

Call me 'at-risk': Maternal Health in Sao Paulo's Public Health Clinics and the Desire for
Cesarean Technology

by

Laurie Michelle Denyer

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Submitted to the Department of Urban Studies and Planning in Partial Fulfillment of the
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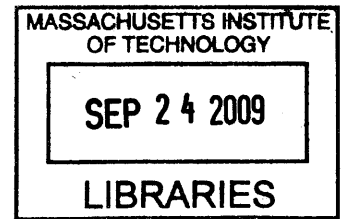
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ABSTRACT

This paper is based on ethnographic field research undertaken in a public health clinic in the periphery of São Paulo, as well as an examination of the “Humanisation of Childbirth Campaign”. The Humanisation Campaign is a Brazilian public health initiative targeted at low-income women that aims to drastically lower country-wide caesarean rates. This paper will consider how pregnant women actively seek to be labeled ‘at risk’ during ante-natal care by doctors, nurses and health care technicians in order to ensure access to caesarean technology during their birthing process, in order to avoid the discrimination and physical abuse often associated with a vaginal delivery. I suggest that experiences of *riscos*, or riskiness, bear heavily on women’s pragmatic adoption of interventionist birthing. *Riscos*, as it has been explained to me, is experienced both bodily and socially, as a physical threat to bodies that is experienced via physical and social violence within the clinic. In this paper, I plan to explore the phenomenology of risk, and how, for women from the periphery, risk to body and health is an embodied experience, and situated within the social and political context within which individual experience occurs. Ethnographic work suggests that women seek inclusion into ‘expert’ biomedical risk assessments and categories that ordinarily exclude or overlook them. This paper will be situated in an examination of the Humanisation of Birth Campaign, it will explore the conflicting meanings about what ‘natural, normal and traditional’ means in Brazil, and the ongoing debate over birthing that is currently encapsulated in the narratives surrounding the Humanisation Campaign. This pragmatic desire to adopt risk labels offers a window into understanding a new range of questions about how public health narratives have direct implications for women’s reproductive health, while at the same time reconfigure women’s conceptions of, and negotiations with, bodily risk and flexibility.

Thesis Supervisor: Diane E. Davis
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Biographical Note

Laurie Michelle Denyer has worked at the University of Guelph and the Canadian Centre for the Study of Resource Conflict (CCSRC) as a public policy researcher. She is interested in the development and implementation of gendered public health policy. She has studied marginalized and periphery communities in Brazil, Zambia, Uganda, Sierra Leone, Malawi, and Canada. She has a Bachelor's Degree from the University of Guelph in Collaborative International Development. After the completion of her Master of Science in Urban Studies and Planning, Laurie will go on to complete her PhD in Medical Anthropology at McGill University.

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Introduction

On a humid day I arrived at a tiny apartment in a six-story cement public housing block with barred windows and surrounded by tall iron fences. I had come to meet Janina¹, a girl in her early twenties who had given birth to a small baby boy a week prior to my visit that she named Lucas. The apartment was small and dark, with all the curtains drawn in an attempt to keep out the heat. With my t-shirt and skirt wet with sweat, Janina invited me into her room to talk and meet the new baby. Janina rented the single 6 by 8 room from another family. She had just enough room to squeeze in a single bunk bed and a small dresser. We sat side-by-side on the single mattress while we took turns holding Lucas and cooing at him. Janina had arrived in Sapopemba, a shanty-town neighbourhood located in the periphery of Brazil's largest city, São Paulo, when she was seven months pregnant. She had come to live with the baby's father who had originally come from the same part of Northeastern Brazil as she, and who she had become pregnant with when he had returned home for a short period of time to visit his family. When the baby's father had not materialized in Sapopemba, she had rented this room from family friends. Janina explained that she had gone to her doctor at home for at least two or three (she couldn't remember for sure) pre-natal visits, but had been too busy finding housing and work to go for another pre-natal visit in São Paulo before the baby arrived. When she did go into labour, she said, she regretted the decision not to have visited the public health clinic in town. The doctors were rude and rushed with her, chastising her for being ill-prepared to give birth, and referring to her as *Baiana*, a derogatory reference to the predominantly Afro-Brazilian and poor Northeast region of

¹ Except for public figures, pseudonyms used throughout.

Brazil that she came from. The term 'Baiana' signifies these two things. When I asked Janina if she had had a caesarean or a 'normal' birth, she laughed at me and said:

"me? I could never have a caesarean here (laughing), Laurie, seriously? I have no family, no friends, how could I manage a caesarean here? Maybe back home, but here, no. No, for me [pinching her dark black skin between two fingers, as if reminding me in case I had forgotten what colour skin she had] no. Of course I wanted a caesarean, I knew that for me [again pinching her skin] a normal delivery would mean I was hit, treated badly. For me, yeah, a caesarean would have been the best. Of course I wanted the caesarean, who like me wouldn't want the safest way to birth? But no, Laurie, no not for me, not this time".

In many other similar conversations about birthing, children and women's health, Brazilian women often wove together accounts of their health and their birthing experiences with accounts of their skin colour, class status and housing situations, a sum of parts they often described as *nossas vidas na periferia*, or "our lives on the periphery", referring to their geographical as well as their social status in São Paulo. Risk of illness, disease and violence touched numerous corners of daily life, but the risks involved in pregnancy and birth seemed like they made women the most anxious, as if they required the most resources (both formal and informal) to maneuver. It must seem as funny to the reader, as it did to Janina, that I asked her whether she had a caesarean or a 'normal' vaginal birth, as we are used to mapping inequalities in access to maternal technologies onto low-income spaces. But São Paulo, Brazil has one of the world's highest incidences of caesarean births. Compared to a national rate of approximately 30 percent, São Paulo's rates are estimated to be as high as 80 percent in private hospitals and 33 percent in public hospitals (Kilsztajn et al 2007:66). While it is difficult to make definitive claims, the World Health Organization notes that rates over 15 percent are not medically justifiable (WHO 1985). These rates stand in stark contrast to estimates of 1 to 2 percent

in lesser developed regions around the globe where access to medical technology is limited yet the percentage of women requiring caesarean technology is most likely higher due to poor antenatal care and larger obstetric risk (Dumont et al 2001). This global inequality in access to caesarean technology is indeed mapped on to São Paulo where rates are higher in private care venues that serve more wealthy women and lowest in peripheral, or *favela* communities, of the city. Caesareans do seem to be distributed based on socioeconomic status, not via medical need. Studies indicate that low-income women with high-risk pregnancies who would benefit from a caesarean section are less likely to receive one than low-risk, high-income women (McCallum 2005a:222). But rates within the periphery and among low-income women are still high. And, when speaking to these women it is ordinary to hear caesareans described in the most complimentary terms while vaginal births are described as a second-rate and risky option. It is also common to hear of women going to great lengths to ensure their access to caesarean technology, even if this requires covert and surreptitious means.

In my first experiences with women seeking reproductive care both before and after birth at a public primary health care clinic (PHC) in a large low-income community in São Paulo's periphery, I became interested in São Paulo's high caesarean rates. While most researchers, lay-people and the media have explained Brazil's high caesarean rates as being the result of doctors finding caesareans lucrative for business in terms of time, insurance, and cost (Hopkins 2000; Mello e Souza 1994), I began to see that financial incentive on the part of hospitals and physicians could not fully explain the complexity involved in São Paulo's caesarean rates. Women seemed to be talking about the technology in highly positive terms. This was very different from discourses emerging in

the US, where some women were becoming advocates for ‘natural’ birthing, while declining and critiquing highly medicalized and interventionist birthing techniques (see Behague 2002; Johnson 2008). Why did the situation look and feel so different in São Paulo? What could account for this difference?

Dominique Behague (2002), who has also provided an in-depth study of caesarean technology in Brazil, has suggested that while the availability of caesarean technology could increase demand, a simple model of economic gain on the part of physicians coupled with an oppressive medicalizing discourse advocating intervention, seems to reduce human agency to capitalist principles, ignoring as a result how women themselves might be active and pragmatic users of the technology. Her research, then, attempted to understand how caesarean technology was understood locally and how women might benefit, or even seek out, its use. Behague then convincingly argued that caesarean technology is an empowering tool for women that allows them to assert their own “medicalized position” (477). My own research is in full agreement with her suggestion that for some women, especially those who are vulnerable to receiving poor care in the public health system due to their inclusion in racialized minority groups or due to their low social status linked to seeking reproductive care in public clinics in *favela* communities, the ability to achieve control over their birthing experience, via technology, rewards them with higher social status and access to improved care. Her focus on how rituals of health care and birthing, and all the diversity found within these rituals, are linked to involvement in relations outside birthing is another important finding. She reminds us that “as in any ‘system’ based on webs of social relations, these rituals are imbued with moral values, often conflicting, which make social statements” (477).

My own work in São Paulo suggests that the social statements embedded in birthing are about the included and the excluded, authoritative and local knowledge, the city and the periphery, and how risk is perceived and acted upon based on different situated knowledges (Haraway 1988). During the course of my research women explained how a vaginal birth is often a traumatic experience, characterized by physical violence and discrimination (most of these women were part of a racialized minority group). In the publicly-funded health clinics and hospitals, which are usually the only sources of health care in these peripheral spaces, women are often denied medication or anesthesia, castigated for being pregnant and/or are not allowed to have a family member or friend present during the birthing process (Behague 2002; McCallum 2005b; Diniz and d'Oliveira 1998). Further, practices such as episiotomy (a procedure wherein a woman's perineum is cut in order to assist in birth) are still routine in the majority of vaginal deliveries despite the World Health Organization's suggestion that such procedures be used with caution (see Diniz and Chacham 2004; WHO 2003). Additionally, Oxytocin is routinely used to induce contractions. While the use of Oxytocin is known to increase pain, I noted that this was not discussed with patients (see Behague 2002 for a similar observation).

It seems that for these women -as for many women in Brazil- quality of health care and access to services during vaginal childbirth are so problematic, unsafe and confusing to navigate that women argue that any pregnant woman with good sense that is concerned about her and her child's well-being should not accept a vaginal childbirth (Diniz and d'Oliveira 1998). Instead, they suggest that women should seek out caesarean

technology, often via covert and surreptitious means, in order to mitigate the physical violence, risk and insecurity embedded in vaginal deliveries. During my ethnographic field work, however, many women were not able to attain the caesarean they desired, in much the same way that they were unable to attain the level of pre- and ante-natal care they felt they required. For women who did, their explanations about their experiences with caesarean technology reveal that their relationship with the technology did indeed empower them, and that they were certainly not coerced into the procedure. Rather, they felt they had demonstrated a special 'knack' for negotiating a health system that seemed determined not to serve their needs. My own research, then, is largely about the women who did not receive caesareans, why they felt they needed one, and how and why those needs were overlooked. While most previous research on caesarean technology in Brazil has focused on the women who *do* receive a caesarean (Hopkins 2000; Behague 2002; McCallum 2005a), I am interested more in the production of desire for a caesarean, both for women who have received one *and* those who have not. Broadly, my research questions are: How do experiences of violence, insecurity and the adoption of notions of biomedical 'risk' categories shape women's desire for, and interpretation of, caesarean technology? How might risk be an embodied experience for women in the periphery? Can we situate a phenomenology of risk within biosocial and political contexts? How has the societal and political context of the periphery molded women's lives and thus shaped locally contingent meanings and interpretations of caesarean technology?

I consider how pregnant women desire to be labeled 'at risk' during ante-natal care by doctors, nurses and health care technicians in an attempt to gain access to caesarean technology during their birthing process and in order to avoid the

discrimination and physical abuse often associated with a vaginal delivery. I suggest that experiences of *riscos*, or risks, bear heavily on women's pragmatic desire for interventionist birthing. *Riscos*, as it has been explained to me, is a biosocial form of risk: it is experienced both bodily and socially as a physical threat to bodies that is experienced via physical and social violence within the clinic. I aim to explore the phenomenology of risk, and how for women from the periphery risk to body and health is an embodied experience situated within the social and political context in which individual experience occurs. A central ethnographic finding of this study is that women seek inclusion into 'expert' biomedical risk assessments and categories that ordinarily exclude or overlook them. This pragmatic desire to adopt risk labels offers a window into understanding a new range of questions about women's conceptions and negotiations with bodily risk in reproductive health and care. In Chapter 2 I explore this in greater depth. Based on ethnographic narratives and analysis I investigate how women patients reflect on their status as targets of health intervention programming and how patients and doctors each differently conceptualize the risk and violence involved in caesarean and vaginal birthing.

While I am interested in the production of desire for caesarean technology and its links to women's conceptions of risk and quality reproductive care, I am concurrently interested in the ongoing public health interventions that aim to decrease women's desire for caesarean technology. I am interested in the spaces that exist between public health campaigns that aim to lower caesarean rates, doctors in the public health system, and the women who use public primary health care clinics (PHCs): How are public health messages interpreted differently and negotiated between the three? The city is an interesting place to roll-out a large-scale maternal public health campaign: public health

messages are widely distributed and women encounter these messages on television, the radio, and on buses, in the metro and on newspaper advertising (Galea and Vlahov 2005). Additionally, people also use multiple forms of health care. They can access divergent views of public health messages in the public health clinic, in private care facilities, and, if they are low-income, from actual public health agents who visit them in their homes. If they only use the public system, they still no doubt have a neighbour, friend or acquaintance that uses or has used the private system, and messages travel between these networks of people (Behague 2002; McCallum 2005a).

New public health messages and campaigns are being rolled out all the time, but overburdened doctors rarely have a chance to contribute to health policy conversations. For their part, doctors seek out private facilities for their personal and family health care, so the messages they receive about their own health is often different than the public health messages they are being asked to deliver to their patients. Patients are keenly aware of this and are skeptical about accepting the advice of a doctor who is advising them to have a vaginal delivery when they know that the doctor herself chose a caesarean instead. While patients are often suspicious of doctors and their motives for promoting 'natural' birthing, doctors very rarely have the chance to participate in public health policy development. Indeed, in the city, we must address the exceptional complexity of the relationships that coalesce around public health policy development. The involvement of local, national and international NGOs, large-scale actors such as the World Health Organization and the Pan-American Health Organization, and a globalizing media served by novel means of communication, has produced a multi-sited, multi-vocal arena for interaction of exceptional proportions, raising a number of questions about the validity of

the category 'the local clinic'. By introducing this new global cast of agents and a novel range of interconnected locations public health delivery is anything but a simple localized experience between a woman and her doctor. In this way, it would be too simple to suggest that low income women's desire for caesarean technology, and the road blocks they encounter in attempting to access one, is due to a battle of competing conceptions of risk between doctors and their patients. Rather, doctors face their own constraints in the clinic. Doctors explained how their position within the public health system provides them little seniority or credibility in contributing to public health discussions, as 'general practitioners' within the public health system is not considered a "respected" medical profession by doctors who work in the private system. Indeed, it seems as if how risk is conceptualized, and how those conceptualizations are mapped onto health interventions, is being negotiated not just in the clinic, and not just between doctors and their patients. Instead, privileged international actors, organizations and institutions' role cannot be ignored.

In Chapter 3, then, I examine a specific public health campaign, the Humanization of Birth Campaign, and the network of organizations that is behind it. I argue that doctors in the public health system have little ability to actively participate in the construction of interventions, and show how privileged international actors seem to be the dominant players in public health policy development. What I aim to demonstrate is how public health interventions come to be imagined and deployed. I explore the Humanization of Birth Campaign's reverence of natural, normal and traditional (see Johnson 2008) modes of birthing. When we dispose of the archetype of the 'local clinic', we can begin to ask a series of important questions about privileged actors' involvement in public health

interventions. Whether a birth can ever be ‘natural, normal or traditional’ is not the question. Rather, we should ask what these claims mean about the people who are making them, how they imagine their target populations, and how health interventions are crafted and deployed. I argue that the Humanization Campaign is not an objective and neutral intervention but an intervention constructed using a lens that treats not only biological bodies, but also symbolic bodies (i.e. ‘The Third World Woman’).

Methods: The Ethics of Intervention

This research is based on approximately two years of ethnographic field work. My clinical encounters are based on research at a public primary health care clinic (PHC) in the periphery community of Sapopemba, in the city of São Paulo, Brazil. Research was approved by MIT’s ethical review board, The Committee on the Use of Humans as Experimental Subjects. I worked in the PHC as a research intern, and though I always introduced myself as a student of medical anthropology interested in women’s birthing and pre and ante-natal care experiences, most doctors assumed this was just an interesting hoop that American medical students had to jump through in order to become a doctor. While I always corrected this assumption it was never entirely gone, and doctors would (frustratingly) introduce me as a doctor to patients and friends, even as they were concurrently training me to do simple things like take blood pressure. I always corrected this miscommunication with patients and would explain my research. However, I often thought that the distinction between ‘doctor’ and ‘someone interested in women’s health care experiences’ was lost in translation and worried that women might have told me more than they would have told a researcher that wasn’t also a doctor. Certainly women

did make a distinction between me and the Brazilian doctors. This distinction was usually clear very quickly to women, as I sat in their homes, ate their food, drank their coffee and lounged on their furniture (all things that most doctors refused to do, and reprimanded me for doing: “Laurie, that food is disgusting: it is not meat barbeque but cat barbeque, don’t eat it!”). Research was done via participant-observation and semi-structured interviews. Over the months of research in the clinic more than 25 women were interviewed, along with 8 community public health agents and 6 doctors. Many others still shared their stories and their time.

Reproductive issues in Brazil, specifically the high rates of caesarean births, have been placed high on the agendas of Western and upper-middle class organizations that aim to increase women’s equality in the developing world. For these organizations the city is often their first access point to these women and women in the city seem much more intensely targeted by public health interventions than rural women. Numerous organizations, both international and national, have ventured to provide assistance for women’s health issues in Brazil’s biggest cities: Rio de Janeiro, São Paulo and Recife, often with little first-hand knowledge about Brazil or the experiences of the urban poor. Rather, they draw on an armoury of critique and many decades of experience in women’s activism at home. They appeal to the language of gender equality in order to direct funds to public health campaigning and programming that focus on women’s reproductive rights and individual choice. This has had the impact of coalescing the goal of improving women’s health with the politically salient goal of democratic change in a post-dictatorship landscape (see Diniz and Chacham 2004; Diniz and d’Oliveira 1998; Tornquist 2007; Birth International 2007).

As a feminist medical anthropologist myself, I was deeply sympathetic to these organizations attempts to place women's interests at the centre of the birthing experience at the beginning of my research. Post-fieldwork, I can also see how I envisioned my own ethnographic research as a form of intervention itself. I hoped that providing an in-depth analysis of women's own maternal care strategies might inform how to improve women's health programming. I am less sure now that my insights would be well received. While I remain sympathetic to interventions that aim to lessen the suffering that undoubtedly occurs during birthing for many vulnerable women (a central theme that I examine in my research is how power is deployed during these interventions) and how powerless groups in need of aid and assistance come to be constructed. I worry that Western agencies, along with their upper-middle class (and usually white) Brazilian partners do not seem to consider how their knowledge might be shaped by particular historical, cultural and institutional experiences that might not intersect with the experiences of the low-income minority women they aim to help. Neither do they seem to offer up their methods of intervention and critical examination and how they too might be fused to systems of power and inequality.

Theoretical Departures

Caesarean Rates and Public Health

This study builds on an important body of literature concerning public health in Brazil that has detailed the wide scale vulnerability of pregnant women and infant and the lack of support provided to them via health systems and in everyday life (Scheper-Hughes 1992). Brazil's high caesarean rates have been the focus of much of this

scholarly research and policy development during the past few decades, producing highly charged results. Scholars have attempted to investigate the non-medical reasons contributing to the increased use of medical interventions in the birthing process. Studies suggested that attention needs to be paid to obstetricians' professional profiles, including investigation into their medical training, experience, working schedules, health management and organizational structures (Barros et al 1996). Concurrently, researchers began to wonder why women were passively accepting these invasive interventions. One model of analysis suggested that standard obstetric models are dominated by compelling technology and a masculine style which led to gender imbalances and limited autonomy for women to oppose technological interventions (Hopkins 2000). Working mainly with statistical data, formal interviews, and large-scale surveys, these studies have laid the ground work for providing a more nuanced picture of women's experiences during pregnancy and birthing.

What remains to be done is to explore both ethnographically and theoretically the ways that health, and maternal health in particular, have become sites for negotiating the subjective meaning of risk for women and how these risk conceptions are linked to larger questions about distinctions between the centre and the periphery, as well as authoritative versus local knowledge. In São Paulo, caesarean sections, as well as the interventions aimed to lower their rates, seem to be a node where multiple discursive cultural, social and political categories of risk, the body, the 'rich' vs. the 'poor', and technologies of exclusion and inclusion intersect. Indeed, it seems that for experiences as complex as those involved in birthing, models that attempt to explain caesarean rates by seeking out the most salient risk factor (i.e. physician demand, women's preference, or fear of pain)

often prove reductionist. Hopkins (2000) set out to discover what women really thought about caesarean technology. Taking physician influence over patients as a given, Hopkins asked, whether low-income women were being coerced into medicalized birthing procedures by unequal doctor-patient power relationships. Might doctors be framing vaginal birthing within negative terms? Hopkins demonstrated that a minority of low-income women actively verbalized a preference for vaginal deliveries and argued that high caesarean rates are a result of women having little power to resist doctors' claims to authoritative knowledge. Doctors misuse this position of power Hopkins suggests, to compel women to 'choose' caesarean births even though they may prefer a vaginal birth, by intentionally reinforcing fears about the pain of vaginal birth while describing caesareans as unfalteringly safe, efficient and pleasant. Doctors, it is suggested, benefit from this popular 'choice' because it allows them to schedule births in advance, therefore allowing them to attend to more births while suffering fewer disruptions in their professional and personal life (726-727). Hopkins' research design only employed survey research, however. It has been my experience that due to the onslaught of negative media, scholarly and public health attention devoted to rising caesarean rates in Brazil, women are hesitant to respond openly to questions about them, especially when questions come in the form of questionnaires or structured interviews (see Behague 2002). Furthermore, direct questioning seems to hinder a more complex understanding of how multiple factors such as physicians' attitudes, policy environments, hospital settings, and less tangible factors such as gender, race, socioeconomic status, social class and prevailing social representations of the body intersect in women's desire, preference, 'choice', or pragmatic use of caesarean technology (see also Behague 2002; McCallum 2005a).

Other researchers, as well as physicians, have attempted to explain Brazil's high caesarean rates by appealing to a macro notion of culture (Mello e Souza 1994). In these analyses, physicians and women have been said to be caught up in a 'culture of caesareans'. This 'culture of caesareans' is thought to have initiated from well educated, high-income Brazilian women who have become swept up in the project of 'modernity' and who see vaginal birth as primitive. Technological intervention, on the other hand, is a symbol of modern motherhood (Mello e Souza 1994). This conviction is supported in popular media as well. Soap operas that are watched nightly by millions commonly portray natural birth as unbearable, dangerous and archaic, and typically take place in the wilderness or in a historical milieu. This portrayal of natural birth stands in stark contrast to the depiction of upper-class characters that give birth by caesarean section within clean and modern private hospitals (McCallum 2005a). There are many analogous cases in which "culture" is deployed as an analytic that, curiously, freezes and naturalizes historically and politically produced practices, such as the mobilization of "culture of poverty" arguments in the 1960s.

Researchers (see Behague 2002, McCallum 2005a) who have carried out extensive ethnographic inquiry on Brazilian caesarean rates have moved beyond this 'culture of caesareans' argument. They suggest that while many women actually prefer caesarean technology, it is not due to a desire to be 'modern' but is because by using medical technologies they are able to negotiate more control over their health, their bodies, and their birthing experiences. This research coincides with more nuanced medical anthropological perspectives that have begun to reconceptualise medicalization

in more balanced terms (see Rapp 2000; Chacham and Perpetuo 1998; Lazarus 1994; Petchesky 1987; Hunter de Bessa 2006). Rather than conceptualise medicalization as a binary function between an oppressive biomedical authority and a passive woman victim, new studies are recognizing that “medicalization is better understood as an interactive process” (Hunter de Bessa 2006:222). As Catharine Kohler Reissman has argued, we cannot define women merely as passive victims to medical authority (1983:3); rather, we need to understand how women are pragmatic users of medical technology. As Margaret Lock and Patricia Kaufert describe, in their edited collection *Pragmatic Women and Body Politics*, women’s relationship with medicalization is “usually grounded in existing habits of pragmatism. By the force of the circumstances of their lives, women have always had to learn how they must best use what is available to them. If the apparent benefits of a procedure outweigh the costs to themselves, and if the technology serves their own ends, then most women avail themselves of what is offered” (1998:2).

While these arguments to pragmatism are appealing, the analytic risk here is to leave pragmatism as a black box. Many anthropologists have worried about this ‘culture versus practical reason dilemma (see Sahlins 1976). But there are alternatives to the simple call for pragmatism. What I detail in my research is how race, class, age, religious belief and other markers shape decisions in ways that are at once practical and always entangled with symbolic meanings that may have multiple and shifting valences. In numerous conversations with women in both pre- and post-natal care, narratives of the pragmatic desire for a caesarean section are weaved with narratives about their status as Afro-Brazilian favela dwellers and the social stigma that is attached to that status. As Janina, the young migrant from the Northeast explained so well, it is not just that women

consider caesareans to be the safest method of birthing overall, but that positioned as she is, caesareans represent the best form of care attainable. Heather Paxson's (2002) work in Greece exemplifies this kind of analysis. She demonstrated how family planners' attempts to shift women towards the use of "rational" modern contraceptives and away from "irrational" abortions, fell short because they did not consider how local ideas about love, sex and inequalities in gender relations impacted women's family planning decisions.

Still, the flurry of studies emerging from public health over the last few decades on Brazil's high rates of caesarean sections has paid minimal attention to the subjective experiences of birthing and how social relations contribute to the organization of birthing methods and the risks understood to be involved in them. To date in Brazil, public health interventions focusing on caesarean rates have ignored many of the intersecting variables that coalesce around the 'culture of caesareans' or around what appears to be the over medicalization of women's bodies. Indeed, most scholars of public health in Brazil have paid little attention to the connection between socio-economic processes of exclusion with the meanings people attribute to health, illness and disease (see Scheper-Hughes 1992; Biehl 2007, Parker 1991 for compelling exceptions). Outside of literature on Brazil, Adriana Petryna's (2002) work on "biological citizenship" provides a similar case of the desire to be placed in 'at-risk', or other seemingly non-ideal categories: Petryna demonstrates how the bureaucratic and institutional practices in Post-Chernobyl Ukraine have made the label of 'sufferer' a prized designation. This designation denotes a person as ill and disabled, which has become a necessary survival strategy in an environment of impoverishment and hopelessness (2002). Petryna joins a growing group of

anthropologists that have begun to investigate communities around the globe that have endured extensive and/or ongoing violence, and are making the connection between biological illness and “social suffering” (Das et al 2001; Farmer 1992; Kleinman 1973; Kleinman, Das and Lock 1997). In some ways public health literature has integrated socio-political and economic facets into their investigations of certain public health dilemmas. The World Health Organization, for example, defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Yet, anthropological sensitivities about the various and divergent meanings of ‘disease’ and ‘well-being’ to diverse communities are missing from the definition. Consequently, public health research that uses this definition of health as its departure point fail to account for the historically and locally situated logics via which people in everyday situations strategize to maintain their health and avoid disease (Rivkin-Fish 2005: 20).

Health and ‘Risk’

There has been a flurry of research over the past three decades that has focused on risk, its social context and the multiplicity of subjectivities it has cultivated. Paying particular attention to how the phenomenon of risk has derived meaning and significance in particular social, cultural and historical moments, my own research sits in contrast with much of the research today that is focused on ‘techno-scientific’ approaches to risk which is assumed to be an objective and measurable phenomenon. In this techno-scientific approach, risk is conceptualized as calculable by expert and accurate scientific measurement while lay people’s judgments about risk are typically understood as ‘biased and ill-informed’ (see Lupton 1999). In conventional public health research, risks and risk

factors are identified by experts guided by their disciplinary training; they are described qualitatively and then measured analytically using quantitative methods. In the classic epidemiological approach to health risks, a positivist epistemological position is relied upon. Via this methodology risks are considered objective facts that have measurable effects on human health. Research conducted within this framework endeavours to analyze the character, degree, and distribution of health risks (Obrist, Van Eeuwijk and Weiss 2003:268-269).

For example, a guiding conceptual framework, the “mandala of health” (Hancock and Duhl 1988), that stressed the complexity of risk factors involved in urban health, has influenced much pioneering urban health research. The framework suggests that individual health is shaped by the interaction of multiple factors and their interrelationships. Health is the result of a matrix of biological and social factors, such as the body, physical environment, health care options, personal behaviour, lifestyle, and economic status. This web of factors working together is then analyzed at multiple levels – from the household, to the community, to the broader culture. This system adds up to a set of risk factors that are knowable via scientific knowledge and may determine health outcomes, representing a positivist epidemiological position. Over the past two decades we have seen some innovative research reorient this model and approach health using a biosocial lens while leaving the positivist position behind- such as in mental health issues resulting from social origins of distress and violence (Desjarlais *et al* 1995). For the most part however, conceptual frameworks like the mandala of health now live under the heading “population health” and the positivist approach continues to inform this popular strand of urban health research (Obrist, Van Eeuwijk and Weiss 2003:269).

This approach seems incomplete to me. There is clearly a need for research that incorporates people-centered, meaning-centered and power-centered approaches to health risks that compliments biomedical and high-level policy considerations. Notable theorists (see Douglas 1966; Douglas and Wildavsky 1982; Beck 1992; Giddens 1990; Foucault 1991) have posited a conception of risk that suggests that risk cannot be excavated from its sociocultural and political context. Rather, 'risks' as identified by 'experts' (and lay people) are understood as the *outcome* of sociopolitical contexts, and that such 'risks' have a tendency to serve specific social, cultural and political functions (Lupton 1999). Indeed Douglas' (1966) writings on risk emerged from her earlier work on the concepts of purity and contamination where she argued that these concepts help to construct cultural boundaries between social bodies, groups and communities. What is conceptualized as contaminating and polluting are culturally specific categories and these categories help to both construct and preserve notions of the self and 'the other'. Risk then, Douglas and Wildavsky (1982) suggest, acts as a site of blame, wherein 'risky' or 'at-risk' groups are singled out as undesirables and dangerous. A 'risky other', then, might be a threat to their own individual social body or to the larger social group. Foucault's (1991) notion of normalization helps to unravel this further. Normalization, or the process and methods involved in the construction of norms of behaviour and health status, is used to determine who is positioned outside the norm. In much current public health literature those who deviate from these norms are typically labeled 'at risk'. In this way, Brandt's (1987) notion that sexually transmitted diseases always seem to be the diseases of promiscuous men and women is apt.

My own central ethnographic findings about risk are two-fold. First, what the above outlined approaches to risk seem to have in common is an emphasis on risk as a tool of social exclusion – to be positioned as ‘at-risk’ is to be excluded from your own ‘normal’ body, or from the ‘normal’ and ‘healthy’ social body. In my own research, however, the inverse relationship seems to be taking place. In periphery communities in São Paulo, Brazil low-income women are locked in a continuous battle for quality care during birth. They are acutely aware that their bodies, as women of colour, and their position within peripheral favela communities puts them ‘at-risk’ of having a physically and emotionally painful vaginal birthing experience in a public hospital, or, of being denied a caesarean-section if they medically require one. This knowledge of being ‘at risk’ however, due to doctor’s perceptions of their bodies located in a specific space, does not seem to intersect with doctor’s authoritative knowledge over the construction of risk categories. These women’s “way of knowing” about risk is not “knowledge that counts” (Jordan 1978:152-154). What seems to be taking place, then, is that the category ‘at-risk’ is not a label constructed to exclude marginal groups from the social body, but a desirable label, which many women find themselves being excluded from possessing.

This came up time and again during my research at the clinic. Doctors, surprisingly, positioned themselves in ‘at-risk’ categories for their own birthing experiences. Doctora Francisca, a young doctor in her mid-thirties believed that caesarean technology was the best form of care during birth. She had undergone a caesarean-section when she had given birth, and she had regaled me with the story of how she “just knew that hers was going to be a risky birth” and how during her first visit with her obstetrician, in a private care venue, she had told the doctor that a caesarean

would clearly be *medically* necessary for her and they had scheduled one right away. This aligned closely with what other middle or upper-class women had explained to me as well. When middle and upper-class women did undergo caesarean sections they were not describing them as elective or ‘modern’ but were clearly positioning themselves at the centre of risk discourses. Doctora Francisca told me this story after we had just seen a young Afro-Brazilian woman named Laura who was in her first-trimester at the clinic. Laura was clearly nervous about having a vaginal birth and explained her worry by telling us a story about how her sister’s baby had been “torn” from her using forceps. She explained that after her sister’s vaginal delivery a nurse had privately told her that a caesarean would have meant avoiding such an incident and that the doctors should have conducted one but used forceps to save their own time. Doctora Francisca did not believe the story and made that clear to Laura at the time. Later, to me, Doctora Francisca explained “all these ‘Baiana’ girls, they all think they need a caesarean! You think I’m going to waste a friend doctor’s time with that? Imagine! A vaginal delivery is just fine for them”. After this, when I questioned her about her own birth she quickly changed gears, explaining that where Laura was in no way ‘at-risk’, she herself would never risk a vaginal delivery, because she said “you never know what will go wrong, better to have the baby quickly and safely”. In this way, Doctora Francisca, like other upper-middle class women, was suggesting that a caesarean would be necessary for her because she was ‘at-risk’ (due to unknown complications and/or medical history), while women from the periphery, like Laura, were not.

Laura’s story represents was most likely the first in what would be many attempts to convince doctors, nurses and other health professionals that she too be included in the

coveted ‘at-risk’ categorization. A few weeks later when I went and spoke to Laura in her home, a small concrete building in the *favela* community in the valley below the clinic, I asked Laura about what she thought about vaginal deliveries and caesarean-sections.

Laura explained with considerable passion and insight how

“doctors have their own way to make decisions about who needs a caesarean. They ask you lots of questions about things, but they don’t think about the things right in front of them. They all [doctors] give birth in private health system, so maybe they don’t know about the bad treatment to girls like my sister”.

Laura’s insights about what makes a woman ‘at-risk’ during pregnancy and birth are pivotal to my second suggestion about how we reconsider risk. To date, little attention has been paid to how people might understand risk information and construct meaning about risk information in the context of their everyday lives (Gabe 1995). In my own research on ‘risk’ in maternal health in Sao Paulo, I have aimed to place at the centre of my analytical interest the people who interpret facts and experiences, and in so doing construct and reconstruct their own meanings and values about health risks in particular cultural and social contexts. In this way, I am concerned with the personal and embodied experience of risk in health.

Rapp’s (2000) study of amniocentesis is an excellent and guiding example of this kind of research. Her study raises interesting questions about the relationship between risk as a technical and objective dimension communicated numerically and a socially experienced and lived dimension of risk felt via visible suffering (see also Gifford 1986). Rapp’s study of genetic counselling and amniocentesis demonstrates that the risks potentially embedded in a fetus are communicated to women numerically. But Rapp also shows that numerical risk is not neutral – but that its meaning is interpreted differently by

differently situated women. Brandt (2007) also shows how numerical risk is a powerful discourse that statistics have a certain kind of power. Brandt also demonstrates how statistics can be hijacked via epidemiological studies that are contested by corporations or by “moral organizing principles” (Craddock 2000:160) which sway the kind of knowledge and facts that are sought out in medical research, and the kinds of bodies which are constructed as dangerous.

Social scientists have widely studied lay perceptions of health risks in terms of environmental risks (Douglas and Wildavsky 1982; Douglas 1994), reproductive genetic risks (Rapp 2000) and more recently, lay perceptions of risk for specific diseases, like breast cancer (Robertson 2000). The distressing spread of HIV/AIDS has spurred much research into how perceptions of risk influence health behaviours, such as condom use, substance use, seeking out HIV testing, and more (Lupton et al 1995). This research has been helpful and instructive. It aims to formulate models that explain how individual’s beliefs about risk become constructed and then transformed into specific health actions. Another focus of research has been lay versus biomedical perceptions of risk. The concept of authoritative knowledge in the production of risk has been of much interest to medical anthropologists engaged in critical investigation of the social construction and production of knowledge (see Fassin 2007; Greene 2007).

It seems that a significant focus of anthropologists’ work on risk has been the critique of the privileged status of biomedical knowledge, conceived as objective and valid, which is distinct from cultural or social knowledge. Cultural analyses of biomedicine, then, attempt to contextualize the domain of biomedicine by highlighting its

historically and socially produced roots (Scheper-Hughes 1992; Lock and Scheper-Hughes 1987). In her compelling ethnographic account on birthing, Brigitte Jordan (1978) explains how multiple “ways of knowing” (87) exist in birthing situations, as well as in other social situations, wherein some “ways of knowing” seem to possess more authority and weight than others. Biomedicine, in risky birthing experiences, appears to be the knowledge that “counts” (87), while lay perspectives receive far less credence.

The Excluded Periphery

A central theme of my research relies on extensive research conducted in São Paulo that investigates the construction of a geographic and symbolic periphery of the poor and marginalized lower classes. Periphery communities in São Paulo, Brazil, while by no means homogenous, are mainly home to marginalized minority communities that have been subject to historical processes of exclusion and discrimination. The periphery differs drastically from the downtown core of the city, as it is shunned by large businesses and has a noticeable lack of economic infrastructure, such as banks and shopping centers. There is little state investment in periphery districts. The lack of state investment is evident in the deficiencies of necessary physical infrastructure such as water and sewage systems, electricity and roads, and social infrastructure, such as well-funded schools, hospitals and health clinics. The majority of residents are regional migrants to São Paulo, and are disproportionately Afro-Brazilian, from the northeastern part of the country (Caldeira 2000). Unlike in Rio, where symbolic peripheries, or ‘favelas’, sit directly next to wealthy enclaves and are nestled into the centre of Rio’s geography, São Paulo’s periphery is a geographic, as well as symbolic, space. The

growth of São Paulo is analogous to the growth of a tree – with the centre of the city marking the oldest, most wealthy and elite parts, and the concentric outward rings and peripheral areas of the city are much newer and poorer.

The periphery, while marked by its geographic location, physicality and rates of violence and crime, is also marked by perceptions of what the ‘periphery’ symbolizes. Using the term ‘periphery’ often has the impact of fixing the identities of locations in ways that negatively affect the people who live in there – such as in their access to health care and/or job opportunities. Characterizing a community as part of the periphery often identifies it with chaos and squalor (Shubhanigi R. Parkar et al 2003). Peripheral living then marks the status of individuals so that the periphery becomes to be associated not only with dirty and chaotic living, but also with dirty and chaotic people. The ‘periphery’ then, is not just a physical space but also a symbolic space marked by the areas’ racial composition and class status.

Race and class has restricted equality of opportunity and health outcomes for centuries in Brazil. Since colonial times, socioeconomic status of Brazilians has been inextricably linked to race, with white-skinned individuals dominating the highest class levels (Burgard 2004:1129). Women of colour have been particularly affected by these racial and socioeconomic hierarchies when seeking maternal health care in Brazil’s public health care system, particularly in urban spaces where race has become a marker of low social and income status. Due to these structural inequalities, ‘pregnant women’ in São Paulo cannot be understood as a homogenous category (Behague 2002:477). Rather, women are categorized pre-pregnancy by their race and class. These hierarchies -and

their consequences- remain with them during pregnancy and delivery, resulting in inadequate care and higher maternal and infant mortality rates for women of colour who have low socioeconomic status.

The United Nations Development Program (UNDP) defines health equity as “the absence of systematic disparities in health (or in major social determinants of health, including access to healthcare) between groups with different levels of underlying social advantage/disadvantage” (UNDP 2006:29). This definition provides an interesting lens through which to examine maternal health discrepancies in São Paulo. In São Paulo, 16 percent of women over the age of 15 have lost at least one child born alive. However, when this statistic is examined by racial group, the distribution reveals that race is a major factor in child mortality: 33 percent of indigenous women and 20 percent of Afro-Brazilian women over 15 have lost at least one child born alive, whereas this figure is just 13 percent among white women. The affect of race on child mortality rates is even greater among women in the lowest income quintile. In this demographic, 26 percent of women over 15 have lost one child. Again however, when these women are examined by race, additional inequities become apparent: 42 percent of indigenous women and 30 percent of Afro-Brazilian women in the lowest income quintile have lost at least one child, while among poor white women; the figure is just 23 percent (The Pan-American Health Organization 2001:109-111). Furthermore, The World Bank reports that maternal and infant mortality rates are more than three times higher in the peripheral zones of São Paulo, zones that are mainly populated by poor Afro-Brazilians (The World Bank 1999:3; Kilsztajn et al 2007:66).

In São Paulo, non-white groups are disproportionately present in urban slums, the informal economy, the lowest income quintiles and are associated with violence and crime (The Pan-American Health Organization 2001:86). Due to this situation, women of colour in São Paulo are often constructed as less-worthy of health care, typically denigrated as 'the Other' and discriminated against by health care professionals, who are largely white. In fact, health professionals (physicians and specialists) are distributed as follows: 83% are white, 12% are brown and only 1% is black. Among other medical auxiliaries the numbers are only slightly less skewed: 59% are white, 33% are brown and 8% are black (The Pan-American Health Organization 2001:86).

The creation of the public health care system in Brazil - the Sistema Único de Saúde (SUS, Unified Health System) - in 1998 laid the groundwork for a comprehensive antenatal care program across Brazil (The World Bank 2005:1). Despite these health reform efforts maternal health indicators remain unsatisfactory when compared across racial and socioeconomic lines. Although the Brazilian average of antenatal care coverage is high – more than 90% of women receive one visit or consultation and an average of 6 or higher – adequate coverage is not available to all women. If we define adequate care by SUS standards that require the first consultation in the first 20 weeks of pregnancy and at least 6 consultations in total there remains significant disparity. Although 69 percent of women in São Paulo receive adequate antenatal care, in peripheral neighbourhoods 26.7 percent of women receive adequate antenatal care (The World Bank 2005:2).

The periphery, then, has largely come to symbolize a zone of exclusion. Using this analytic of exclusion throughout my research, my ethnography demonstrates how environmental and social contexts interact in shaping local experiences of health for women seeking maternal care. In São Paulo, risk in reproductive health seems to bypass those whose lives are deemed politically and socially insignificant. Agamben's (1995) notion of 'bare life' might be apt here: are peripheral communities constructed as 'camps' and are women's reproductive bodies specifically the targets of non-punishable violence? Does constructing the periphery as a zone of exclusion and the lives of its inhabitants as 'bare life', permit health interventions on bodies and in locations where they might not have been permitted otherwise? While this paper negotiates these questions, there remains an opportunity for further research and analysis here.

Chapter Two: *Call me 'at-risk'*: Women's Local Understandings of Maternal Health and Technologies in the 'periphery'

Risk: 'Walking the Streets, Walking the Halls'

It seems that the themes of risk and the body are critical concepts to investigate in relation to developing a framework through which to understand low-income minority women's experiences with gendered and physical violence in the health care system. The following chapter will explore narratives of subjective individualized risk as the background against which women manage their reproductive health care and needs.

Women in Sapopemba explained to me that caesarean sections were not sought based on 'rational' decision making about the best form of childbirth. On the contrary, public health messages that described vaginal birthing as the safest method of birthing were well-understood. Caesareans, however, were sought as the best form of delivery that women could attain in their own complex socioeconomic and racialized circumstances. Women in Sapopemba reflected on their own position within a racialized group and a marginalized social space (the *favela*). They acknowledged openly how achieving good quality health care was an ongoing struggle that required negotiation skills and a good amount of *jeitinho*, a creative and informal method for getting things done, usually reliant on social wit or 'knack' and the bypassing of bureaucracies (see Scheper-Hughes 1992:188 for detailed account). Many women, if they had not experienced discrimination and/or physical violence previously within the public health system, had a sister, neighbour or other close friend or relative who had, as Laura's experience with her

sister's birth indicates. Because of this, many women noted that any woman who did not at least try to arrange a caesarean for themselves (either by using *jeitinho* skills, or by saving money in order to 'buy one' in the private sector) were labeled 'deviants' by their family and friends (see Behague 2002). Indeed, Júlia, a new mother I first met in the clinic and then again in her home, explained to me that her brother was a technical staff at a near-by private hospital and that he had helped her meet an obstetrician working at the private hospital who arranged an affordable fee for a caesarean delivery. While the caesarean did require Júlia to spend most of her savings and to borrow money from her brother, the opportunity to have a caesarean in a private care facility was something she could not pass up. Júlia elaborated, "I would have spent any money to have the caesarean; people would have thought I was crazy if I hadn't". It was, however, also noted that oftentimes methods to attain a caesarean did not work and that a vaginal delivery was the only option available for many women.

Viviane, for example, a fifteen year old new mother, who I met on a routine home care visit with two community public health agents and one doctor, told the doctor that she had been forced to walk the hallways, and had been denied a bed at the hospital during her delivery. She explained that she had arrived late into her labor at the hospital, and that while the hospital had admitted her no delivery bed had been available. She said that though she had been in incredible pain and was scared and alone in the hospital without her mother or any family during her first birthing experience the doctors had made her walk up and down the hospital hallways, had refused to administer pain medication and had made snide comments to her about how she "...hadn't minded walking the streets, so why do you mind walking the hallways" suggesting that she had

become pregnant while involved in sex work. Upon leaving Viviane's house, the doctor I was working with, Doctora Debora, complained that "...these girls, they don't know anything about giving birth, they just complain, they don't understand that the doctors make them walk to help speed up the pregnancy - they just want us to give them all caesareans", asking me "do you think the public hospital can afford to do that for *these* women"?

A few things seem to be happening in this story that need further explanation. For one, Viviane's explanation that she had gone to the hospital late in her labour is a specific strategy associated with her *jeitinho* skills to attain a caesarean (even though in this case it did not work). Women from the periphery districts of São Paulo who depend on public health services typically gain knowledge about available birthing facilities and the routine techniques and practices employed by health professionals via local narratives and sharing with other women. This is a kind of "health services lore" (McCallum 2005b) that all women seem familiar with, even if they have never given birth. It is gained through exchange and conversation with other women and from personal experiences. This lore moulds women's expectations and their preparation for the delivery experience. It has become common knowledge among women that finding a public hospital to admit them to give birth in is exceptionally challenging. Based on other women's advice, parturient women typically stay at home after labour has begun, waiting for the periods between contractions to become shorter, with the knowledge that if they arrive at a hospital late into their labour, a woman will maximize her chances of being admitted and having a quick caesarean performed due the lack of hospital beds. When admittance is not possible because there is no bed available, even in late-stage labour, nurses will direct

women to a public pay-phone, and give out the telephone number for the public health service “Dial-a-Maternity”². This begins a search that usually involves visiting up to three hospitals before finding a bed. Some Brazilian human rights activists have named this search for a hospital bed the “pilgrimage to death” (Diniz and d’Oliveira 1998), as many women have died while in labour and seeking medical attention (see McCallum 2005b for in-depth review of ‘Dial-a-Maternity’).

Secondly, what was particularly interesting about the comment from Doctora Debora concerning public health care’s inability to give ‘these’ women caesareans, was that she did not contest that a caesarean was the preferred form of birthing. In fact, during a previous conversation with her, she explained to me that despite what she tells patients, she herself would have a caesarean if she ever had children. In her explanation of why, however, she did not couch her desire for requiring a caesarean because it reflected her social-status (Doctora Debora came from an upper-middle class family), but instead explained to me that because she was petite, and sometimes suffered from feeling light-headed she would be ‘at-risk’ during a vaginal delivery and therefore would need a caesarean birth. In this way, she was actively placing herself in at-risk categories, but excluding her patients from the periphery and denying their own localized and embodied knowledge about risk.

A few days later I visited Viviane again, this time on my own, to speak with her about her birthing experience. Viviane explained that she hadn’t been surprised when the doctors had suggested she was a sex worker. Instead, she described how she is cognizant

² “Dial-a-Maternity, or ‘Disque Maternidade” is a public health service that was introduced after a maternal mortality commission that occurred in the 1990s. Informants complain that the program does not work (McCallum 2005b).

that her body (being Afro-Brazilian) and her position (within the *favela*) put her at risk of discrimination and violence within the public health care system. She attributed her experiences to a form of ‘exclusion’:

Viviane: We are excluded. We are not part of the doctor’s life. They come from outside of our community. They get to have a caesarean. Get to have good health. I know that birth in the public health is risky.

LD: What do you mean ‘risky’?

Viviane: My body, me, in this place, is what makes it risky – they see me and they won’t give me good care. The doctors, they tell you about high blood pressure or diabetes and maybe these things are reasons why you need a caesarean, but they don’t understand that I am at risk too – I need a caesarean too, because my birth is going to be bad, very bad.

A key feature of the birthing experience for these women is exclusion and risk.

Women’s narratives describing this ‘risk’ were different from other explanations of risk I had heard my own peers in the US and Canada speak of while pregnant, or how popular media had explained it. It did not seem as if ‘at-risk’ was a category that women wanted to (or were compelled to) avoid. Rather, it seemed that ‘at-risk’ might be a prized designation, since it was an acknowledgement that birthing can be traumatic and challenging. Being ‘at-risk’ is a promise or guarantee that they would receive the best form of quality care – two things that women often felt were denied them. For example, two sisters, Margarete, who was twenty-six with four children all by caesarean-section, and Vanesa, who was twenty-two with two children both by vaginal delivery, and currently pregnant, explained that in their birthing experiences, all they were searching for was “God’s grace” in the form of good quality reproductive care- which for them meant a caesarean birth. Margarete noted that she had “good luck” with her births (because they were all caesareans), but that her sister Vanesa had suffered with her

vaginal births. Vanesa explained that she was nervous about the ‘risk’ involved in giving birth again:

I know I am at risk but the doctors don’t see that, they just see me and dark skin, here in Sapopemba. My birth won’t be called a risky one, but it is risky for me because I am just poor and black...they should give me a caesarean, my doctor [at the public primary health care clinic] should help me get a caesarean, she should say I need one. But that won’t happen, because she doesn’t understand anything.

It is clear that women are cognizant that their status as “poor and black” translates into a higher risk for discrimination and/or physical abuse during their birthing experiences. The use of the public health system in Brazil carries a large stigma, and is a decisive sign of class and status. If a woman or her family is not covered by private health insurance she and her family must use the over-crowded and under-funded public health system. In this way, women are adamantly in agreement with Behague’s (2002) contention that pregnant women in Brazil are not a homogeneous category (477). Rather, women understand that they are categorized pre-pregnancy by their skin, class and status, and that these designations follow them in their struggle for quality reproductive care.

Exclusion from risk, not via risk: “Help me, please”

In the public primary health care clinic (PHC) I often participated in the “12-day check-up” for new infants, an antenatal program wherein mothers were encouraged to bring their babies into the clinic for a check-up around 2-weeks after birth. The check-ups were typically a half-hour long with the doctor checking the baby’s weight, height and reflexes and speaking to the mother about exclusive breast-feeding, as mother’s were known to supplement almost immediately with formula or water. Mothers were also checked for any infections after undergoing an episiotomy. When Analisa came into the doctor’s office with her new infant, after waiting more than three hours in the waiting

room (a typical wait), both she and her baby looked grossly tired and malnourished: Analisa's eyes were severely bloodshot. She looked like she had been crying, hadn't been sleeping, and was at the end of her rope. One of the first things she said to us was "help me, please you need to help me, help me, help me". Analisa explained that her new daughter wasn't sleeping, wasn't eating, that she herself was desperate for the crying to stop, and was listless and tired. The doctor dismissed Analisa's concerns and told her she would have to get used to motherhood. The check-up with the infant did not go well either. The infant was fairly unresponsive during the check-up and was showing signs of slower development (underweight, not meeting the growth charts for height, and poor reflexes). This was a clearly a case for intervention on the part of the doctor who appeared to recognize this. The doctor, Fransisca, who was a young doctor from the centre of São Paulo, did the reflex test three or four times during the course of the check-up as each time there was no response. When the check-up was over, however, Fransisca sent the woman home, with no future appointment scheduled (I thought that she would have set-up an appointment with one of the social workers at the clinic), no recommendations for the mother about her or her baby's health and without mentioning the signs of slower development. After the appointment I questioned Fransisca about this, "why didn't you do something", I asked. Fransisca's response was that the woman was poor, there was little chance that she would have followed any of her recommendations, and that "really, Laurie, this woman is from the favela, what I am going to do for her or her baby?" So, with little fanfare, a women who was clearly not managing life with a new baby well, may have been suffering from post-partum depression (something that is only ever talked about among upper-class women, and I

never heard discussed in the PHC), and whose child was clearly under-developing, were not classified as ‘at-risk’, or worthy of follow-up care. Later that day I overheard Fransisca complaining about the check-up to a fellow doctor. Both acknowledged that the child and mother were indeed in a precarious, or risky position, but neither acted on these concerns.

Perceptions of exclusion were also embedded in women’s scrutiny of multiple public health campaigns that target low-income women and aim to drastically lower caesarean rates (Behague 2002). Women from Sapopemba argue that the primary motive for these campaigns is not to reduce caesarean rates but to lessen the financial burden that doctor- and cost-intensive caesareans place on the public health care system. In interviews many women expressed that they perceive the policies of these campaigns as a form of “gate-keeping”. Their analysis is compelling. These women are cognizant of the fact that lower income women have been more intensely targeted by the campaigns. This is because while the highest rates of caesarean sections occur among wealthy women who have the financial capacity to seek care in private venues, public health education typically targets the poor. Played out on the local level, de-medicalization policies and programs get channeled through the public health care system towards poor women, sharpening a perception among poorer women that medical technologies and the best-care practices are being safeguarded for the rich (see Behague 2002 for further discussion). Again, it seems like women understand these campaigns as attempts to limit who has access to ‘at-risk’ labels. Many women suggested that the campaigns attempt to make women believe that ‘natural’ births are safe and desirable while denying the risks that women understand are central to their experiences with vaginal deliveries.

In sum, it seems that the meanings embedded in reproductive technologies cannot be assumed outside of local experience and context (de Bessa 2005). In the urban Brazilian context where I conducted my research, ethnographic examinations have revealed that differently positioned women interpret, oppose, reshape, or embrace reproductive technologies in ways that intersect with multiple facets of identity. While the fact that interpretations of technologies often intersect with identity articulation (whether that identity is self-fashioned, imposed, or some combination of the two) has been noted by several other researches (Rivkin-Fish 2005; Paxson 2002; de Bessa 2005; Behague 2002) , what remains to be answered is how, or if, interventions can accommodate such articulations. Reproductive health policy and programs often overlook the views of poor and marginalized women (Sen, Germaine and Chen 1994; Sadana and Snow 1999). However, if we aim to understand how existing medical interventions add or subtract from these women's health needs, women's own understandings and conceptions of their maternal and reproductive experiences, and the risks embedded within them, need to be incorporated into our analyses. Can interventions negotiate what cross-cultural ethnographic research has revealed: that the conceptions, meanings and organization of reproduction and its risks are highly culturally specific, and that, accordingly, notions of reproductive rights and empowerment may not be culturally commensurable? (Hunter de Bessa 2006).

Chapter Three: Normalizing ‘Normal’: Public Health/Biomedical Perspectives on Maternal Health and Technologies among the Urban Poor in Sao Paulo, Brazil

Women’s groups, both national and international, have been active interlocutors in the movement to improve maternal health, decrease caesarean rates in Brazil, as well as to publicize the physical and emotional violence that seems to characterize vaginal birthing among poor women (Diniz and Chacham 2004; Diniz and d’Oliveira 1998; Dias 2009; Tornquist 2007). Taking as their starting point quantitative indicators of maternal and infant mortality, feminist organizations have come together over the past three to four decades to ‘deliver’ to Brazil’s maternal health care system a more ‘humanized’ approach to birthing and maternal care. These groups have advocated loudly and successfully for maternal health laws in Brazil that both ensure a positive birthing experience and empower women to make their own decisions regarding birthing methods, pre and post natal care, and family planning. High rates of caesarean sections seem to be one of their biggest concerns. With high rates of caesareans and women’s desire for them standing in as a symbol for all that they argue is wrong with birthing in Brazil -dictatorial physicians, lithotomic birthing position³, high rates of maternal mortality, inadequate post-natal care, and so on. The reduction of caesarean rates seems to be many organizations’ main goal as they understand high caesarean rates to be the main obstacle to shepherding in more midwifery and doula care, which they argue is necessary to lowering maternal and infant mortality rates. One of the earliest feminist partnerships with Brazil’s Ministry of Health (MH) was the Integrated Woman’s Assistance Health Program in 1983, which although

³ Perhaps the most recognizable position for child birthing: the woman is laid on her back, with her knees bent and positioned above the hips, with feet occasionally in stirrups.

had little impact on maternal and perinatal indicators, resulted in the ‘Natural is Normal’ public health campaign in 1988. This educational campaign was rolled out along with financial assistance in public health facilities for analgesia for vaginal deliveries and payment for births assisted by nurse-midwives. Furthermore, many MH publications resulted from the campaign, including, “The Rights of the Pregnant Woman” in collaboration with the Health and Reproductive Rights Feminist Movement, the translation and distribution of the World Health Organization’s recommendations for Normal Birth Assistance, as well as a booklet entitled “Working with Traditional Midwives” in collaboration with the feminist Recife-based NGO Curumin. Other interventions adopted by the MH due to feminist urgings were the creation of a prize for public maternity services that achieved the most ‘humanized care’, financing the opening of birth centres, the training of midwives and doulas, and a changed definition of ‘caesarean rate limits’ in the public system from 40% to 25%. Additionally, the Humanisation of Childbirth Program was developed in an attempt to lower caesarean rates and to ensure at least six pre-natal care visits and HIV testing for all pregnant women in public clinics (see Birth International 2007).

One of the largest NGO networks I have worked with in São Paulo concerning ‘humanisation’ is REHUNA (Network for the Humanisation of Childbirth), a group of health professionals, childbirth educators and ordinary women (typically white and upper-middle class) who came together in 1993 to begin to protest Brazil’s high caesarean rates in private health care clinics. Since their founding they have broadened their scope to include a concern with maternal and prenatal mortality rate in Brazil over all. However, their main goal remains to lower caesarean rates by diminishing

unnecessary medical interventions and promoting pregnancy and childbirth care based on “the comprehension of the natural process of childbirth”. REHUNA has grown considerably since 1993, hosting two international conferences on humanised birthing, attracting the attention of the World Health Organization, the Pan American Health Organization, and also midwifery schools in the United States and Canada. REHUNA is now an international network of feminist health practitioners and concerned women who often work in partnership with Brazil’s Ministry of Health (Birth International 2007).

When I arrived in São Paulo on my first research trip in 2006 I, like REHUNA, was concerned about Brazil’s high caesarean rates. I was interested in how doctors might be pressuring women into c-sections in order to lessen their work load and save their hospitals and clinics time and money. I was concerned that Brazil’s Ministry of Health was not doing enough to support the training and work of midwives, nor the voices of poor women who I felt were being coerced into highly medicalized and oppressive birthing situations. I was concerned that biomedicine - with its diagnostic focus on biological processes, and its therapeutic model of situating pathology in the body and self – might obscure power relations inherent in highly medicalized birthing situations. I was concerned that biomedicine presented itself as humanitarian, as a neutral supplier of objective truth and in doing so bracketed out relations of domination. These concerns of mine about the over-medicalization of women’s bodies had been informed by feminist literature that had for some time convincingly argued that the medicalization of women’s bodies had standardized medical intervention into and defined as pathological what should be normal events in women’s lives such as menstruation, pregnancy and menopause (Purdy 2001:249; see also White 1991). These feminists have also argued that

the medicalization of reproduction is a type of biopower, which they understood as an insidious form of social control, masked by benevolence, which oppresses women and maintains unjust social conditions (see Sawicki 1991).

This understanding of biopower, however, is very much a caricature of what Foucault intended when he used the term. Foucault (1980; 1988) argued that power has become less visible and less perceptible since the time of repressive sovereigns that characterized political order in eighteenth century Europe. The construction and deployment of authoritative knowledge has become the central mode for discipline and control. The individual body, as well as the societal body, have become the target of knowledge/power deployment, not just by states, but also by experts and institutions that have constructed various modes of normalization, standardization and order. The term *biopower*, as Foucault intended it, meant that this knowledge/power that was derived from discipline and control of individual and social bodies, such as women's reproductive processes. Regimes of experts made biopower their goal. They became concerned with monitoring, improving, and intervening on the "population" and individual persons for the 'good of society' including in areas of health and wellness. For example, 'normal' ways of acting and behaving were imagined, and the care of 'self' became associated with being a modern and responsible citizen. In this way, Foucault describes how biopower became a form of self-discipline wherein individuals monitored and ensured their own 'normality', rather than being coerced into certain arrangements.

Medical knowledge, as a principal expression of biopower, became a site of critique for many feminist scholars, as I documented above. And indeed, had I remained

interested in documenting the medicalization of women's bodies in the public health care system, there are plenty of examples of the disciplinary methods of doctors and institutions intervening in women's reproductive lives that I could have written about. However, early in my fieldwork I began to feel differently. Fieldwork in the clinic complicated the picture enough so that the analytic of medicalization began to feel insufficient in its ability to explain the complex interactions I was observing. For one thing, there appeared to be no simple binary opposition between powerful doctors and victimized patients, rather, I was struck by the manoeuvring and negotiations both patients and doctors seemed to be engaged in. Women patients acted strategically to ensure a caesarean birth, often via covert and surreptitious means. At the same time, doctors seemed to be negotiating what risk, in the clinic and in their daily lives, meant to them and their patients.

Concurrently, I was surprised to learn about the interactions of powerful national and international public health actors within the 'local' clinic. I began to think about the meaning-making occurring within claims about 'natural', 'normal' and 'traditional' birthing methods being the best modes of birthing for poor women at the clinic. While so many previous studies in Brazil had linked caesarean technology to the medicalization of women's bodies as a coercive form of biopower, I became interested in the biopower involved in *de-medicalization* interventions. As I describe in greater detail in the previous chapter, women at the clinic often complained to me that these 'Humanisation' health programs seemed more hindrance than help, as most women interpreted 'humanisation' as a form of gate-keeping preventing women from accessing caesarean technology (which they understood as the best form of care). Their argument resonated with me, not

because I believed that feminist health practitioners wanted to prevent access to good quality care for these women, but because it seemed curious that ‘natural, normal and traditional’ birthing methods had become such a powerful lens to view and organize interventions around that local women’s own concerns and desires about the birthing process seemed to be being ignored. Why were de-medicalization policies so popular among privileged public health actors? Why were privileged women expressing their discontent with technological interventions on poor women in the language of ‘nature’, ‘tradition’ and ‘normalcy’? And why did it seem as if these policies, intended to empower women, were using the language of freedom and rights to construct a new mode of authoritative knowledge?

While the previous chapter focused on women’s own experiences with de-medicalization policies, and what this means in terms of their conceptions of risk in health, what I plan to focus on in this chapter is this ‘return to nature’ (Johnson 2008:890) that seems to be descending on the ‘local’ clinic via privileged public health actors, and how doctors in the clinic are responding. I suggest, drawing on well established literature, as Johnson did, that “reverence for the natural is a political claim” (2008). While this is not new argument and the politics of reproduction and the political nature of ‘nature’ have been well studied (see Johnson 2008; Ginsburg and Rapp 1995), it is important nonetheless to evaluate how this bears on the clinic. I suggest that the Humanisation of Birth Campaign is not a neutral intervention. In a context where global health interventions are meant to be both improve overall health and empower marginalized women, how can we acknowledge the deployment of power and inequalities that are necessary to make such interventions possible? I focus here on the conceptions of ‘target’

women by interveners, as well as what the focus on ‘empowering’ women via attempts to re-educate and change their attitudes and behaviors concerning birthing suggests about urban health interventions in general.

The Political Nature of Pregnancy: How Public Health Intersects with the ‘Local’ Clinic

Over the past few years of field work I have had the opportunity to see many of these ‘humanisation’ campaigns in action, have interviewed a few active feminist advocates, participated in ‘humanisation’ workshops for health care providers, and also seen how these campaigns unfold (and continue to unfold) in the public clinic. My first encounter with the Humanisation Campaign was actually not in São Paulo but in Recife, North-eastern Brazil’s largest urban centre. In Recife I met with Paula Viana, the Executive Director of Curumin, an NGO that trains women to be traditional birth attendants (TBAs) and supports the efforts of current TBAs. Curumin and Paula Viana are major actors within REHUNA, and while Curumin’s work is limited by lack of funding, they have received increasing attention and support from the international community, resulting in partnerships with Brazil’s Ministry of Health, involvement in multiple international health-related conferences, as well as attention from North American Midwifery Schools, including Canada’s largest midwifery school at McMaster University.

When I met with Paula, she explained that reviving traditional methods of birthing was key to reducing caesarean rates, as well as reducing maternal and infant mortality rates. In a language with which I had come to be familiar with in midwifery

publications, Paula explained that “teaching traditional methods of birthing which ensure that poor women have positive and meaningful natural and normal births is my goal”. Paula talked about how appalling the routine care women received in the public health system was. While speaking about the routine episiotomies that women had to endure during childbirth, she equated an unwanted and non-medically justified episiotomy with an unjustified caesarean, saying “they [doctors] are literally cutting these women up and sewing them back together for sport”. Paula, it seemed, was not thinking about each individual procedure, or about each individual women and their individual needs. Rather, it seemed that during her impassioned speech to me, she was linking together diverse situations, technologies and women to construct a larger narrative about the dehumanized, poor woman in Brazil. This image served her purposes well, as she explained that the cure to this situation was women’s empowerment, self-determination, and, thus, a less medicalized birthing experience. At the time of my visit to Curumin I could not have agreed more with her, and when I met Juliana, a young teenage mother who had come to the Curumin clinic (a one-bed facility in the NGO’s main office) to give birth, I mostly dismissed a line I wrote in my field notes the night after accompanying her during delivery: Juliana said that she “would have been happy with either this [a natural birth at Curumin with a midwife] or a caesarean, but a vaginal birth in a public hospital? No, that would be terrible, not an option”. It wasn’t until more than a year later that I would consider what this comment meant: that perhaps for Juliana, Curumin’s natural birth and a caesarean were really the same thing – they represented the best possible care, while a vaginal birth in a public hospital represented violence and risk. This, however, was not quite Paula’s vision for Curumin. Paula explained that women needed to be

“taught to see how caesareans are dangerous – they need to be educated about the natural and normal processes of their bodies and how returning to traditional methods of birthing means becoming in touch with what our bodies [as women] are meant to do”. In this way, while Paula was certainly concerned with lowering rates of maternal and infant mortality, one kind of violence against women, her main concern seemed to be what she considered the violence of the caesarean-section, without consideration for the violence inherent in vaginal births from which the caesarean seemed to be protecting many poor women of colour. Indeed, it seemed inconceivable to Paula that any empowered or educated woman would ever actively choose a caesarean birth.

Later in the same month, I attended a two-day workshop in São Paulo organized by REHUNA on the training of birth doulas (birth assistants who provide non-medical and non-midwifery care, and emotional and physical support during and after birth for women). The first day of training centred around REHUNA’s ideology, mainly the importance of a return to natural and traditional methods of birthing for Brazil’s women. A feature length movie, filmed during the 1970s in the United States and Russia, was screened for the attendees. The film was meant to set the tone of the day and to be a visual representation of what we would be learning at the workshop. The film’s aim was to demonstrate the ease of giving birth for women if natural methods were resumed, with an emphasis on the idea that women already know how to give birth; that it is a natural process that each woman, with the help of a midwife, can control herself. The film featured water births, in bath tubs and lakes, as well as birthing in a squatting or kneeling position, as opposed to the supine position that women are typically required to take in hospitals. All of these methods were attributed by REHUNA as birthing techniques still

used by traditional birthing attendants in Brazil's Amazon. At the time, I did not think twice about REHUNA's linking of these techniques to indigeneity as a marker of their naturalness and normalcy in a room full of affluent white women training to become birth doulas. Today, however, this raises a number of questions for me about privileged actors' involvement in public health interventions. Whether a birth can ever be 'natural, normal or traditional' is not the question, but rather, what do these claims mean about the people who are making them, about how they imagine their target populations, and about how health interventions are crafted and deployed?

Margaret MacDonald reminds us that "identification with tradition is often used as a rhetorical strategy in political struggles of the present...or as a political symbol" (2004:50). She goes on to say "In other words, calling something a tradition creates a sense of authenticity and ownership for the group making that claim. To understand tradition as invented does not invalidate its authenticity, nor the right of a group or culture to claim it, but rather draws analytical attention to the processes of its production and use" (2004:51). MacDonald's comments make sense considering what Johnson describes as the culture of midwifery's simultaneous reverence, appropriation and devaluation of the myth of the primitive or Third World Woman as closer to nature (2008:901). As Nestel elaborates "Indigenous Latin American women have been awarded a particularly revered status in natural childbirth iconography...The theme is that women in the West have lost the innate ability to give birth naturally, while those in Third World, frozen in time, have retained it" (2006:73).

It seems then that we find ourselves on well-trodden ground. The Humanisation Campaign, as a feminist health intervention, is bonded to long-standing identity politics, and how the campaign is deployed and depicted is not based on objective health data, but demonstrates how health is interpreted, how health statistics are collected and broken down, and how women negotiate their relationship with biomedical technologies through the rubrics of gender, race, socioeconomic status and prevailing social representations of the body. Indeed, the ‘local’ clinic is often a place where many of these issues are reckoned and contested with, when public health campaigns (imagined and constructed on the outside) intersect with competing ways of knowing.

Public health interventions imagined by Western bodies or privileged Brazilian organizations do not just contrast target populations’ concerns about birthing, but often with doctors and public health agents conceptions as well. In conversations with doctors about the humanisation campaign I would often come up against their indifference to the campaign and its intentions. When asking about the Humanisation Campaign, most doctors would suggest I go and speak to REHUNA. It proved frustrating to explain to doctors that I wanted their opinions on the campaign, caesarean rates and what the best form of care was, not just REHUNA’s. When I spoke to doctors about caesarean rates and they acknowledged that they were high and that they promote “normal deliveries” to their patients, they would often explain in the next breath that they themselves would never deliver vaginally and that a caesarean is what they planned to have. This explanation was typically coupled with a medical rationale for why they required a caesarean and why they did not fit the normal category. Towards the campaign most doctors were apathetic. In one instance, trying to explain to a doctor that I wanted to

know what she as a doctor thought of the campaign, the doctor pulled out a box of dusty pamphlets and booklets on natural birthing and the dangers involved in unnecessary caesareans and then said quite earnestly “These might help your research. Do you want these? Take as many as you like. They explain the whole campaign. I don’t need them, I’m not going to hand them out”. In this one act much was explained about the lack of trust women patients have when doctors advise them to deliver vaginally: doctors were not taking their own advice and when they did advise women to deliver ‘normally’, they did so without providing further educational materials, making it further seem as if the Humanisation Campaign was just another road block for women to overcome in their attempts to acquire a caesarean.

One of the issues in translating public health policy into the clinic is the inability for public health actors to access doctors. Directors of Public Health Clinics are often nurses, not doctors, raising issues of power and authority. Doctors are uninterested in directing clinics as there is no prestige in this work, only added hours. Nurse-Directors often find themselves in a weak managerial position, as they feel they do not have the authority to oversee the activities of doctors including their attendance at work, their patient loads or whether they are keeping up-to-date on public health training seminars or education programs. This situation is further complicated by the fact that most doctors work in the public system for only a short time. Many work in the public health system while continuing to go to medical school part-time while working towards a medical specialization. This means high-turnover and a general attitude among doctors that they are only working in the public health system for short-term employment. Over a three year period in the clinic where I conducted my research I have seen at least three doctors

move to the private sector, mainly replaced by young doctors fresh out of medical school who aim to do the same thing.

This chapter demonstrated how public health interventions and campaigns come to be imagined around constructions of nature, normalcy and tradition that serve certain interests and are produced in particular contexts. The Humanisation Campaign is not an objective and neutral intervention but an intervention constructed using a lens that treats not only biological but also symbolic bodies (i.e. 'The Third World Woman') (Mohanty 2001). In many ways, the 'humanisation' of vulnerable women's bodies and birthing experiences intersects with many of the social statements that seem to be embedded in birthing experiences: we see questions of exclusion and inclusion, risk and security all being grappled with, both for the women that the Humanisation campaign targets and those that imagined it. In the Humanisation Campaign bodies and biology are situated within a larger matrix of culture, society, history and political economy as nodes or pressure points (Arronowitz 2008). Doctors' attitudes further represent how the clinic is a contested space: the public health clinic is really a multi-sited stage where international, national and local conceptions of health and risk compete.

Conclusion: Thinking About Embodied Risk – How Can Feminist Health Interventions Be More Effective?

In my research I have aimed to add to the budding literature on risk experiences and also the construction of ‘at-risk’ categories to serve certain social ends by exploring how lay-knowledge about the risk of physical and emotional violence and discrimination embedded in reproductive health provision for low-income minority women has fostered an embodied risk that is most often ignored. Using Merleau-Ponty’s perceptual phenomenology and specifically his notion of “reversible flesh” (1945), or the ways in which we feel ourselves and perceive through the body, I suggest that for low-income minority women in São Paulo’s periphery risk is experienced and understood bodily, guiding women’s risk prevention strategies (i.e. seeking out caesarean technology).

I suggest that ‘risk’ has become a dominant signifier of exclusion but not in the way that risk has traditionally excluded ‘deviants’. Instead, *riscos* appears to be a powerful discourse which is allowed for the rich but limited for the poor. It is a powerful medical space or discourse that is being denied to women who seek an expression or acknowledgement of their uphill struggles in receiving adequate reproductive care. But while risk seems to be an exclusive categorization in the clinic, I suggest that women are reshaping the subjective meaning of risk for themselves and fostering an embodied conception or sense of it. While poor women from the ‘periphery’ find themselves embedded in an ongoing struggle for quality care involving negotiations with health institutions and actors, *riscos* seems to be the idiom of expression for this struggle. What this suggests is that ‘risk’ in health can not be quantified or narrowly defined, as women’s responses to risk, or interventions aimed at lowering risk, can be understood neither as

singular or universal. In Brazil conceptions of risk seem to emerge from a complex milieu of identity markers, society and culture. Jessica Gregg's (2003) recent ethnography on Brazil explores risk in health care as well. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*, attempts to explain the world's highest rates of cervical cancer by investigating the links between suffering, disease and intervention. Gregg explains how pap smears, an intervention targeted at poor women, has become associated with the socially marginalized meaning that rich women will not have them and poor women feel shame and degradation in receiving one. Gregg deftly employs Sandra Gifford's (1986) insight that risk rhetorically floats, mediates and expresses the liminality between health and disease, becoming a substitute for the concept of cause (217). Mary Douglas uses the notion of liminality to explain how blame and perceived sin denoted those things that were "out of place" (1966) and later explained how "well-advertised risk generally turns out to be connected with legitimating moral principles" (1986:60). It seems here that Gregg is suggesting that those who pronounce 'risk' (detected via a pap smear) are almost never included in risk categories themselves. In my own case, while the designation of *riscos* does legitimate 'moral principles', the moral principles on display here are that socially marginalized women are excluded from the label 'at-risk' while middle and upper-class women receive the label 'at-risk' to denote their moral legitimacy and modern status.

While very different, what both Gregg's and my own ethnography implies is that illness, disease, technological interventions and spaces of risk are refracted through contested social statements about the included and excluded, the city and the periphery, the rich and the poor. At a theoretical level, it seems that the themes of risk and the body

are critical concepts to investigate in relation to developing a framework through which to understand low-income minority women's experiences with discrimination and violence in the health care system. Their bodies are social and historical constructions, in addition to being biological entities that change across time and space (Bordo 1993). Human bodies and the risks they face must be contextualized within the lives of individuals, situated within specific cultures and through the matrix of class, race, gender and age inequalities. Meanings and values are understood to be constructed upon and through the body and the physical sensations it experiences. The concept of embodiment helps us to approach risk and the body in this way by allowing us to theorize a multifarious set of relations along a spectrum from the biological to the social, which continually reproduces living bodies and bodily risk. Marcia Inhorn's (2003) ethnography on in vitro fertilization in Egypt provides a similar example of how science and technology are shaped by local (as well as global) discourses on biomedicine. Specifically her notion of embodiment, which suggests that women carry within them a "body history" of suffering (186), is an excellent concept to think about how risk becomes embodied, due to previous experiences of violence and discrimination, as well as stories about suffering told by female friends. Many theorists of the body have reminded us that the body is not ahistorical, and that we should not, therefore, refer to one "female body" within biomedical knowledge (Bordo 1993). Instead, we must recognize women's embodied experiences as historically located and shaped via diverse biological and social sites. Fassin's (2007) ethnography on HIV/AIDS in Post-Apartheid South Africa points in this direction as well. Fassin notes that memories of apartheid are embodied, in that the facts of history inform both subjective and objective experiences of

the past. An interesting direction in São Paulo then, would be how colonial or eugenicist encounters might have shaped conceptions of birthing (see Stepan 1991; Peard 1999).

What my own research seems to demonstrate about embodied risk is that the label ‘at-risk’ or ‘risky’ does not seem to always be a tool of exclusion. Rather, being denied the opportunity to be ‘at-risk’ seems to be a vehicle of exclusion as well. Risk, in other words, is a cultural product given a specific moral lexicon depending on the ideological needs of a society at a particular moment in time. Using a post-structural analytic, we can understand that medicine is an institution where the construction of knowledge is produced via cultural knowledge about gender, sexuality, poverty and social normality (Foucault 1978). Biomedical interpretations about risk therefore do not just elucidate neutral epidemiological findings about ‘at-risk’ groups but instead situate risk and risky bodies vis-à-vis dominant norms of conduct, morality and social order. In order to understand the multiple levels that risk seems to work through in São Paulo, as well as its uses (for inclusion or exclusion) we need to move to an analysis of reproductive health, women’s negotiation of violence and discrimination, and the risks embedded in both, that refuses to disconnect various experiences and conceptions of life, including the medical, the lay, or even ‘bare life’ (Agamben 1995). Unfortunately, research that takes its starting point at women’s own local conceptions of risk, of effective interventions, or of embodied experience, is still a nascent field.

Indeed, a critical eye needs to be turned to feminist health interventions. My research supports the conclusion that promoting the empowerment of poor and marginalized women requires, first, self-reflexive attention to the methodologies of

intervention: how problems are conceptualized, and how change is conceived (Rivkin-Fish 2005). Feminists can position themselves as activist-partners with the women they aim to work for, but this positioning is not enough. There needs to be a genuine shift away from health campaigns that aim to educate poor and marginalized women. Interveners must be open to their own re-education by their ‘targets’. Rather than ‘deliver’ to Brazil better and safer modes of birthing which my research clearly demonstrates are necessary, health interventions need to find an approach that acknowledges women’s diverse responses to birthing technologies and works within social and cultural and economic systems that mark identity and inequalities (for both ‘targets’ and ‘interveners’).

While caesareans do pose some demonstrated dangers to health, I agree with women’s own assessments about the risks involved in c-sections versus vaginal births. In this way, I recognize that women’s relationships with technologies are moulded not only by need, pragmatism, and authoritative and local knowledge, but also by a host of identity markers, such as race, age, and conceptions of the body. Knowing this, and what I know about how ‘empowerment’ is constructed during interventions, I still remain ambivalent about doing away with any notion of empowerment or self-determination for women during birthing and about disregarding the possibility of a women’s health intervention being crafted that accounts for power asymmetries and inequalities. I argue that perhaps women’s strategies and desires should be understood as potentially leading to empowerment, or better put, as a set of dynamic practices that can be used to demarcate the way that empowerment might be fostered for women seeking quality health care.

Finally, I would make two critical suggestions to improving the public maternal health care system in São Paulo, as well as elsewhere in Brazil. First, I argue that doctors in the public system need to be more seriously engaged with public health policy development. Public health doctors are the main link between women and public health policies and campaigns, so while the relationship between provider and patient must be strong, so too must the relationship between public health development actors and health care providers if health campaign messages are to be successfully translated from the policy design room, to the clinical encounter, to the home. There needs to be a concerted effort made to bring doctors into early discussions about public health direction and reforms. Again, while I believe my research makes clear that there needs to be more for advocating for women's health empowerment and rights that is compatible with women's own conceptions and experiences with maternal health risk, what is less clear, but still entirely necessary, is this need to engage doctors. While considerable money, time and effort are being invested into the Humanisation of Birth Campaign, the aim of the campaign is being lost. This is not because of a poor understanding of the constraints and violence women face in the public health system during vaginal delivery, but because implementation is being thwarted by unidirectional relationships between public health actors and doctors, doctors and their patients, and almost zero relationship between patients and public health actors. The result has been a lack of meaningful exchange of health information, and thus little change in how vaginal delivery unfolds for women in the public health system. If public health campaigns are to succeed, public health policy makers must ensure that their educational materials are not gathering dust in doctor's

offices, or clinic store rooms. This means getting into the clinic, making contact with doctors, and engaging them in public health design and delivery.

Secondly, I think my research contributes further to the recognition that detailed ethnographic work is needed in public health policy research in Brazil, as elsewhere (see Scheper-Hughes 1992; Biehl 2007; for elsewhere see Farmer 1992; Rivkin-Fish 2005, Rapp 2000). While anthropological research has been critiqued for its reticence to make policy prescriptions, I believe that what anthropological research does is break down old ways of thinking and acting, and open up new directions for improved interventions. By approaching health systems and institutions with a focus on the dynamics of local knowledge, practices and meaning-making, we demarcate routes for constructing health interventions that treat 'targets' on their own terms, and requires 'interveners' to self-examine how they effect and impact interventions. Only via inclusive policy development that incorporates the voices of target populations can we yield more effective and context-specific policy. Public health policy is not solely 'evidence-based'; rather, it is shaped by competing power dynamics and politics. In the city of Sao Paulo, this process is even more intensified, as sharp socioeconomic divisions ensure that some voices are highlighted while other voices are routinely silenced or marginalized. Thus, I suggest that research on risk in health not only focus on the biological, but the local social, political, economic and moral processes that intersect with biological processes.

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