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## Childbirth in Santiago de Chile:

Stratification, Intervention, and Child Centeredness

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*On the basis of ethnographic work with women from different economic and educational backgrounds in Santiago, I describe the experiences of labor and birth from the point of view of women's priorities, socioeconomic constraints, and relationships with the medical system. I specifically focus on their desires expressed during the late prenatal period and their narratives of the actual birth. Class and the differences in opportunities resulting from educational and class inequalities melt down into near invisibility as vulnerability rises and women become increasingly subjected to medical decision making. The long-standing Chilean focus on child centeredness, while shown to benefit bonding, can work to obliterate women's own desires and choices by encouraging them to "sacrifice their all" for the sake of the baby. This kind of sacrifice defines the meaning of the maternal body in Chile. I suggest further analysis of these factors is essential for an understanding of the hypermedicalized Chilean context. [Chile, childbirth, medicalization, motherhood]*

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Some anthropologists have suggested that understanding the relationship between medicalization and women requires a multidimensional approach, one that considers technology as a product of historical, cultural, and political contexts to which women respond (Lock and Kaufert 1998:2). Others highlight the relationship among technology, medicine, medical systems, women's bodies, and body politics (Davis-Floyd 2001, 2004; Martin 2001) and the need to account for women's differentiated access to knowledge (including the technical knowledge and ideology underlying medical and hospital procedures; see Esposito 1999; Lazarus 1994). The anthropology of birth and reproduction has demonstrated the need for a more comprehensive consideration of cultural differences, power structures, meanings, and practices of childbirth in different contexts (e.g., Jordan 1993; MacCormack 1994), and the need for long-term studies that consider birth within social, medical-cultural, and political economic contexts of maternity care that tackle both women's priorities and the factors such as pain, fear, stress, and anxiety in context (Gamble et al. 2007:338–339). Martin (2001) calls attention to relevant differences in birth outcome and meanings that depend on differences in race, ethnicity, and class.

In this article, I reflect on the pregnancy and birth experiences of a group of women of different classes, income, and education levels in Santiago de Chile, a

society with significant social inequalities and differences in health attention and place of birth that are constructed according to the logic of the neoliberal organization of the health system. What are the main differences in meanings, priorities, and constraints throughout the process of becoming a mother for women in different social classes? What are the main differences affecting women's birth experiences that are because of their participation in Chile's differing health care systems? How do health system adscription, birth places, and information management relate to women's differing experiences of birth? Are there identifiable wider cultural trends that impinge on these differences? These are the guiding questions of this article. I first introduce contextual data for an understanding of current Chilean trends in childbirth. I then present the ethnographic findings of my work with 16 informants, highlighting the contrasts between their expectations before birth and their experiences of the actual event.

### The Chilean Case: The Cesarean Debate and the "Humanization" of Birth

Chile has one of the highest rates of cesarean births in the world (40 percent), with a strong difference between public hospitals (28 percent) and private clinics (60 or even 80 percent; see Agenja et al. 2006; Cabrera et al. 2006; Murray 2000). As in other contexts with lower c-section rates,<sup>1</sup> there is a marked difference in types of birth according to income and place of birth. In earlier research on Chile, Murray (2000; see also Murray and Pradenas 1997) placed the responsibility for high cesarean rates on doctors' options. Murray and Pradenas (1997:260–262) note that cesarean rates in Chile were already high in the 1980s at 27 percent (one of the highest in the world at that time) and identified a relationship between increasing cesarean rates and the privatization of the health care system. On the basis of 22 interviews with obstetricians, Murray (2000) specifically concluded that private practice obstetricians who transited from clinic to clinic at unexpected hours to attend deliveries were those with higher c-section rates. These physicians concentrated their patients in as few locations as possible and programmed births (mostly c-sections) as a time-management strategy, in contrast to physicians working at public hospitals where the number of births did not affect personnel income—a situation that remains true today. At the same time, when asked, most women in Chile said that they would prefer a vaginal birth (80 percent)<sup>2</sup> with no difference among those giving birth in hospitals and private clinics, income, or education (Angeja et al. 2006; Cabrera et al 2006; Murray 2000).

In Brazil, a country with similar birth outcome rates according to place of birth (private clinic vs. public hospital)<sup>3</sup> and kind of medical professional assisting labor (doctor or midwife), the academic and policy discussion on the subject has focused on a reductionist argument of "preferences" as a one-time option, obscuring the complexity of the problem. There appear to be two options: either a significant amount of women prefer more technological intervention and c-sections or they do not (Hopkins 2000; Potter et al. 2001), in which case the high prevalence of cesareans in the private sector is undesired by women—and what is mostly at stake is private doctors seeking to reduce time attending birth deliveries, maximizing their own benefit and income (Hopkins 2000).<sup>4</sup> Considering the bad publicity on the negative effects of c-sections in recent years and the low probability of women

speaking openly about their preferences, Béhague and colleagues (Béhague 2002; Béhague et al. 2002) have made the same point on the politics and pragmatics of “what women really want.”

Parallel to this trend, the awareness and critique of the hypermedicalization that turns women into patients who lose control over their own bodies has also increased in the last two decades (Davis-Floyd 2001, 2004; Martin 2001). In Latin America, the reconsideration of birth practices that empower women and respect their values, beliefs, and sense of dignity and autonomy during childbirth has been promoted under the names “humanization of birth” (Odent 1984; Wagner 2001) or “personalization of birth” (Sadler 2009). A “humanized childbirth” “promotes the active participation of women regarding decision making and other aspects of their own care, one that takes advantage of the expertise of both physicians and non-physicians, and allows them to work together as equals” (Behruzi et al. 2010: 2). This trend reached high social momentum during the First International Humanization of Birth Conference in Fortaleza in 2000, during which a range of over 1,800 academics and professionals claimed the need to fight against unnecessary and even dangerous interventions in the birthing process—including enemas, shaving of the pubic area, electronic fetal monitoring, anesthesia, and, above all, unnecessary cesareans. Instead, they proposed a humanistic model involving closer relationships among doctors, midwives, and mothers; alternative birth practices and places; and personalized rather than standardized care for each woman (see Page 2001).

In Chile until recently, the discourse on a “natural” (or “humanized”), less medicalized birth belonged to a small group of upper- and middle-class women (Godoy and Reynaldos 1984:152). A still marginal but increasing set of discourses along this line have permeated academia and policy innovations (Sadler 2009), inspired by foreign experiences (e.g., Misago et al. 2001; Santos and Siebert 2001). For example, in some Chilean hospitals a few “less medicalized” labor and delivery rooms have been implemented so that mothers can spend the different stages of labor in one place instead of having to be moved to a different room when birth is impending.<sup>5</sup> Rather than a discourse built around women’s rights and a call for control of themselves and their bodies, in Chile the current emphasis on the humanization or personalization of birth has been combined with the much more influential theories of attachment (e.g., Bowlby 1988; Lecannelier 2006) that constitute the basis for current policy and law on child rearing in the country.<sup>6</sup> The ideology of less medicalized births in this country now goes in tandem not with “women’s rights to choose” but, rather, with the attachment theory that insists on keeping mother and baby together in order to facilitate bonding and breastfeeding, thereby “enhancing” the mother–child relationship.

## Giving Birth, Before and After: The Experiences of 16 Women in Santiago De Chile

### *Research Methodology*

As part of my current research on early mothering in Chile during 2010–11,<sup>7</sup> I worked with a group of 16 women of different classes, incomes, and living areas in Santiago de Chile. I visited each mother monthly during a whole year to achieve a deep understanding of the process of becoming a mother in context. I first met with

these women during their third trimester of pregnancy and then visited them on a monthly basis in their homes until their babies reached one year of age. Taking into consideration that in Chile, birth styles and outcome are stratified in accordance with the place of birth (clinic vs. hospital) and the kind of medical professional assisting labor (doctor or midwife; see Cabrera et al. 2006; Murray 2000; Murray and Pradenas 1997), in what follows, I present the different priorities and possibilities regarding birth from the point of view of my informants involved in the different systems.

### *Three Groups of Informants*

For the purposes of this article, I have heuristically placed my informants into three groups; my groupings are based on which type of health care system they participate in and the place of birth they choose: *Group 1*: upper- and middle-class informants with tertiary education, who use the private health care system and choose to give birth in private clinics; *Group 2*: lower-middle-class informants with secondary or technical education, who use the public health system with a mixed arrangement of care in the prenatal period and who give birth in private clinics under a copayment system; and *Group 3*: lower-class informants who participate in the state health care system and who give birth in public hospitals.<sup>8</sup> Following the advice of Martin (2001) and McCourt (2010) to provide ethnographic accounts of the “times” lived by women giving birth, I highlight two moments in the process: their expectations and priorities one month before birth and their narratives, weeks after birth, of what actually happened during labor.

### *Planning and Preparation: Birth in Context*

The centrality and meaning of birth to my informants varies according to their educational level and their income. Hence, their pragmatic decision making (Lock and Kaufert 1998) varies according to their different possibilities and priorities within the Chilean maternity care system. I found that the main differences among them regarding their decision-making process had a great deal to do with the relevance they attributed to technical information and its sources, the weight they gave to their own mothers’ and kin experiences and support, and the role they assigned to medical care and the health care system, and much less to do with their perceptions of birth risk or the knowledge of “the experts.” As other researchers have noticed (Lazarus 1994; Zadoroznyj 1999), I also found that my more educated informants (Group 1) were much more concerned with information and control management than the women in the other two groups. Following the rationale of the Chilean private health system regarding women’s rights to personal selection of professionals and birth place, these women searched for a medical team that would provide clear, honest information and would also respect their own preferences. For these women, choosing the right professionals was an act of care and precaution—a “logic of choice” as Annemarie Mol (2008) calls it, and they stated that they would readily change practitioners if they did not meet expectations.

These informants started reading magazines and books (such as the Spanish version of *What To Expect When You’re Expecting* [Eisenberg et al. 2005]) and

registered on the website Babycenter (which is translated into Spanish) to access a weekly update of their fetus's "advances" "in real time." Most of their attention focused on expert information on mothering and child rearing, rather than on childbirth. They were "up to date" with local and global trends in attachment theories, breastfeeding, and early infant stimulation. This individualized search for advice contrasts with the roles they attributed to their own mothers, whom they thought of as sources of moral and logistic support, but not as legitimate sources of "technical" or even experiential information.

Two of these Group 1 informants were deeply inspired by the idea of a "natural birth."<sup>9</sup> They did their own research and took lessons with their partners to achieve a birth that would be "as natural as possible."<sup>10</sup> For them, the relevance of natural birth was tied together with the possibility of developing a secure mother-child bonding, and to a set of "attachment" beliefs and practices regarding child rearing, such as long-term breast feeding, resembling what anthropologists have named a (middle-class) tendency toward "intensive mothering" (e.g., Faircloth 2010; Hays 1996). Their appropriation of the natural-birth discourse was important to them, yet placed within the parameters of what they felt was reasonable risk management of mother and child safety. For example, Irene (economist, 32) became more and more committed to natural birth as she heard more about its benefits for her, the baby, and their relationship in the natural birth course. She chose to attempt to achieve her choices within the parameters of the private health system in Chile and her own management of risk:

I wouldn't do it [homebirth] because it is much riskier and, even though I believe this to be a natural process, if something happens I want to have the doctor, the pediatrician and everything by my side.

Her understanding of a natural birth highlights the achievement of a vaginal birth, avoiding painkillers and "unnecessary" medical intervention "as much as possible." Her midwife, the relevant companion to the couple, took on the role of her rights defendant against interventionist professionals in the clinic.

Low-income informants (Group 3) faced a rather different situation. They had prenatal exams in local medical practices and gave birth in public hospitals. Rather than placing their explicit concerns on information management and control, they placed those concerns on "continuity of treatment"—that is, a more personalized medical attention by a few professionals throughout the process (Lazarus 1994; Zadoroznyj 1999). Their early personal site selection and decision making were limited to choosing a hospital with a better reputation and to maintaining the option of complementing official advice with that of their mothers or sisters. Even if many times critical of the system and professionals, who could be rude and mistreating, these women in general had an obedient attitude toward medical advice and the prenatal control schedule.

Yet their obedience toward medical advice should not be confused with a passive attitude: "obedience" in this context appeared to be to them a concrete way of presenting themselves as responsible, caring mothers from an early stage—a role that is highly encouraged, even insisted on, by their social surroundings. Following the advice of mothers and other relevant women, they exercised patience toward

their maternity care professionals while sometimes quietly complementing publicly paid, free pregnancy and ultrasound exams with privately paid ones, as a means of extra care, concern, and enjoyment. Family support, specifically mothers' or other women's experiential knowledge (Abel and Browner 1998:320), and their own experiences formed their most important sources for developing a sense of safety and confidence.

These informants recognized improvements in the public health system that have bettered the treatment of the traditionally excluded. For example, as part of the state policy on early childhood *Chile Crece Contigo* (Chile Grows with You)—which highlights bonding, baby stimulation, and early mothering practices—they received music CDs to play to the baby in the belly and were advised about a set of exercises to keep them active during pregnancy and birth. They did not necessarily appropriate these practices as significant per se, but they did appreciate the material and advice as a sign of concern by authorities, who allowed them to feel “up to date” in new trends. Alejandra (housewife, 34) said:

I heard I should also get a book that I didn't receive (. . .). I have the CD back there in my room and I've been listening to it, but I know nothing about the program ChCC (. . .) I haven't informed myself . . .

Alejandra has too many other things in mind and two children to look after while pregnant, and she has not made any effort to get a less fragmentary knowledge of the program. Still she appreciates these offerings as a sign of concern from authorities. Melanie (25), a low-income, first-time single mother (with a technical midwife assistant degree) related meaningfully to this discourse, played the music, and did the exercises.

My Group 2 informants made use of a copayment system, which was implemented for the segment with higher income within the public health system earning at least \$500 a month. These families paid \$400 to get a state-subsidized birth in a private clinic. These Group 2 informants described to me multiple kinds of mistreatment, long waits, crowded rooms, and even hygienic problems that they either experienced or heard of in the public hospitals. Possibly because they managed to escape the public system, and to justify their decision to do so, they were more open to critiquing the public hospitals they avoided than those in Group 3: Angélica (40) explains:

It was inhumane. I came [to a public hospital] with high blood pressure (. . .) the obstetrician started with a vaginal exam and from then onwards I had contractions every five minutes (. . .) the older women in the room having their second child told me “Don't listen and don't say anything because these fools mistreat you when you complain.” I kept quiet and fainted a few times but no one noticed. I heard a midwife telling the woman next to me saying: “What do you complain about? Didn't you like “it”?”<sup>11</sup>

This kind of discourse evinces the reasons for the widespread bad reputation of the public health system, specifically the public view of hospitals as “second class,” and the efficacious campaigns by doctors, clinics, and private medical centers that

embody the dream of social mobility with their newer, brighter buildings and nicer professionals. Within this frame, some Group 2 informants told me that they decided to go to a private clinic to avoid “unnecessary suffering” during labor, specifically regarding long waits before painkillers and anesthesia were provided.<sup>12</sup> Camila (33) stated:

My sister-in-law told me that in the hospital they leave you in pain for much longer than in a clinic. The doctor also told me that in the clinic things are different, because in a hospital they put you under anesthesia just once and that’s it. But in the clinics, because you’re paying, the doctor asks for another anesthesia. So, pain is not an issue there (. . .) I used to be much more afraid of vaginal birth, now I am not.

Camila’s account brings the double sources of suffering—womanhood and poverty—to the forefront and points to the pragmatic need to soften at least what can be softened with the help of paid biomedicine. It is not surprising that for these women the search for a good, comfortable clinic became the first priority in their preparation for childbirth. They asked for advice and even visited the clinic before they decided, and they felt relieved to know they would avoid unnecessary mistreatment and pain. After having made this decision, they relied on the experts, on their own experience (in the cases of those who had given birth before), and, importantly, on other relevant women, usually relatives, as important sources of knowledge. Only two of the six informants in Group 2 read a couple of magazines and none of them read books or searched on the Internet for information while pregnant.

### *Labor Time and Birth Experiences*

With the exception of the two mothers who took childbirth education classes to help them achieve a natural birth, in our meetings one month before the expected date of birth, my informants seemed much more concerned with the arrival of the baby and were busy arranging rooms and purchasing or receiving clothes—and more broadly getting prepared for the important changes that were about to arrive, particularly in the case of those expecting their first child. Just as Murray (2000) observed with Chilean women, all of my informants claimed they would prefer a vaginal birth to a c-section; faster recovery and a better bonding experience were the main reasons provided. These preferences must be considered together with their assumption that they “would not risk anything happening to the baby,” and that they would make use of every (medical) resource available or make any medically required sacrifice. As Irene suggested in the previous section, even those concerned with having a birth “as natural as possible” were open to “fate” and to medical authority when the moment arrived. Their trust rose as the time of birth neared, while any sort of desire to fight for control over their bodies or against medicalization as a source of violence vanished.

In spite of my anthropological understanding of the Chilean medical system, I was nevertheless surprised (and disappointed) when 11 of these 16 healthy informants expecting healthy babies had c-sections, and only three of the remaining five

did not have labor inductions (via artificial oxytocin). As an anthropologist, I am not qualified to judge whether the medical indications in each case were or were not justifiable, but the results were striking. In this section, I focus on mothers' narratives of their experiences of labor, their accounts of the medical indications and procedures they experienced, and how, following their narratives, they came to believe that many of these could have been vaginal deliveries.

During pregnancy four informants had been indicated a cesarean delivery following previous c-sections, the main reason for cesarean in Chile (Salinas et al. 2007). One of these mothers, Ignacia (28, mother of one, Group 2) also had heard the argument that "her baby is too big." At this stage, the rest expected vaginal deliveries. In their last pregnancy exam (after our last meeting) three informants were prescribed a c-section delivery. Ester, a 26-year-old fine art professional (Group 1), explained:

I went to my doctor and he told me the baby was too big; he was supposed to weight 3,9kg . . . and my hips are too narrow. He told me I rather should have a c-section (. . .), vaginal birth would be too complicated.

Ester never questioned her doctor's decision until months after she gave birth to her baby boy. Camila (31, Group 2) was told that the baby was in the breech position and that she required a c-section: ". . . the baby never turned upside down and we waited until week 38. Then the doctor told me: "Ok, we'll get her out on Tuesday." Jennifer, a low-income 18-year old (Group 3) with an unexpected pregnancy, was told that she required a c-section because her 37-week prenatal exam showed that the baby's heartbeats were "too slow" and that the baby could suffer unnecessarily if it went through a vaginal birth, considering that her doctor also suggested that teenagers' deliveries are usually longer.

Two informants had scheduled Pitocin-induced births. Dafne, a 25-year-old lab technician (Group 2), explained that at week 38 in the last prenatal exam with her gynecologist, she was scheduled a birth date for the following week. "The baby is ready" she heard, but she did not hear any specific reason for the induction. In contrast, Soledad (office assistant, 31, Group 1), who had gestational diabetes, was passing week 40 when the doctor told her to schedule her birth on a specific date, because waiting too long was not recommended for pregnant women in her situation. These two first-time mothers were satisfied with their birth experiences: strong contractions began soon after the provision of artificial oxytocin, and in both cases they say they were very lucky to have a supportive, caring midwife close to them. The doctors ruptured their membranes and they were in labor for around six to eight hours. Similar to other informants with scheduled cesarean or induction, they appreciated the possibility of time management before and during birth. "It was a good thing leaving home without rushing, and then doing all the paperwork with enough time (. . .) later, when I was in labor I thought I couldn't imagine riding in a car with this pain (Soledad). It is hard to know whether this kind of comment is a kind of compensation in some cases.

Only Melanie (Group 3) and Rosa and Cecilia (both Group 1) went through spontaneous vaginal childbirth. Inspired by knowledge and their aim of achieving a "natural birth" with the least possible intervention, they waited for many hours at

home before going to the hospital and clinic, respectively. They achieved their aim of a vaginal birth after long hours in labor, more than 48 hours in Rosa's case, who waited 24 hours at home with soft contractions before calling the midwife and 24 more after the midwife told her it would be a long process. Yet once in the hospital, they went through vaginal exams by midwives and doctors to speed up cervical dilation, letting go of more orthodox versions of how to achieve a "natural" birth. Melanie's doctor performed an artificial rupture of the membranes because the baby "was too high and not in position." All of these informants asked for anesthetics at some point in the process to achieve relief from pain.

Finally, six informants went through emergency cesarean deliveries. (Two of them were originally scheduled to have c-sections, but they started labor before the planned date, so their cesareans were medically coded as "emergencies.") Another informant, Kelly (31, Group 2), experienced a sudden rise in her blood pressure and had to rush to the clinic after her last doctor's appointment. The final three informants had cesareans because of what their medical professionals called "lack of sufficient dilation." They all had a safe recovery and healthy babies, yet their experiences varied widely in terms of the time involved in the process, the relevant others involved, and, more importantly, their expectations regarding birth. I exemplify with the cases of Muriel (Group 2) and Irene (Group 1).

Muriel, a 39-year-old hairdresser having her first child, had always been very open to the idea of a cesarean in case it was required and was just not interested in getting further information than that provided by her gynecologist, an old client from the hairdresser's. After experiencing strong contractions for only one hour, she arrived at the clinic. They monitored her and a performed a vaginal exam to check cervical dilation: she had no dilation at all. Despite the small amount of time and the lack of cervical dilation—which is not considered sufficient for hospitalization (Greulich and Tarrant 2007; see also Holmes et al. 2001; Rahnama et al. 2006)—she was not sent back home. Instead, she was left in the clinic and was given synthetic oxytocin. She consequently felt terrible pain and asked for an epidural, which could not be provided without dilation, she was told. She felt out of control and swore against her husband and mother, who were with her all the time trying to comfort her. After three hours the professionals moved her from prelabor to a labor room, and they waited for another hour before she was prescribed c-section:

To wait and wait and wait, and the pain is terrible. I went through that: others don't suffer at all (...) at 1 they told me "you know what, we'll take you downstairs [labor room] to see what happens, just in case the baby is almost there." They said: "Ten more minutes, ten more minutes, dilate two more centimeters, two more." I just wanted him [the baby] out, but nothing happened. Then they came in and said: "You know what; we'll have to do a cesarean section because the baby's heartbeats are going up and down."

Irene's experience is extremely different from Muriel's. Irene—one of the Group 1 informants who took a course to achieve a natural birth—was extremely frustrated with her c-section, which she considered a failure in the process. When the day came she waited at home for 18 long hours while the contractions became stronger and more frequent. She did her breathing exercises and her husband helped with

massages until they, together with the midwife, decided it was time to go to the clinic. She first felt anxious after arriving at the private clinic and hearing that there were no beds available! With a contemptuous tone she reflected: “Fridays are the days for the scheduled c-sections, and they leave no room for us.” She had to go to another clinic, a distressing experience. She still managed to stay concentrated on the breathing and managing the pain. Unfortunately, Irene never dilated more than 6 cm. When the doctor told her she might have a c-section, she told me she lost concentration and felt terrible pain. Her main thoughts focused on the “problems in the attachment with the baby” and having what she called “an army” of doctors in the room. In the meanwhile, the doctor tried to calm her down and provided anesthetics. After 25 hours of labor she gave birth to baby Julieta, by c-section.

At first we were terribly upset. There were tears . . . my midwife tried to calm me down saying “it doesn’t matter, you did your best. It’s not your fault, it’s just the way it is,” and there was also the baby, they had to take the baby away. Then I got through, this was only for 30 or 20 minutes. Then it was all about the baby, which is what really matters.

Muriel and Irene experienced their cesarean deliveries in very different ways, according to their expectations and the value they attributed to birth itself. Muriel, a laid-back woman recently married to a younger man, opted for relying on expert knowledge and technology, under the idea that nothing should be risked in the case of a first-time mother in her late thirties, and easily placed trust in a professional she knew personally. Irene, a successful, hard-working professional, took birth as a further personal challenge. Inspired by the natural birth movement, she did all that was asked for her to achieve the desired birth. She consequently experienced her cesarean as a big failure.

Although Muriel’s and Irene’s experiences shed light on differing priorities and concerns about the technical knowledge of medical experts and the ways in which they managed these births, it is also true that for both of these women, as for the rest of my informants, the importance of the baby, and then the relationship and attachment, achieved a substantial relevance that temporarily eclipsed the women’s concern with or even awareness of their own body, plus any other concerns. Following the local Chilean encouragement of attachment, all the babies were born “with bonding” (*con apego*). This is the colloquial name for the now-widespread practice of placing babies on their mother’s chests right after they are born—as opposed to the older custom of separating the baby from the mother for a long time after birth and during their stay at the hospital—for some minutes in the case of hospital-born babies and up two hours in Rosa’s case.

In our first meetings two weeks after delivery, my informants, all of whom gave birth to healthy babies, were getting used to their new role as mothers and were focused on their newborns, breastfeeding, and trying to get a few hours of sleep. With the exception of Irene, who at this stage blamed the cesarean for her having problems with breastfeeding and bonding,<sup>13</sup> their attitudes toward their birth experiences were benevolent and they were simply grateful for having a healthy baby at their side.

McCourt and Dykes (2010) note that women may be more critical of their birth experiences later in time. Six months after birth, my informants recalled their experience with distance, and some provided more details than in previous meetings. Now that things had cooled down, some did indeed have less romantic, more critical perspectives on their birth experiences. For example, Ester, the first-time mother who was diagnosed a c-section because of her small body contexture, gave birth to a 3.5 kg baby, smaller than was originally predicted. She wondered whether it could have been a vaginal delivery and relieves herself thinking she will try vaginal birth with her second baby. What will happen when these women confront pregnancy and labor again and, as “the time” arrives, their priorities and feelings about their prior births mix up, and their sense of vulnerability increases?

### Birthing in Santiago: The Limits of Class Stratification in the Face of Medicalization

The hypermedicalized birth experiences of the women in this article evidence a poor and unequal distribution of information regarding both labor and medical and hospital procedures (Esposito 1999; Lazarus 1994) available to informants at the time of making their decisions before and during labor. During the prenatal period, stratification operates as women with less education become much more open toward medical authoritative knowledge (even fatalistic, see Blaxter 1990) than the more empowered middle-class women who require justification of suggested procedures.

At this stage, middle-class, tertiary-educated women (Group 1), who are more concerned with information management and control, require further details and explanation for prescriptions and procedures. This unequal distribution of information and control in the prenatal stage does play a role at the time of confronting labor, when vulnerability and openness to experts’ decisions rises. For example, Muriel (Group 2), who barely prepared for birth and was ignorant of basic information regarding the physiological process of labor, would have possibly waited longer at home before going to the clinic if she had been more informed or motivated for it.

On the other end, two of the five vaginal births in this study correspond to informed women who were firmly committed to achieving vaginal birth. Rosa proudly published on her Facebook page: “After three days of labor, Gaspar arrived,” receiving all kinds of congratulations for her strength, to which she replied that it had been the most important experience in her life, and that she did it all for her son (not for herself). At the other end of the city, Melanie—whose midwife assistant studies armed her with privileged information—also felt proud for having managed to spend a very long time before she asked for anesthetics. For these informants a vaginal birth was important, and they prepared and fought for such a birth.

These informants’ attitudes are to some extent reminiscent of Martin’s (2001) account of middle-class women in a similar situation in the United States, who in retrospect would have waited longer before going to the hospital to avoid being “caught” at the hospital, following a logic of resistance. These informants of mine made use of their very different sets of resources to achieve their goals: Rosa paid a midwife who guided her throughout the process; Melanie could not gain access

to the less medicalized room in the hospital (which required drawing lots) and so approached her desired birth as much as she could within her means. Paradoxically, though, Melanie's desire for a less medicalized birth had more chances to be fulfilled in a public hospital than in a private clinic. These women's main inspiration for desiring a less medicalized or more humanized birth was their primary concern with motherhood and attachment, while discourses regarding women's rights regarding their bodies or women's oppression—a main inspiration of the women in Martin's study—were almost nonexistent for my Chilean informants.

Overall, rather than a question of "preference" (Béhague 2002; Hopkins 2000; Potter et al. 2001), for the women in my study the achievement of vaginal birth—particularly for those giving birth in clinics—relied importantly on information management throughout the process, more importantly on women's commitment and the value they assigned to this kind of birth, and most importantly on the supportive or nonsupportive care they received from their medical professionals. In the global birth-activist discourse, which focuses primarily on the importance of achieving normal, physiologic, vaginal birth, these findings are controversial considering that for the women in my study, type of birth is only one of several preoccupations during pregnancy, and rarely a priority or a meaningful fulfilling event for its own sake.

In this article, I describe how informants in Group 2, who are mostly first generation outside of poverty in a situation of partial trespassing of social thresholds in a highly stratified society, placed most of their efforts regarding birth toward achieving the continuity of care and dignity that they believed would be provided by private practice and private clinics ("the best possible birth"), trusting the process to paid medical authoritative knowledge. With the exception of Melanie, women in Group 3 limited their birth preparation to following medical indications and hopefully selecting a nicer hospital with a better reputation regarding mistreatment. Women are making their pragmatic decisions (Lock and Kaufert 1998) generally without taking into account nonmedical information regarding birth that might change their priorities and birth preparations.

Differences in opportunities, information, and priorities in the prenatal period appear to give a much greater degree of choice to wealthier or more educated women (Group 1 in my study). Yet the medical management of the dynamics of labor with its resulting interventions, including covertly prescribed "emergency cesareans," contradict that very finding. For example, during this period none of the informants who were prescribed a cesarean because of a previous cesarean questioned this controversial medical decision (e.g., see Landon et al. 2004), an important finding considering that repeat cesarean is one of the main reasons for the high rate of cesarean deliveries in Chile (Salinas et al. 2007).<sup>14</sup> The birth outcomes of all three groups of women in this study show that as the time of birth approached, the seemingly clear-cut stratified divisions in birth opportunities—the educational advantage, health system adscription, and place of birth (private clinic or public hospital)—melted down and seemed to become irrelevant when we observe what actually took place during and after labor.<sup>15</sup>

The women's stories recounted in this article certainly cannot provide a detailed account of the experiences of wider groups of women in the population. Yet these women's stories and experiences do call attention to the necessity for further research

that focuses specifically on the negotiations women confront as “the time clock starts” (Martin 2001:140) and women’s decrease in control rises in each of the differing health care systems described in this article. In this highly interventionist Chilean medical system, time management and women’s informed disposition to confront uncertainty and anxiety constitute pivotal variables for understanding birth outcomes.

In the previous sections, I have shown how during the prenatal period, birth (interest in and access to) knowledge and priorities are mostly stratified by education level and material resources. However—and in line with birth intervention rates in this country—as the time of birth approaches and vulnerability and risk increase, the sociocultural stratification of “freedom of choice” regarding degree of medicalization of birth (which differs significantly during these women’s prenatal periods when they make choices about the kind of birth and the kind of care they want to have) melts down, collapsing in the end into general acceptance of the choices made for these women by the medical system.

## Conclusion

This study of birth-giving women in Santiago demonstrates the need to consider the wider sociocultural (Davis-Floyd 2004; Jordan 1993), political-economic, and medical-cultural context in which women negotiate priorities, constraints, and meanings of birth at different stages. First, in Chile birth cannot be understood separately from traditionally rooted ideas of motherhood, which are currently being reinforced by the increasingly widespread trends of attachment theories and long-term breast feeding. Womanhood is only completed by motherhood in a country in which kinship roles and gender are constructed around the axes of the women-mother and the men-child (Montecino 2010; Morandé 1981). As the accounts of my informants in this study confirm, in this context women of whatever group or class are expected to do anything within or even beyond their possibilities for the well-being of the child; birth is one in many technologies for the consolidation of child centeredness and the nourishing mother.<sup>16</sup>

For decades feminist academics have studied the different relationships that women establish with biomedical systems, importantly inspired in a microphysics of power and body politics. The main metaphor under which these feminist scholars have worked is the body (Lock and Scheper-Hughes 1987)—a female body that discovers itself and tries to avoid social control and power. Yet my informants were not interested in placing their own bodies as a locus of resistance. On the contrary, they put their bodies at the service of the child. It is the baby’s existence and not birth that fulfills them, so even if a “perfect birth” may be desired, they do not really relate to the global birth-activist idea and ideal that the more empowering their births, the more empowered they will be as mothers. In contrast to this ideal, the ideology promoting less-medicalized births in Chile goes in tandem with the attachment theory that promotes keeping mother and baby together in order to facilitate bonding and breast feeding—thereby enhancing the mother-child relationship—and not with “women’s right to choose.”

In this context, it is not surprising that my informants’ critiques of their birth experiences only appeared in their discourses months later, after the ecstasy of the

baby's arrival had diminished. The baby was so important that all the rest—for example, the psychological effects of a mother's negative birth experience—became shadowed. Time is a relevant factor here. Women have to make important decisions regarding their birth precisely during the time in which they are less aware or critical about procedures. They may regret those decisions later, when, freed from the hot emotions that accompany the direct experience of birth, they can engage in colder, more intellectual analyses.

Second, in this context women's pragmatism regarding birth goes hand in hand with neoliberal uses of medicine under the logic of choice or purchase, rather than a logic of care (Mol 2008), highlighting the multiple subjectivities—the patient–consumer, attendant–provider—at stake (Rutherford and Gallo-Cruz 2008:93). Women escaping (resisting) mistreatment by the public health system privilege the aesthetics of a nice place for birth and the upwardly mobile trespassing of class boundaries that achieving that “nice place” entails, trusting the rest to the experts. In the end they are able choose the place of birth but are not able to choose the type of birth, no matter what their class, social status, or education level. As we have seen, their medical treatment during birth tends to melt them down into simply patients subjected to medical decisions.

Finally, this study highlights the need for further research on the medical system's rationale for its current highly interventionist practice and the understandings and beliefs about women and birth held by medical personnel. It is well known that medical practitioners make various decisions before and during labor without informing women (Murray 2000), and that a second opinion reduces the chances of a cesarean by 25 percent (Althabe et al. 2004). Further, understanding of medical priorities and negotiations would allow a better understanding of what actually took place in these and other births.

## Notes

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1. For example, in Barcelona private maternity units have an average of 38 percent of c-sections, while public hospitals have 19 percent (Salvador et al. 2009). In Greece, higher rates of cesareans are also associated with a higher income (Mossialos et al. 2005). Exceptionally, in Norway the rates are inverted (Tollånes et al. 2007)

2. The reasons women gave for choosing either vaginal childbirth or a cesarean were the same for groups, safety (for mother and baby) and a fast recovery.

3. Thirty-one percent of c-sections in the public sector and 72 percent in private hospitals (Hopkins 2000).

4. Previous to 1997, sterilization was virtually illegal for poor women in Brazil, but it was allowed and reimbursed as a consequence of a c-section, so many women requested this type of delivery to get sterilized (Barros et al. 1991).

5. See Complejo Asistencial Doctor Sótero del Río (n.d.).

6. Following well-established medical, developmental, and psychological theories mostly inspired in attachment theory and developmental psychology, this program commits to securing opportunities to the newly born citizens by attacking biological, psychological, and social inequalities since the beginning of life (Silva and Molina 2006–10:20). See also Chile Crece Contigo (n.d.).

7. See Murray (2010–2013).

8. In Chile, 70 percent of the population is affiliated with the public health system (FONASA), 16 percent with the private health system (ISAPRE), and 14 percent with other systems. FONASA categorizes its population (families) in four groups (A, B, C, and D) according to monthly income and number of dependent people in the household. The two groups with lower income (A and B) have access to health free of payment; families in C and D pay established percentages for health service. The system allows beneficiaries to attend “modalidad institucional” (public services and hospitals) and “libre elección” (private practice, paying a percentage). In this study, women in Group 1 participate in the ISAPRE system; women in Group 2 participate in FONASA (C and D); and women in Group 3 participate in FONASA (B).

9. This paradigm is currently encouraged by WHO Better Births Initiative (n.d.).

10. For a critical account of the natural-birth discourse see Michie and Cahn (2000).

11. These accounts resemble the experience by low-income informants in the United States (e.g., Martin 2001:154).

12. In Chile, the administration of epidural anesthesia is a routine procedure, and the Ministry of Health guarantees analgesia to every birth in the public system.

13. Her daughter was not gaining enough weight, and she was prescribed with formula milk (she chose soy formula). Irene did not give up and contacted the La Leche League to help her achieve natural breast feeding. After a couple of months, she succeeded.

14. The most frequent reasons adduced for c-section prescription are fetal suffering (22 percent), failure in the progress of labor (20 percent), previous cesarean (14 percent), and breech presentation (11 percent; see Salinas et al. 2007).

15. This is consistent with Cabrera and colleagues’ (2006:95) quantitative finding, which suggests that in Concepción, Chile, when considering only women with possibilities of a vaginal birth and excluding elective cesarean, for every two women who achieve a vaginal birth in the public system, only one does in the private system.

16. See also Godoy and Reynaldos’ (1984) study for a similar observation in the case of low-income mothers in the 1980s in Chile.

## References Cited

Abel, Emily, and Carol Browner

1998 Selective Compliance with Biomedical Authority and the Uses of Experiential Knowledge. *In Pragmatic Women and Body Politics*. Cambridge Studies in Medical Anthropology. Margaret Lock and Patricia Kaufert, eds. Pp. 310–326. Cambridge: Cambridge University Press.

Angeja, Alea, A. Eugene Washington, Juan Vargas, Ricardo Gomez, Iván Rojas, and Aaron Caughey

2006 Chilean Women’s Preferences Regarding Mode of Delivery: Which Do They Prefer and Why? *BJOG: An International Journal of Obstetrics and Gynaecology* 113(11):1253–1258.

- Althabe, Fernando, José Belizán, José Villar, Sophie Alexander, Eduardo Bergel, Silvina Ramos, Mariana Romero, Allan Donner, Gunilla Lindmark, Ana Langer, Ubaldo Farnot, José Guilherme Cecati, Guillermo Carroli, and Edgar Kestler  
 2004 Segunda opinión obligatoria para reducir cesáreas innecesarias en Latino América: Un estudio controlado randomizado en racimo. *Revista Chilena de Obstetricia y Ginecología* 69(5):404–338.
- Barros, Fernando, César Victoria, J. Patrick Vaughan, and Sharon Huttly  
 1991 Epidemic of Caesarean Sections in Brazil. *Lancet* 338(8760):167–169.
- Béahgue, Dominique  
 2002 Beyond the Simple Economics of Cesarean Birthing: Women's Resistance to Social Inequality. *Culture, Medicine and Psychiatry* 26:473–507.
- Béahgue, Dominique, César Victoria, and Fernando Barros  
 2002 Consumer Demand for Caesarean Sections in Brazil: Informed Decision Making, Patient Choice or Social Inequality? A Population Based Birth Cohort Study Linking Ethnographic and Epidemiological Methods. *British Medical Journal* 324(7343):324–330.
- Behruzi, Roxana, Marie Hatem, William Fraser, Lisa Goulet, Masako Ii, and Chizuru Misago  
 2010 Facilitators and Barriers in the Humanization of Childbirth Practice in Japan. *BMC Pregnancy and Childbirth* 10:25.
- Blaxter, Mildred  
 1990 *Health and Lifestyle*. London: Routledge.
- Bowlby, John  
 1988 *A Secure Base: Clinical Applications of Attachment Theory*. London: Routledge.
- Cabrera, Jorge, Germán Cruz, Clemencia Cabrera, Marjorie Cisternas, Carmen Soto, Katia Sepúlveda, Sonia Sepúlveda, Hilda Teuber, and Heriberto Araneda  
 2006 Características del peso, edad gestacional y tipo de parto de recién nacidos en el sistema público y privado. *Revista Chilena de Obstetricia y Ginecología* 71(2):92–97.
- Chile Crece Contigo  
 N.d. Sistema Integral de la Infancia. <http://www.crececontigo.gob.cl>, accessed March 22, 2012.
- Complejo Asistencial Doctor Sótero del Río  
 N.d. CASR ofrece atención de parto integral. [http://www.hospitalsoterodelrio.cl/home/index.php?option=com\\_contentandview=articleandid=150:casr-ofrece-atencion-de-parto-integralandcatid=1:latest-newsandItemid=121](http://www.hospitalsoterodelrio.cl/home/index.php?option=com_contentandview=articleandid=150:casr-ofrece-atencion-de-parto-integralandcatid=1:latest-newsandItemid=121), accessed March 22, 2012.
- Davis-Floyd, Robbie  
 2001 The Technocratic, Humanistic, and Holistic Paradigms of Childbirth. *International Journal of Gynecology and Obstetrics* 75(1):S5–S23.  
 2004[1992] *Birth as an American Rite of Passage*. Berkeley: University of California Press.
- Eisenberg, Arlene, Heidi Murkoff, and Sharon Mazel  
 2005[1984] *Qué esperar cuando se está esperando [What to expect when you're expecting]*. Bogotá: Editorial Norma.
- Esposito, Noreen  
 1999 Marginalized Women's Comparisons of Their Hospital and Freestanding Birth Center Experiences: A Contrast of Inner-City Birthing Systems. *Health Care for Women International* 20(2):111–126.
- Faircloth, Charlotte  
 2010 "If They Want to Risk the Health and Well-Being of Their Child, That's Up to Them": Long-Term Breastfeeding, Risk and Maternal Identity. *Health, Risk and Society* 12(4):357–367.

- Gamble, Jenny, Debra K. Creden, Chris McCourt, Jane Weaver, and Sarah Beake  
2007 A Critique of the Literature on Women's Request for Cesarean Section. *Birth* 34(4):331–340.
- Godoy, Marcela, and Carolina Reynaldos  
1984 Una aproximación psicológica a la maternidad en mujeres de estrato social bajo. *Escuela de Psicología*. Santiago: Pontificia Universidad Católica de Chile.
- Greulich, Betsy, and Beth Tarrant  
2007 The Latent Phase of Labor: Diagnosis and Management. *Journal of Midwifery and Women's Health* 52:190–198.
- Hays, Sharon  
1996 *The Cultural Contradictions of Motherhood*. London: Yale University Press.
- Holmes, Paul, Laurence W. Oppenheimer, and Shi Wu Wen  
2001 The Relationship between Cervical Dilatation at Initial Presentation in Labour and Subsequent Intervention. *BJOG: An International Journal of Obstetrics and Gynaecology* 108:1120–1124.
- Hopkins, Kristine  
2000 Are Brazilian Women Really Choosing to Deliver by Cesarean? *Social Science and Medicine* 51:725–740.
- Jordan, Brigitte  
1993 *Birth in Four Cultures*. Long Grove, IL: Waveland.
- Landon Mark B., John Hauth, Kenneth Leveno, Catherine Spong, Sharon Leindecker, Michael Varner, Atef Moawad, Steve Caritis, Margaret Harper, Ronald Wapner, Yoram Sorokin, Menachem Miodovnik, Marshall Carpenter, Alan Peaceman, Mary Jo O'Sullivan, Baha Sibai, Oded Langer, John Thorp, Susan Ramin, Brian Mercer, and Steven Gabbe  
2004 Maternal and Perinatal Outcomes Associated with a Trial of Labor after prior Cesarean Delivery. *New England Journal of Medicine* 351(25):2581–2589.
- Lazarus, Ellen  
1994 What Do Women Want? Issues of Choice, Control, and Class in Pregnancy and Childbirth. *Medical Anthropology Quarterly* 8(1):25–46.
- Lecannelier, Fernando  
2006 Apego e intersubjetividad: Influencia de los vínculos tempranos en el desarrollo humano y en la salud mental. Santiago: LOM.
- Lock, Margaret, and Nancy Scheper-Hughes  
1987 The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly* 1(1):6–41.
- Lock, Margaret, and Patricia Kaufert  
1998 Introduction. *In Pragmatic Women and Body Politics*. Cambridge Studies in Medical Anthropology. Margaret Lock and Patricia Kaufert, eds. Pp. 1–27. Cambridge: Cambridge University Press.
- MacCormack, Carol  
1994 *Ethnography of Fertility and Birth*. Prospect Heights, IL: Waveland.
- Martin, Emily  
2001[1987] *The Woman in the Body*. Boston: Beacon.
- McCourt, Christine  
2010 How Long Have I Got? Time in Labour: Themes from Woman's Birth Stories. *In Childbirth, Midwifery and Concepts of Time. Fertility, Reproduction and Sexuality*, 17. Christine McCourt, ed. Pp. 184–201. New York: Berghahn.
- McCourt, Christine, and Fiona Dykes  
2010 From Tradition to Modernity: Time and Childbirth in Historical Perspective. *In Childbirth, Midwifery and Concepts of Time. Fertility, Reproduction and Sexuality*, 17. Christine McCourt, ed. Pp. 17–36. New York: Berghahn.

- Michie, Helena, and Naomi R. Cahn  
 2000 Unnatural Births: Cesarean Sections in the Discourse of the Natural Childbirth Movement. *In* Gender and Health an International Perspective. Carolyn Sargent and Caroline Brettel, eds. Pp. 44–56. Upper Saddle River, NJ: Prentice Hall.
- Misago, Chizuru, Carl Kendall, Paulo Freitas, Kiyoshi Haneda, Dirlene Silveira, Daisuke Onuki, Taeko Mori, Toru Sadamori, and Takusei Umenai  
 2001 From “Culture of Dehumanization of Childbirth” to “Childbirth as a Transformative Experience”: Changes in Five Municipalities in East Brazil. *International Journal of Gynecology and Obstetrics* 75:S67–S72.
- Mol, Annemarie  
 2008 *The Logic of Care*. New York: Routledge.
- Montecino, Sonia  
 2010[1991] *Madres y huachos. Alegorías del mestizaje chileno*. Santiago: Catalonia.
- Morandé, Pedro  
 1981 Consideraciones del concepto de cultura en Puebla desde la perspectiva de la sociología de la cultura de Alfred Weber. *CELAM Religión y cultura* 47:182–198.
- Mossialos, Elias, Sara Allin, Konstantinos Karras, and Konstantina Davaki  
 2005 An Investigation of Caesarean Sections in Three Greek Hospitals. *European Journal of Public Health* 15(3):288–295.
- Murray, Marjorie  
 2010–2013 *Motherhood and Early Childhood in Chile today: A Study of Mother–Infant Dyads from an Ethnographic Perspective*. No. 11100432. Funded by Consejo Nacional de Ciencia y Tecnología CONICYT. Santiago de Chile: FONDECYT Inicio.
- Murray, Susan  
 2000 Relation between Private Health Insurance and High Rates of Cesarean Section in Chile: Qualitative and Quantitative Study. *British Medical Journal* 321:1501–1505.
- Murray, Susan, and Fanny Pradenas  
 1997 Cesarean Birth Trends in Chile, 1986 to 1994. *Birth* 24(4):258–262.
- Odent, Michel  
 1984 *Birth Reborn*. New York: Random House.
- Page, Leslie  
 2001 The Humanization of Birth. *International Journal of Gynecology and Obstetrics* 75:55–58.
- Potter, Joseph, Elza Berquó, Perpétuo Ignez, Ondina Leal, Kristine Hopkins, Marta Souza, and María de Carvalho  
 2001 Unwanted Cesarean Sections among Public and Private Patients in Brazil: Prospective Study. *British Medical Journal* 323(7322):1155–1158.
- Rahnama, Parvin, Saeideh Zaei, and Soghra Faghizadeh  
 2006 Impact of Early Admission in Labor on Method of Delivery. *International Journal of Gynecology and Obstetrics* 92(3):217–220.
- Rutherford, Markella, and Selina Gallo-Cruz  
 2008 Selling the Ideal Birth: Rationalization and Re-Enchantment in the Marketing of Maternity Care. *In* Patients, Consumers and Civil Society. *Advances in Medical Sociology*, 10. Susan M. Chambré and Melinda Goldner, eds. Pp. 75–98. Bingley: Emerald.
- Sadler, Michelle  
 2009 *Re-visión del parto personalizado: Herramientas y experiencias en Chile*. Santiago: Chile Crece Contigo.

- Salinas, Hugo, Benjamin Naranjo, Jorge Pastén, and Beatriz Retamales  
 2007 Estado de la cesárea en Chile. Riesgos y beneficios asociados a esta intervención. *Revista Hospital Clínico Universidad de Chile* 18:168–178.
- Salvador, Joaquín, Gemma Cano-Serral, Maica Rodríguez-Sanz, Anna Lladonosa, and Carme Morel  
 2009 Inequalities in Caesarean Section: Influence of the Type of Maternity Care and Social Class in an Area with a National Health System. *Journal of Epidemiology and Community Health* 63:259–261.
- Santos, O. M. B., and E. Siebert  
 2001 The Humanization of Birth Experience at the University of Santa Catarina Maternity Hospital. *International Journal of Gynecology and Obstetrics* 75:S73–S79.
- Silva, Verónica, and Helia Molina, eds.  
 2006–2010 Cuatro años creciendo juntos. Memoria de la instalación del Sistema de Protección Integral a la Infancia. Santiago: Chile Crece Contigo.
- Tollånes, Mette, Anne Daltveit Thompson, and Lorentz Irgens  
 2007 Cesarean Section and Maternal Education: Secular Trends in Norway, 1967–2004. *Acta Obstetricia et Gynecologica Scandinavica* 86(7):840–846.
- Wagner, Marsden  
 2001 Fish Can't See Water: The Need to Humanize Birth. *International Journal of Gynecology and Obstetrics* 75:S25–S37.
- WHO Better Births Initiative  
 N.d. Best Evidence for Practices during Labor. <http://apps.who.int/rhl/resources/BBlebmtalkSlidescompressed.pdf>, accessed March 22, 2012.
- Zadoroznyj, Maria  
 1999 Social Class, Social Selves and Social Control in Childbirth. *Sociology of Health and Illness* 21(3):267–289.