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## Introduction

The purpose of this article is to move beyond the vulnerability model in women's health and to focus on women's strengths and their ability to maneuver and be resilient in spaces that restrict their access to adequate health and care (Harpham 2009). Resilience should be conceptualized as a dynamic process of intersecting coping mechanisms, influenced by numerous individual and social factors.

Understanding the concept and process of resilience can provide an important basis for theoretical development, empirical research, and public health intervention. Resilience can provide a framework within which to examine the consequences of multiple responses to health-related challenges.

Knowledge of the factors that promote resilience can provide an important foundation for a paradigm shift away from a focus on illness and pathology toward one that understands, explains, and nurtures health. However, special care must be used when working with the concept of resilience in health care, as resilience cannot be conflated with empowerment. Rather, resilience 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.

This paper aims to explore women's resiliency strategies in seeking out reproductive care in Sao Paulo, Brazil, with specific attention being paid to peripheral spaces of Sao Paulo and the low-income women of colour who reside in those spaces. Women's access to reproductive care, or the ways that women ensure their access to reproductive care, within urban spaces is an important area for research.

Harpham suggests that reproductive health services should be a priority area of research in urban spaces, as there appears to be “no urban advantage in reproductive health for poor women” (Harpham 2009:111). Rather, 'poor' women in urban environments tend to mirror their rural counterparts in terms of fertility rates, contraceptive use (Harpham 2009:111), and in urban Brazil maternal and infant mortality rates as well (Kilsztajn et al 2007:66). These rates differ dramatically, however, from urban women in higher income quintile groups with concurrent higher social status.

This paper explores the high rates of caesarean sections in Sao Paulo, Brazil. Sao Paulo has one of the world's highest incidences of caesarean births. Compared to a national rate of approximately 30 percent, Sao 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 potentially higher due to poor antenatal care and larger obstetric risk (Dumont et al 2001). This global inequality in access to caesarean technology is 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. Indeed, caesareans do not seem to be distributed based on medical need, but instead via socioeconomic status. 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 2005:222).

I argue that low-income women of colour from periphery communities seek out caesarean technology as a resiliency strategy, allowing them to assert their own “medicalized position” (477). I suggest 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 their low social status linked to seeking

reproductive care in public health 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. I also suggest that reproductive technologies are not neutral technologies, but rather that technologies associated with birthing experiences are linked to social worlds outside birthing as well. In sum, it seems that the meanings embedded in reproductive technologies cannot be assumed outside of local experience and context (de Bessa 2005).

During the course of my research in Sao Paulo, women explained how a vaginal birth is often a traumatic experience, characterized by physical violence and discrimination (most 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 (see also Behague 2002; McCallum 2005). 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 abandoned or 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, concerned about her and her child's well-being should not accept a vaginal childbirth. Instead, they suggest that women should seek out caesarean technology, often via surreptitious means or social networks, in order to ensure that pain medication will be available, the best surgeons will be on call, and that adequate post-natal care (involving a hospital stay) will be provided. I argue, then, that this is a resiliency strategy deployed in order to mitigate the physical violence, risk and insecurity embedded in vaginal deliveries.

In order to explore these ideas, this paper aims to do four things: First, I will use quantitative data to explore the reproductive health care experiences of low-income women of colour on a city-level scale, using data from the Brazilian Ministry of Health as well as data from the World Health Organization, the World Bank, the Pan-American Health Organization, and the United Nations Development Programme. Secondly, I will employ my own qualitative data from an in-depth study of a particular '*favela community*' in the periphery of Sao Paulo in order to provide a detailed analysis of women's own resiliency strategies for achieving quality reproductive care for themselves. Finally, I aim to place this data in an urban resilience lens, in order to explore how resiliency strategies, while not empowering themselves, might demarcate the routes to empowerment in reproductive health care for marginalized women.

## The Maternal Health Care System in Sao Paulo, Brazil

In order to fully understand why marginalized women in Brazil might choose to pursue a caesarean section as a resiliency strategy, it is important to contextualize this decision by discussing how this choice is influenced by the intersection of many factors, such as social class and race. In this way, McCallum explains, we can understand why caesarean sections are not sought based on rational decision making about the best form of childbirth, but rather, are sought as the best form of delivery they can attain in their own complex socioeconomic and racialized circumstances (McCallum 2005:218).

For the purposes of this paper, I define race as a “socio-political construct that has been used in part to justify the exploitation of groups classified as inferior” (Burgard 2004:1128), as well as a marker of identity, both personally and externally applied (although differently in each case). In Brazil, race has restricted equality of opportunity and health outcomes for centuries. Since colonial times, socioeconomic status of Brazilians has been inextricably linked to race; with white-skinned individuals dominating the highest class level (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 Sao 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 Sao Paulo. In Sao 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 Sao Paulo, zones that are mainly populated by poor Afro-Brazilians (The World Bank 1999:3; Kilsztajn et al 2007:66).

In Sao Paulo, due to historical processes of discrimination, 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 Sao 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, which 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 Sao Paulo City receive adequate antenatal care, in peripheral neighbourhoods, mainly populated by poor, black

and indigenous peoples, only 26.7 percent of women receive adequate antenatal care (The World Bank 2005:2).

## Seeking out Caesarean Technology: A resiliency strategy for low-income women of colour in Sao Paulo's Periphery?

Low-income women, faced with the prospect of a vaginal birth characterized by discrimination and prejudice in the public health care system, have become pragmatic users of caesarean technology. By receiving a caesarean section, women are ensuring that their birth will be assisted by better-qualified doctors, nurses and specialist health workers, who otherwise, they would not have had access to.

The process of persuasion and negotiation is a critical part of women's resiliency strategies. These women do not have the socioeconomic status or the social and economic resources necessary to challenge their discrimination directly. Instead, they must pursue indirect and informal strategies to overcome discrimination. Women in Sao Gotardo<sup>1</sup>, a periphery neighbourhood of Sao Paulo, 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, for them, achieving good quality health care was an ongoing struggle, which 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 de Barbosa 1995 for detailed account; also Scheper-Hughes 1992:188). 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. 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 'risk-takers' by their family and friends (see Behague 2002).

Analisa, a nineteen year-old, unmarried woman of lower socioeconomic standing, who had migrated from the North of Brazil when she was a child, described to me the methods she used to attain a caesarean section in a public hospital while giving birth for the second time. She explained how the first time she gave birth (when she was 17 and unmarried), the doctors and nurses had been rude and discriminatory towards her. She explained how she been ignored, left to sit in a waiting room while in labour and pain and had not been given drug treatments. When she went to the public hospital for her second birth, however, she went prepared to pressure the hospital staff into granting her a caesarean section. Analisa arrived late at the hospital, after being in labour for several hours already, and upon her arrival she became unruly and disobedient with the nurses and doctors. She refused to let the nurses take her vitals, refused to be confined to a bed and screamed for her family to be allowed to stay by her side. Analisa explained how she exaggerated her labour pains and complained loudly to nurses and

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1 Due to the sensitive nature of this research, pseudonyms for both the name of the community and the names of research informants are used. This research is based on approximately six months of ethnographic field work in the periphery community, or 'favela' community, just outside of Sao Paulo, Brazil. Research was conducted in a public health post/clinic and was approved by MIT's ethical review board, The Committee on the Use of Humans as Experimental Subjects. I worked in the health post as a research intern, and conducted home visits with community public health agents, as well as participated in clinic visits of pregnant women, and women who had given birth in the last four months. Over the months, more than 25 women were interviewed, along with 8 community public health agents, and 6 doctors. More informally, many others still shared their stories and their time.

doctors. According to Analisa, this approach, in tandem with an overcrowded waiting room and an overworked physician, prompted the medical staff to intervene through a caesarean birth.

Behague and McCallum have documented similar strategies enacted by women in order to attain a caesarean in Pelotas and Salvador, Brazil. Behague describes how low-income women sometimes bring along family members who pressure physicians on the pregnant woman's behalf, how women will go to the hospital on the day that they know a doctor who is more 'caesarean friendly' is working, and/or how women will use personal connections with hospital attendants from their community to ensure a caesarean birth (see Behague 2002; McCallum 2005).

Analisa's strategy to arrive at the hospital late into her labour is an important aspect of her story; it is a specific resiliency strategy associated with her *jeitinho* skills to attain a caesarean. Women from the periphery districts of Sao 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 2005) 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 available in the city. 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"<sup>2</sup>. 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 1998), as so many women have died while in labour and seeking medical attention (see McCallum 2005 for in-depth review of 'Dial-a-Maternity').

Women with low socioeconomic status often do not have empowering individual resources such as education, income or control over household income. Rather, they rely on informal health networks to empower themselves in the public health care system (Cattell 2001). These informal health networks are made up of neighbours, mothers, mother-in-laws and other members of women's socioeconomic community who aid women in making decisions about their health, especially pregnancy-related health and the best form of child birthing.

These informal health networks among women with low socioeconomic status facilitate the communication of stories of discrimination within the health care system and confirm that the type of care you receive is linked to socioeconomic status.

An example of this type of networking is seen in this interview with a few neighbourhood women:

**Christina:**...and then when his head was coming out he got stuck, I was going to kill him, oh, I didn't have any strength left. And all those women [nurses] around, saying, "Push! Harder!" I was dying for them to put the IV [oxytocin] on me, grab all of them and push them down, and

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<sup>2</sup> "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 2005).

I couldn't move, I couldn't! And then when the baby got stuck, the doctor said to me, "You're going to kill the baby!"

**Christina's neighbour:** Oh my god, can you imagine, without meaning it, you lose strength like that and your child dies? My Lord.

**Christina:** But they would have been the one's to blame, because they were insisting, making me have him like that, without anymore strength. They should have done a caesarean section!

**Christina's neighbour:** A caesarean! Huh. Yes, but you think they are going to waste money on anaesthesia...all those things, on you!?

**Maria's neighbour:** Oh, when they see that the person is dying, you rip all over down there, and there's nothing to be done.

**Maria:** Yes, only if the woman really does not have any strength at all, then they will do it.

**Neighbour:** Yes, only in the last of cases, if not they'll even use forceps if they have to, to avoid doing a caesarean section.

**Maria:** My sister-in-law, this one's sister, they took her baby out with forceps, poor thing, both of them...it's much worse when the child gets stuck.

**Neighbour:** Can you imagine? Stick metal in there to pull the child out, can you imagine the pain that one must feel? (Behague 2002:492-493)

In Sao Paulo, women in informal health networks commonly labelled women who did not attempt to pursue a caesarean section as 'risk-takers'. This characterization strongly influences and shapes women's desire to seek out a caesarean birth. Naturally, women fear a risky pregnancy and will go to great lengths to mitigate this risk and ensure a caesarean birth. Often young women had a sister or friend that had been treated very poorly during a vaginal birth in the public health system and they were now afraid that the same thing would happen to them, as we see in the above interview. Friends and/or sisters in health networks would describe to them what they had to do in order to ensure a caesarean section. In Sao Paulo, young-women explained how they were often coached by a friend on how to ensure a caesarean birth in a public hospital and avoid discriminatory and prejudiced care. This informal communication among women, including stories of discrimination, painful ripping, the chance of a child dying from a natural birth and the characterization of women who have vaginal births as 'risk-takers', puts pressure on women to seek out and ensure that they receive a caesarean section, by whatever means.

Informal health networks act as substitutes for the lack of individual social and economic resources, such as education and income, which women from the periphery of Sao Paulo usually do not have. These tight-knit networks, made up of women in the same socioeconomic demographic, work together to strengthen their resiliency strategies by fostering dialogue, sharing strategies and legitimizing fears and tales of discrimination. The information provided to women via these informal health networks shapes how women approach the public health care system, by empowering them with the information they need to negotiate the health care system, and sidestep discrimination via informal avenues.

## Thinking About Urban Health via an Urban Resilience Lens: Reconciling Resilience and Empowerment

Emergent literature on the urban poor has taken as its focus 'resilience'. The foregrounding of resilience in development and planning studies means taking seriously how households and individuals "carve

out a living for themselves” (Beall 2005:97), or in other words, how they empower themselves in constrained urban environments (see Beall 1996). Abdoumalig Simone, writing about African cities, describes the creative and resilient ways many Africans make their lives livable via self-empowerment. While Simone recognizes how African cities have become “ambivalent” (2005:2) spaces of refuge from vulnerable rural livelihoods, and that African cities typically service the needs and agendas of elites, he nonetheless argues for a conceptualization of Africa’s urban poor as active agents shaping their lives and the city (2-5). Indeed, while African cities are often perceived as spaces of disorder (Rakodi 2003:45-46) and informality, Simone suggests that informality and disorder cannot be conceived as compensation for unsuccessfully urbanized environments, or as ‘real’ economies which can be used as temporary instruments to bring about ‘normative’ urbanization (2005:4). Rather, Simone suggests that informal economies and activities can be understood as an alternative model for urban configuration (2005:4). In other words, Simone is arguing for a conceptualization of urban Africa as an empowering space for individuals and collectives to mould cities and livelihoods for themselves, despite external constraints which demarcate the social and physical topography of what is possible in terms of development and empowerment. Jo Beall describes a similar, but slightly less optimistic, model for thinking about urban resilience. Beall notes that despite constraining factors, such as the spread of HIV/AIDS, the imposition of Structural Adjustment Programs, and poor governance systems, Africa’s urban poor are resilient and adaptable – they deftly devise coping strategies for themselves and their families (2005:97-100). Beall remains cautious, however; she argues that while an urban resilience approach is meant to highlight the adaptability of the urban poor, it is not meant to obscure vulnerability or to exaggerate the options of those in poverty. Rather, a focus on how the urban poor strategically maneuver is meant to point to the significance of household level activity for policy, and to analyze the linkages between the small scale and the large scale (2005:100-101).

Using a ‘resilience’ lens to understand women's health in cities can highlight the ways that cities can potentially be empowering spaces for urban poor women by foregrounding how they are not passive actors, but resilient authors of their own empowerment in heavily constrained environments. However, I worry with the resilience literature that here is a tendency to conflate resilience with empowerment, to suggest that resilience might be equivalent to ‘thriving’, rather than note how resilience might be a step towards the potential for empowerment, or demarcate the way that empowerment might be fostered.

The relationship between women’s reproductive health and women’s empowerment has been of mounting interest to researchers and development organizations. Since the 1994 International Conference of Population and Development in Cairo made ‘empowering women’ one of its central themes and put to print in its policy document that women must be empowered in order for them to reach their reproductive goals, including ensuring healthy pregnancies and deliveries, researchers have gone to great lengths to define and measure women’s empowerment and to quantify the affects of empowerment on reproductive health (see Sen and Batliwala 2000). These researching groups have tended to use a framework that is based on the idea that empowering women, by improving their capacity to make key life choices in economic and social areas, will lead to better reproductive health outcomes. In these studies, empowerment of women, or the agency of women, is typically defined as ‘active decision-making power’ and is measured based on a woman’s formal participation in strategic household decision-making within the social and economic spheres (see Kabeer 1999). Emphasis is typically placed on women’s access to individual resources such as education, income and control over this income (see Kishor 2000).

Other researchers, however, have challenged the ability of this framework, or this particular perspective on empowerment, to accurately capture all the avenues through which women empower themselves or gain agency. Due to its strict focus on formal and active decision-making, the framework ignores the



needs and experiences of large numbers of women who live in societies that constrain their access to the empowering social and economic resources that lead to improved health outcomes (see Luke 2003; see Greenhalgh and Li 1995). As in Brazil, where low-income women and women of colour suffer from socioeconomic and racial discrimination, and are systematically denied educational opportunities and income earning jobs, we must ask: “What happens when the recognized avenues to empowerment are constrained?” (Luke 2003:284).

In order to understand the context and actions of these constrained women, we must widen and modify how we operationalize empowerment. Firstly, rather than only acknowledge active power, we must widen our framework to include the more passive or indirect forms of power, which women, who lack the formal power to engage in active decision-making, employ. Feminist researchers have highlighted the more informal or indirect methods that women use to gain agency, such as deception, passivity, ‘foot-dragging’ and other informal strategies (Luke 2003:283, see Scheper-Hughes 1992). Via these ‘backdoor’, or covert, methods of resistance, women are able to negotiate the strict confines of gender, race and/or class oppression.

Secondly, traditional empowerment frameworks emphasize individual resources such as education and income as the central means to gaining agency, while disregarding women’s solidarity or support networks as a valid resource in themselves (see Malhorta and Mather 1997). While many feminist researchers have documented instances of women formally joining together at the local level, others have documented the informal collaborations of women, such as networking. Although informal, networks serve as an adequate substitute for the social and economic resources that many women lack (Luke 2003:282; Cattell 2001). In Brazil, low-income women rely on informal health networks to provide information about pregnancy, delivery and health care. These networks are composed of family and neighbours who aid pregnant women in negotiating the health care system throughout their pregnancy. These networks act as messengers of stories of discrimination at the hands of health care workers, and also suggest measures that women can take to resist discrimination and pressure doctors into providing caesarean sections. These informal networks are a replacement for the individual social and economic resources that low-income women of colour in the periphery of Sao Paulo lack.

It follows then, that marginalized women in Sao Paulo are not necessarily actively or formally empowered but also do not lack empowerment, or agency, altogether. Rather, due to the socioeconomic and racial discrimination that they encounter from health care workers in the public system, these women are propelled to find informal strategies, such as medicalization of delivery, and a dependence on informal health networks, to empower themselves in order to gain access to a higher quality of maternal health care. I would characterize *this* as resilience: the informal manoeuvring strategies of those with little to no manoeuvring room in their daily lives. Strategies of resilience are found in the middle ground between structural constraints (in this case gender, race, class, social status) and individual agency. When conceptualizing agency, I prefer how Ahearn defines it: “the culturally constrained capacity to act” (Ahearn 2001:54) – marginalized women in Brazil do not have the formal capacity to directly challenge the systems of socioeconomic and racial discrimination that exist in the maternal health care system. As a result, these women challenge and resist discrimination by convincing doctors to perform caesarean sections through deception, passivity, ‘foot dragging’ (Scott 1985) and a reliance on informal health networking. These are the strategies of resilience open to them in their specific contexts.

## Conclusion: Public Health Interventions

So, does seeking out caesarean technology represent an attempt by women to gain greater autonomy in their reproductive lives, or does it represent a last resort taken by desperate women? In other words, could it be that women are aware of racial and social discrimination and are initiating processes of the deconstruction of power relations in which they have been inserted? If so, does a caesarean represent greater autonomy for women? Or, is a caesarean an option that is the inevitable result of a lack of accessible alternatives that a woman perceives to be trustworthy? My suggestion is that 'resilience' represents the middle ground here. A caesarean section for low-income women of colour is a resilience strategy, meaning that it is a coping mechanism that represents women's own agency under severe structural constraints.

What I have attempted to do in this paper is, using both ethnographic and quantitative data, to examine low-income women of colours' own understanding of their reproductive health options, what factors influence women's reproductive practices and strategies, and their own interpretations of their desire for caesarean technology. By focusing on women's own narratives I attempt not to ignore any of the historical or cultural factors that frame women's lives. Nor do I assume that women 'freely choose' caesarean technology, but rather, I suggest that women's reproductive resiliency strategies depend on the intersection of many factors in a woman's life, including social status, class, age and prevailing social representations of the body. In this way, women's reproductive choices are not based on 'rational' assessments of health costs and benefits, but are embedded in a series of ongoing negotiations, shifting decision-making, and manouvering within health institutions. In sum, when we consider the real impacts of racial and socioeconomic discrimination on the lives of women, it is not enough to simply identify and romanticize the resiliency strategies of these women. Although these women should not be characterized singularly as helpless victims, the right to autonomy – the “comprehensive notion of freedom where not only is the immediate choice uncoerced but the circumstances that structure choice are also free of the coercive dimension of oppression” (Sherwin, 1998:12) – in reproductive health care should also not be forgotten. In this way, it is important to recognize that resilience cannot be conflated with empowerment, but might, no less, steer the direction towards it.

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