over the population (Faria, 1989). Departing from the concept of medicalization, we analyze here how the biomedical paradigm legitimizes the increasing medical intervention in the process of birth, providing the parameters for the obstetricians' practices. The model of medical knowledge permeates a perception of the body, pregnancy and birth shared by both doctors and women. This would be true specially among upper and middle-class women who have more access to medical care and are more likely to accept and to use medical terms and practices (Martin, 1984, 1989). The progressive medicalization of birth it was only made possible by the changing the perception of the birth from a natural process to a potentially pathological one which requires medical management and intervention, as Arney (1982) explains:

> Whilst in the nineteenth century obstetricians were concerned only with 'problem' births, increasingly throughout the twentieth century, all births were reconceptualized as potentially problematic. They were thus established through the use of monitoring procedures (such as electronic fetal monitors).... After the monitoring concept was in place, obstetrics did not to confine itself to the abnormal or potentially pathological birth; every birth became subject to its gaze (p.100).

In this work, we explore the implications of the biomedical model of knowledge about births on the medical practice and on women's believes and preferences about birth. In the following sections we present the results of interviews with 60 women who had had a baby in the year before the research. We discuss how medical values and believes affected women and how their doctors' discourse shaped either their preferences for a specific kind of birth or their acceptance of a type of birth they did not wish.

2. The interviews with women:

2.1. Methodology:

Following a questionnaire with open-ended questions, interviews were the instrument used to gather

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characteristic. (Chacham, Pérpetuo, 1996,1998).

data. This technique was consider the most adequate to capture the subjective aspects of women from different social classes experience with pregnancy, labor and birth. The interviews were done with women who had had given birth recently, both in private and public hospitals. This criteria was used to select women because, above all other characteristics, such as educational level, age, or number of children, the type of hospital where the women gave birth, was the major factor influencing the probability of a woman having or not having a cesarean (Chacham, Perpétuo, 1996, 1998). The questionnaire included questions about the woman reproductive history, her last pregnancy and pre-natal care, labor and birth, post-partum and breastfeeding experiences. The questionnaire was pre-tested with several women who had had births in private hospital and others who were patients at Sofia Feldman (a hospital affiliated to SUS, Sistema Unico de Saude, Brazilian National Health Service), and was revised several times.

In Brazil, as observed by Carranza (1994) and Hopkins (1998), hospitals have important distinctions among them which affect the type of obstetric care they offer, depending how their services are financed. In public hospitals and in private hospitals affiliated to the SUS, the relationship between a SUS patient with her doctor is fundamentally distinct from the one a women has with a private doctor. Normally, the SUS patient had her pre-natal care in a health center with a doctor who in general is the only one available. For the delivery, she is directed to one of the hospitals serving the public sector. Frequently those hospitals do not have vacancies and the woman in labor has to go to different hospitals until she finds a place. In the hospital she is assisted by the doctor on duty, someone she has likely never seen before. In this circumstance, the possibility of booking an elective c-section is remote and the desires of the patient in relation to the type of birth they wish to have hardly matters in the final decision.

Private hospitals that only receive private or insured patients have very high cesareans rates (generally over 70%). Their own private doctors, the same ones who did the pre-natal care, normally assist the patients. Contact with the hospitals' doctors is minimum or non-existent, and the patient's private doctor is the only one responsible for her care during labor and delivery. A private patient can pick the doctor she wishes or if she has health insurance she can select a doctor from a list of names. When a woman wants a

normal birth, it is a common practice to choose a doctor known to have a practice favorable to it. Similarly, when a woman wants a cesarean she can choose a doctor who will concur with her desire. Although, the cesarean rates in those hospitals are higher than the recommended by the World Health Organization (WHO, 1985), they are much lower than the private sector rates (Chacham, Perpétuo, 1998).

Sixty women, evenly divided in two groups, constituted our sample: half had given birth in private hospitals and the other half in a public hospital. Ours was a convenience sample; the selection of women to be interviewed was random. The number was not pre-determined and the criteria used to determine the number was saturation. After we got enough answers to ensure that the research goals were reached, we did a few more, and ended with 30 interviews in each group. In the public hospital, women in the post-labor wards were approached to give us interviews, after being assured of the confidentiality of the research. Only one woman approached refused to give an interview. To select the group of women who had given birth we used indication of doctors or other respondents who knew women who had recently given birth in a private hospital, the snowball method. Since those hospital have very similar cesarean rates5 and type of obstetric services we did not limited to women of only one hospital. We had no refuses in this group. All the interviews with the women in both groups were conducted between the fall of 1996 and the beginning of 1997. By interviewing women in the Hospital Sofia Feldman and women in private hospitals, we managed to interview women who were in the opposite poles of the obstetric treatment in Belo Horizonte: the service with the lowest rate and the services with the highest rates.

2.2. Social and Economic Characteristics of the Women Interviewed:

When we selected both women who have given birth in private hospitals and women who have given birth in a public hospital we interviewed two groups of women very different socio-economic characteristics between them. The women interviewed on the public hospital were in their majority, poor or working class women, with low level of educational attainment. They tended to be young (almost a third were teenagers), black or mixed race, and did not work outside home. The women from private hospitals tended to be older,

middle or upper middle-class and to have a high educational level. Most of them were white, had paid jobs and all of them were married or living with a partner. In the table below, the general characteristics of the women interviewed are listed accordingly to the type of hospital where they have given birth:

Table 1: Characteristics of the women interviewed are listed accordingly the type of hospital where they have given birth:

Characteristics of the women interviewed:	Women who have given birth in private hospitals:	Women who have given birth in a public hospital:
Average age	31 years	24 years
Number of mothers between ages 14 and19	0	10
Race	95% white	70% black or mixed
Origin	Belo Horizonte (Capital)	Small towns or countryside
Median household income in the neighborhood where resides:*	Between 9,5 e 16 minimum wages**	Less than 6 minimum wages
Marital Status	All married or in a union	Six were single
Educational level	Most had college degree	Less than 8 years of schooling
Professional Activities	Professionals	Homemakers or working in the service sector (with low level of specialization)
Average number of children	1,4	2,1
Average number of wanted children	1,9	2
Number of first-time mothers	19	17

*According data from IPEAD/FACE/UFMG.
** In May 2000, Brazil's minimum wage was equivalent to 83 dollars per month.

2.3.The four kinds of female experience with birth:

In this section we present a synthesis of our findings, discussing women's experience with pregnancy, pre-natal care and the birth. We divided the women interviewed in four groups according to the kind of birth she desired before she entered in the hospital and the kind of birth she actually had. Those groups are: women who wanted a normal birth and had a normal birth; women who wanted a normal birth and had a c-section; women who wanted a c-section and had a c-section; women who wanted a c-section and had a normal birth. We describe here the most relevant aspects of each circumstance to illustrate differences and similarities between women from different social classes by type of birth desired versus the type of birth

5 The three majors private maternity have a rate around 70% of cesarean (Chacham, Perpétuo, 1996).

obtained. We also discuss the possible causes of the discrepancy between what they desired and what they got, and when it was the case, the reasons of their "success" in obtaining the type of birth they desired.

Table 1
Distribution of the women interviewed according to the kind of delivery they wanted before entering in the hospital and the kind of delivery they actually had:

Hospital	Wanted NB* Had NB	Wanted NB Had CB**	Wanted CB Had CB	Wanted CB Had NB	Total
Private	9	10	9	2	30
SUS	20	5	2	3	30
Total	**29**	**15**	**11**	**5**	**60**

* Normal birth ** Cesarean birth

2.3.1. Women who desired a normal birth and had a normal birth:

Women who had their children in the Hospital Sofia Feldman largely made up this group. The reason for that seems to be that both the preference for a normal delivery and chances of actually having one are more frequent among women of lower socio-economic levels, who have their delivery in public or private hospital paid by the SUS. The reasons presented by the women for their preference for the normal birth differed significantly across social strata to which the women belonged. Middle-class women normally declared that they preferred normal births because those were "natural" and the best for mother and child. Women from the working class declared that they prefer normal birth to c-sections because it was not surgery, bringing less risk to women and allowing a better, easier recovery. There is a very important distinction to be made here: while the upper and middle classes women perceived the normal birth as a value in itself, poorer women seemed to prefer it by exclusion for being less worse than a c-section. As several women pointed out: "birth is always painful, but at least after a normal delivery the pain is over, after a cesarean it is beginning."

Several values related to a more "holistic" medical approach and life philosophy, oriented towards

more natural healthcare options seem to influence more affluent women in their preference for normal birth. At same time, these women showed more acceptance and absorption of the medical discourse and its values about the birth process constructed by the biomedical paradigm6. This acceptance, even considering it was not absolute in several cases, brought an ambiguity to these women discourses about the normal birth: albeit viewed as the most desirable alternative, is frequently perceived as a potentially risky procedure, almost as the exception to the norm. At the same time the physiological character of the normal delivery is exalted, because it is means to them healthy and natural, positive attributes to them, it is also viewed as representing unpredictability and risk. As a consequence of this conception, for several of them the normal birth is the ideal, but only when it is easy and fast. A longer labor is interpreted as being an unnecessary suffering and risky, and those can be avoided by using the resources of modern medicine. The concept of risk, intrinsic to the medical discourse about birth7, seems to have great weight on the women's easily acceptance of the indication of a c-section by her doctor at the first signal of a possible complication during labor, as we will discuss in the next section. In their discourses seem clear that women absorb those values not exclusively but mainly from their own doctors' discourses. Although only two among the nineteen middle-class women in this group declared they felt their doctors did not support their desire for a normal birth, none directly pushed for a c-sections and most women felt their doctors were very supportive of their desire for a normal birth. Although this support was frequently accompanied by warnings from the doctors such as: "(in a birth) you never know" or "to wait for too long is useless or unnecessary suffering". A woman quoted her doctor as saying "to wait more than two hours is nothing is happening is useless", according to her this is positive because "my doctor won't let me suffer for nothing." Also, it should be pointed that most middle-class women did not feel prepared for the birth by their doctors nor they encouraged to take birth preparation classes or to read about it. Doctors also tended to dismiss the magazines and books they read as useless or no trustworthy, although it was not common to them to indicate any bibliography.

Differences between the two groups of women interviewed are striking in other aspects. Most

6 Floyd (1994) and Martin (1989) both described similar kind of behaviour among american middle-class women.
7 See Oakley for a discussion about how doctors conceptualized birth as a potentially pathological and risk process to obtain

women who went to private doctors declared they had a great relationship with their doctors and a complete trust on them. In general they described their consultations are very pleasurable, the more technical aspects as secondary to the more informal conversations. Their doctors were clearly their main source of information and advice about pregnancy and birth, and their recommendations generally followed. Although few women declared afterwards they felt that their confidence was misplaced, most remained satisfied with the treatment they got. Among the women who had had their pre-natal consultations with doctors from the SUS, the relationship with their doctors was much more impersonal and distant, they demonstrated certain distrust and even sometimes ignored their doctors' opinion. Their consultations tended to be very short and very technical, and none of them referred to their doctors as "my doctor" as middle class women always did. The women who had pre-natal consultations at Sofia Feldman with nurse-midwives were the great exceptions, because they seemed to be able to have more time, to get more advice and more opportunities to ask questions to the nurses.

The perception of natural birth as risky and as a almost exceptional procedure (reserved for the situations everything goes well, according very limited criteria) seemed to have a self-fulfilling character: in this group, only women who had very short and easier births had normal births in private hospitals. According to their declarations, normal births in private hospital took in average 6 hours, a very short period considering that most of the middle-class women interviewed were primiparae (first-time mothers, who tend to have longer labors). Their perception of their delivery were positive, something they wanted and were proud to achieve. However, several expressed a sensation of distance, felling removed and alienated from the process, because they felt they did not participate enough, or as much they expected, on their own deliveries. That was true especially among those who had had anesthesia through most of their labor. One woman declared: "I did not get to feel even a contraction!" (She got epidural in a very early stage of labor). It is clear that what these women understand as a "normal birth" is a very medicalized version of birth: in a hospital, with anesthesia, lying down. (In Brazil practically every hospital still shaves and apply enemas to

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exclusive control of the management of the birth process.

women before birth). Only one among all the middle-class women interviewed did not take anesthesia and used a different position to give birth (she was squatting). However, a few women mentioned they worked hard to push the baby out to avoid a c-section. All of them had to be told when to push by their doctors, and a third of them had their babies extracted by forceps.

The women interviewed in the Sofia Feldman had longer births in average; several had some unexpected complication happening during birth, such as an arrested labor, but it did not conducted to a cesarean. They generally considered their birth as painful, since none had anesthesia and the good part about it was because it was over. At same time, they seemed to accept birth more naturally than middle class women8, something you have to go through to get over it. They also seemed to have participated more actively in their labor. They see their births as something they did, in opposition to middle class women who saw their doctors in the active role, telling them what to do. They always mentioned pushing, several declared that "labor is hard work" or as a woman said "during labor you have to stay calm and work hard". The model of obstetric care which group received seemed to be determinant in their chances to have a normal birth: in the Sofia Feldman nurses-midwives assist normal deliveries and wait longer for a natural resolution of the birth unless there is an indication for c-section. Middle-class women seemed to have had normal births almost in spite of their doctors. The ones who had it had a fast and easy delivery, otherwise they would not have it at all, as we discuss in next section.

2.3.2 Women who desired normal births and had cesareans:

This is the most likely experience to happen to women from upper and middle classes. Most of them desired a normal delivery (even the ones with previous c-sections) and had cesareans. The reasons presented for their preference for normal births are the same as the presented by the middle-class women who had normal birth: it is natural thus the best for mother and child. In this group, they wanted a cesarean since the beginning of their pregnancy but, towards the end, their doctors indicated a c-section, even before entering in labor, presenting some medical reason. At that moment, none of them disputed the need for a c-section,

even admitting they felt sad with the perspective, although some did regret it later. None looked for a second opinion. Few commented they felt pressured by their doctors to accept the c-section, and one woman felt pressured by her husband to accept a cesarean. However, most declared their doctors did support their options for a normal birth throughout their pregnancy, only close to the due date they indicated the cesarean.

The representation of the normal birth as a risky, the exception procedure seemed to have influenced their relatively easy acceptance of a cesarean, as we mentioned before. We have to clarify that most women did not consider birth as intrinsically dangerous, they dispute that notion (presented by women and doctors they know who prefer cesareans), in their discourses. Nevertheless, their doctors' discourses and the fact they know very few successful normal birth stories (given that most middle class women now have cesareans9) seemed to have predisposed them to accept that normal births are the exception now, for a lucky few, and cesareans are the most likely possibility. Another important point is that while risks associated with normal birth are overplayed in the medical and popular discourse, the risks of a cesarean are minimized, presented as a safer, costless and more "modern" alternative. Thus, even middle-class women who prefer normal birth usually do not have negative opinions about cesareans, regarding them as safe and handy resource. The fact they are surrounded by relatives and friends who had also "failed" in having normal deliveries seemed to help to accept easily and without guilt10, since that they accepted their doctors' explanations for the necessity of their cesareans. In this sense, for many of them cesareans are closer experiences than a normal birth, although several did lament not having experimented a normal birth, and some expressed a very strong desire to do so even when they had a cesarean birth before. In their description of their births they seem to be removed from the whole process, not mentioning even when the baby was born, although they were conscious during the whole process. The only thing they mentioned about their participation in their deliveries is that they stayed calm thus helping their doctors.

Among women who had a cesarean in the Sofia Feldman, they normally went through a long labor,

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8 Martin observed the same distinction....

9 They do not seem to be able to relate to their mothers' experiences, who mostly had they children at home with midwives. They seemed to be more influenced by their sisters' or friends' experiences, women from their age group and social circumstances.

10 In the international literature, several researches found feelings of guilty and sadness associated to a cesarean birth (Mutryn,

having then an emergency cesarean. Only two women in this group had elective cesareans, both because had more than three cesarean births before. Another one was primipara, and started premature labor, with a breech presentation. Differently from middle class women, they tended to have a very negative view of cesarean and declared to have had a negative experience with it. They it considered more painful, dangerous and risky than normal deliveries. They complained especially against their recoveries, which they considered painful, long and difficult. This also differed from middle class women who commonly described their recoveries as easy and fast. The reason for this difference apparently can not be attributed to any difference in medical procedures, so maybe the positive perception of middle class women have of cesareans might have help them to play down discomfort during recovery. Also, the fact middle-class women are more likely to have domestic help may contribute for an easier recovery.

2.3.3. Women who desired a cesarean and had a cesarean delivery:

Among the women in this group, middle-class women constitute the majority. For them, it is easier to obtain a cesarean when they wish one. In the case of poor and working class women delivering in public hospitals, even when they want a cesarean they do not get one unless a doctor decides they need them. Most of the time they do not know who is going to assist their birth or they even have the chance to express their wishes.

The reason presented by the women interviewed to justify their preference for a cesarean did not differ among women of different social classes, contrarily of what occurs with the reasons to prefer normal births, which are distinctive by social class. Fear of pain is pointed as the most important reason to prefer a cesarean, both for middle class and poor women. However, we have to point that a few middle-class women presented also another reason to their desire for a c-section: they saw it as a way to have some control over the birth process. For them a cesarean was not only painless, but it also meant a safer birth for the baby, because it was seem as more predictable, as a woman put: “during a c-section you have control over all the factors”. On the other hand, for some women to have control over their birth seems to mean they could

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1993), but that did not seem a common experience among the women interviewed.

decided the day and even the hour they wanted their baby delivered. For them, it seemed that as long as their perceived their doctors as on the control of the birth process, they feel on control and safe. They seemed to accept what Davis-Floyd (1992, 1994) defined as "the technocratic model of birth" which values medical control over the birthing process. For these women is clear that the naturalness of the vaginal birth is associated with insecurity and unpredictability, not a value on itself.

Another characteristic of the experience of this group of women, is that even though most middle-class women who wanted a c-section did obtain it, they all said that their doctors were reluctant to agree with their desire in the beginning. For most of them, only towards to the end of their pregnancy their doctors agreed with the c-section, but always presenting some medical reason for their decision. In this sense doctors retained control over the decision, presenting always a medical cause for the c-section, even a questionable one, other than the patients' wishes. Most middle-class women in this group had elective cesareans. For the women delivering at the Sofia Feldman the decision of a cesarean was taken during labor, with the exception of a woman who had two previous cesareans. Contradictorily, these women did not seem bothered for this initial reluctance from their doctors to give them a cesarean, none changed doctors. They rather considered it a good signal, a indication that their doctors were "good professionals", they did not want to push for a c-section even though that would be easier for them. This suggests that they see the normal delivery as more demanding for the doctor than a cesarean, differently from working-class women who normally said doctors prefer normal births because the women do "all the work".

The middle-class women who were having their first child and wanted a c-section declared to be extremely scared by the perspective of their delivery, even though they wanted it and afterwards they considered a very positive experience. They mentioned that their fears were not discussed with their doctors who did not try to convince them to try a normal birth or explained their doubts or soothed their fears. Several had misconceptions about anesthesia they never discussed with their doctors. They describe it with remoteness; they never went voluntarily past the anesthesia, although they were conscious all the time they did not mention when the baby was born or how they felt. Again, all women who had cesarean in private

hospitals considered their experience positive and their recovery easy. Women who had cesareans at the Sofia Feldman and wanted one were not so unanimous in their response, half of them have considering theirr recovering painful, but the other half did not.

2.3.4. Women who wanted to have a cesarean and had a normal birth:

A very small number of women found themselves in this situation, and they were in general women who had had children at the Sofia Feldman. When a woman's delivery is paid by the SUS normally there is no opportunity for her to express her preference, let alone influence the doctor, if is there a chance of normal delivery. Among the women interviewed from the private sector, when they wanted a c-section and have a vaginal delivery, usually it was their doctor who convinced them at least to try to have a normal birth, or allowed them to try it in the cases they had a previous cesarean birth. In spite the fact that the most cited reason to prefer a cesarean is still the fear of pain, in this group we found a few exceptions. A few women in this group wanted a cesarean because they thought they had an indication for one: one thought she was too small and two others had a previous cesarean. They declared they were happy to have had a normal birth afterwards and had positive feelings about their experience, again, fast and easy for the middle class women.

2.3.5.A synthesis of the experience with pre-natal care and delivery for the women interviewed, divided for social strata:

Characterization	middle-class women	working class women
Medical assistance	personalized	anonymous
Interaction doctor-patient	friendly, plentiful	minimal
Preparation for birth	a little, generally for initiative of the woman	non existent
Transference of information from the doctor to the patient	reasonable	minimal
Confidence on the doctor	plenty	partial
Acknowledgment of the doctor as the only expert in pregnancy and delivery matters	total	partial
Deference to doctor orders	total	partial, sometimes reluctant

Absorsion of medical discourse	significant	minimal
Reasons they prefer a normal birth	because it is "natural" best for mother and child	easier recovery
Reasons they prefer cesarean	fear of pain sensation of control over birth process and/or the date	fear of pain
Perception of their experience with normal delivery	positive experience easy, calm	painful "less worse"
Perception of their experience with cesarean birth	positive easy, fast	negative
Participation in the normal birth	few, conducted by the doctor	active, "hard work"
Description of the cesarean	minimal	none
Recovery after normal birth	more difficult than expected	easy
recovery from cesarean birth	fast	difficult and painful

3. Final Comments:

Our results suggest that although the high incidence of cesareans sections in Brazil, especially among upper and middle-class women, cannot be explained by their demand for this practice, certain elements of their relationship with doctors predispose them to accept cesareans they do not wish. However they are not being simply pressured by their doctors to accept cesareans, although this kind of pressure does happen. Most women here felt encouraged by their doctors to attempt a normal delivery. Still, their lack of preparation and understanding of the birth process coupled with the "discourse of the risk" by their doctors part, seemed to have powerful effect on their acceptance a cesarean they did not want at the first signal of a possible complication. Why do their doctors' words have so much impact? Mainly, it is due to their strong acceptance of the legitimacy of the medical intervention on the pregnancy and delivery and their absorption of the biomedical paradigm about the birth process. Although it does not occur in a linear, complete and uncritical way, their acceptance and absorption of the medical discourse can explain why significant numbers of women who desired a normal birth accepted without much reluctance the indication of a c-section. Even when they acknowledge that there is an abusive use of this practice, they rarely question the validity of their doctors' decisions.

Among the possible reasons to explain this submission to the medical decisions, we can point the hegemony of the biomedical paradigm, especially among the most privileged segments of the population.

Doctors and middle-class women share the same language, and they also share the same beliefs about the validity of the biomedical approach to the management of pregnancy and birth. Even when these medical values seem to conflict with another set of values more "naturalistic" professed by several middle-class women, the acceptance of the primacy of medical discourse and of the necessity of the routine use of medical interventions takes over it. In their discourse, these women frequently reproduce the medical discourse in which birth is always characterized as a risk potential risk, while cesareans are downplayed as a safe, routine procedure.

Of course, women's submission to medical authority is hardly a Brazilian phenomenon. It happens everywhere, in varying degrees and it is a consequence of the process of medicalization of modern societies. The increasing technological growth and specialization of medicine reinforces this trend: the use of medical terms and more technical concepts diminishes considerably the capacity of women to take informed decisions about their own pregnancy and delivery. The use of devices such as the ultra-sound makes women even more dependent on a doctor to interpret what is going on inside their bodies. Also, gender hierarchy tend to make women submissive to the power of a male authority and even to a women in a position perceived as typical male dominate field.

The medicalization of society and more specifically of the body and reproductive process is a practically an worldwide phenomenon. In developed countries, the medical control over pregnancy and birth is even more intensive and extensive than what happens in Brazil, even when the pre-natal and birth are assisted by health professionals others than doctors. But, in Brazil after the sixties the efforts to lower maternal and infant deaths rates led to incentive to have births in hospitals, assisted by doctors. No alternative model was developed to offer an option to the model of obstetric care centered on the figure of the doctor, the only responsible to assist women during labor and delivery. In several countries the figure of midwife or nurse-midwife has been incorporated to the official health system and it seems to have been fundamental to keep low their cesarean rates, even inside a very medicalized model of obstetric care. In the United States, which obstetric model Brazil copied, has one the highest cesarean rates of industrialized

countries but still much lower that Brazilian rates. Probably, the existence of a strong feminist movement coupled with the movement for “natural childbirth” together with the more and the higher level of regulation over medical activities were factors which deterred a even bigger growth of the cesarean rates. Alternatives such as birth centers, lined or not with hospital and also the possibility of home births gave more options for women there (Sakala, 1993, 1993b) while in Brazil, the fight for a more natural and humanized obstetric care depend of isolated actions from few doctors, midwives and women and some health services. Although the Ministry of Health is now taking strong measures to curb cesarean rates such as limiting the number of cesareans a hospital can perform and training more nurse-midwives, these actions have limited impact on the private sector, which detain the highest rates.

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